I

THE HISTORICAL CONTEXT

Ethnohistory of the Puyallup Mental Health Care System

The Puyallup Indians were originally part of the fishing hunting-gathering peoples of the southern Puget Sound who spoke Lushootseed, a language within the Coast Salish language family. The definitive study of the aboriginal culture of the Puyallup, including their ethnopsychiatric beliefs and practices, is recorded in Smith (1940b). From the date of the first recorded contact of the Puyallup with Western culture, by the members of the George Vancouver expedition to the southern Puget Sound in 1792 (Morgan, 1979), the indigenous ethnopsychiatric beliefs of the Puyallup began to be challenged by the outsiders. Medical personnel with the first permanent settlement (1833) and the first American expedition (1841) to the area increased the conflict between Puyallup beliefs and practices concerning mental problems and those typical of Western medicine.

As the aboriginal stewards and guardians of their lands and waters the Puyallup Tribe, as an independent sovereign nation, has historically negotiated with several foreign nations including the United States. The Puyallup Tribe first formalized relations with the government of the United States on December 26, 1854 with the Medicine Creek Treaty. After "negotiations" with Isaac Stevens (at the time wearing three hats as Governor of the Washington Territory, Superintendent of Indian Affairs, and Indian Treaty Commissioner, and having been Head of the North Pacific Railroad exploration), the Puyallup and Nisqually Indians (along with several smaller tribes) signed the Treaty of Medicine Creek with its various provisions. The current boundaries of the Puyallup Reservation were eventually established on a small portion of their original subsistence land following their participation in the Northwest Indian War of 1855 through 1856.

Of nearly 400 treaties negotiated with Indian tribes during the Treaty making years from 1778 to 1871, only about two dozen provided for some kind of medical service (Department of Health, Education, and Welfare, 1978). The Puyallup Treaty of Medicine Creek is one of these. Article 10 in this Treaty provides that the United States will ensure a physician to look after the health care of the Puyallup. The Tribe maintains that since time immemorial and often under harsh and debilitating circumstances the Puyallup Indian Tribe, as a sovereign nation, has provided health care to their people. The Puyallup Tribe firmly considers medical care to be a treaty right, and, as such, a service which has already been paid for through the cession of vast tracts of Tribal lands. The Tribe stresses that health care as a treaty right should be provided "without charge" on a "prepaid" basis as it certainly has not been acquired without its "costs."

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The first doctor to remain any significant length of time as the local practitioner for the Indian Service, Dr. Spinning, began his practice in 1863 (Shackleford, 1918). At this time the Puyallup, especially the older members of the community, were continuing their involvement in traditional healing. Dr. Spinning and his successors, all general practitioners with little or no experience in treating emotional disorders, did more to discredit the Puyallup shamans, those traditionally responsible for mental health care, than any other individuals in the Indian Service (Shackleford, 1918). Traditional herbal remedies and "sucking doctors" were also discouraged. Their strong belief in the "superstitious" nature of traditional therapies combined with their strict adherence to their Western medical training motivated their actions. Spinning, for example, mistakenly thought that traditional healing would be readily abandoned:

> [A]s they associate with the white and witness the superiority of their medication over that of their own, they soon desire to be treated by the physician in charge. They are gradually losing confidence in their own incantations, and will, ere long, abandon them entirely (Spinning, 1864).

A ban on "Indian doctoring" in 1871, by the Superintendent of Indian affairs of Washington Territory (Gunther, 1949), further decreased overt and recorded Puyallup involvement in traditional healing; although, a few instances of the use of the traditional shaman were reported as late as 1899 (Shackleford, 1918). While Indian Agent at the nearby Skokomish Reservation, even Edwin Eells (prior to becoming Indian Agent at the Puyallup Consolidated Agency) permitted in 1871 "the ministrations of an old Indian Doctor...who offered his services" when "confronted with Indian illness for which the agency doctor had 'no suitable remedies'" (Castile, 1982, p. 168).

Many Puyallup later converted to Shakerism and continued practicing spiritual healing without being involved in illegal activities. As noted earlier, Shakerism is a unique Indian Christian religion which first appeared among southern Puget Sound Indians in 1881 or 1882 (Barnett, 1957; Castile, 1982; Gunther, 1949; Mooney, 1896). Even though it advocated spiritual healing, Shakerism was enough of a blend of Christianity and aboriginal shamanistic beliefs and practices to be accepted by Western authorities. Castile has noted that the tolerance of Catholicism to Indian religious ideas and practices helped spark the emergence of this movement (1982).

The first physician to reside on the Puyallup Reservation arrived in 1878 (Sicade, 1927). The Puyallup Indian School, initially opened in 1864, became a boarding school in 1873 (Shackleford, 1918). The first hospital on the Reservation was built for the school children. The Puyallup Indian School, renamed the Cushman Trade School in 1910, changed from a reservation to a non-reservation school in 1912. Consequently, children from all parts of the United States, especially the Northwest and Alaska

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began to be enrolled. Kin of the children moved to the Tacoma area to be next to their loved ones. Thus, the Puyallup Tribal facilities began to be providers of medical services for American Indians and Alaska Natives of diverse cultural backgrounds. This pattern was intensified by the rapid hospital development which followed shortly. Currently, the Tribal community includes Tribal members and American Indians and Alaska Natives from more then 150 tribes and bands.

The Cushman Indian Trade School had expanded by 1918 to be able to meet the needs of up to 350 pupils (Shackleford, 1918). The Puyallup were without special hospital facilities or Western practitioners between 1920 and 1929, when the facility was rented from the Tribe by the Veteran's Administration to provide hospital care to veterans. The Interior Department opened the facility in 1929 as the first Indian hospital in the Northwest. It contained both general wards and wards for the treatment of tuberculosis. When the facilities were bought from the Tribe by the Interior Department in 1939, the Cushman facilities were the largest Indian health facilities in the entire Indian Service (House of Representatives, 1939). A new hospital was completed in 1943 featuring both general and tubercular care (National Lawyers Guild, 1973). It was still the only Indian Hospital in the Northwest. The general wards were closed in 1954, and it became a tuberculosis hospital exclusively.

Even this facility was closed in 1959 despite serious Indian health needs and protests by several tribes including the Puyallup, leaving the Northwest without an Indian hospital to this day. The facility was eventually sold to the State of Washington in 1961 for one dollar. The largest building was remodeled (the hospital equipment, plumbing, wiring, etc., were removed) and other facilities were built. The entire site was used as a State juvenile center called the Cascadia Diagnostic Center.

Thus far we have not been able to identify one Western medical practitioner who was either specifically trained in mental health care or was employed as a specialist to offer mental health therapy during the previously discussed period. At the same time, the role of the only other practitioner who could provide such services, the Puyallup shaman, was being attacked by Western authorities. The rate of emotional illness among the Puyallup during this time is unknown. However, given the rapid cultural change that they were experiencing, emotional disorders surely existed. For example, 8% of the 4,599 cases treated by the three physicians on the main Sound (Tulalip, Puyallup and Skokomish Agencies) between 1883 and 1885 were "nervous diseases of which headache was the most common" (Eells, 1887, p. 274). No cases of "mental illness" were reported. However, an extremely high percentage of cases involved what we now call somatic complaints. Also, St. John (1914, p. 14) stated that in the year following the 1905 Heff decision of the United States Supreme Court which opened up the sale of liquor to Indians, there was a striking increase in the amount of drunkenness, crime, and death on the Puyallup Reservation which ". . . spelled almost absolute ruin and prostration for the Puyallup Indians."

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The extent to which the Puyallup would have utilized mental health specialists is also unknown. Traditional shamans and Shaker healing ceremonies were important alternatives to seeking Western mental health care at differing periods of time. Further, many of the Puyallup avoided seeking Western medical care because of the stigma attached to Western medical institutions on the Reservation. For example, preliminary interviews with former patients and Indian staff of the Cushman Indian Hospital conducted by the authors of this work indicate that the hospital was feared and avoided because it was believed to be the place where people went to die. The existence of tuberculosis wards, the delaying of seeking Western practitioners until sickness became serious, the "yanking" of children off the streets to perform tonsillectomies, and the practice of hauling dead bodies from the hospital to kin (even to other reservations) in the open back of pickup trucks undoubtedly added to the negative perception of the facility. Older people told us that relatives used to cry over people who went to **work** there. This perception was also expressed to the first physician (Dr. Byers) to work for the "self-determination" Indian Community Clinic to be described later:

> The hospital was a source of pride for the Puyallup Tribe. Nonetheless, distrust for "white" medicine still remained under the surface. One woman told me, with obvious bitterness, that, "the ones who went to the hospital died, but the ones who stayed home lived." (Byers, 1979, p. 23)

After the general wards of the Cushman Indian Hospital were closed down in 1954, all health care of the Puyallup community was acquired through private physicians, emergency rooms, the Public Health Service Hospital in Seattle (twenty-five miles distant), or Contract Health Care funded by the Indian Health Service. Few people used the Contract Health Care system. By 1974 the local list for Contact Care was about 45 individuals[1], about 7% of the Tribal service population (Puyallup Tribe, 1975). The Tribe also conducted a survey in the mid-1970's of the health care providers in the Tacoma area concerning the extent of Indian and Alaska Native utilization of existing facilities. They found that few American Indians and Alaska Natives were being seen by any of these providers. The above data is confirmed by the first physician for the Indian Community Clinic: "A Tacoma obstetrician told me that as late as 1970, the majority of Indian births were to mothers presenting to the emergency room in labor with no prior prenatal care" (Byers, 1979, p. 24).

The Puget Sound Indian Health Board was initially formed in 1972 including representatives from local tribes; the Puyallup Tribe continues as a member. The continued discrimination against Indians seeking health care and the failure of non-Indian run institutions to provide sufficient care in such areas as maternity, geriatrics, alcoholism and mental health led to a campaign, organized by the Puyallup Tribe in 1973, to recover the

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Cushman Indian Hospital site and transform it into a Tribally controlled medical center (National Lawyers Guild, 1973). The Tribe had conducted unsuccessful negotiations with the State of Washington since 1971. A group of Puyallup, including the Chairwoman of the Tribe at the time (Romona Bennett), staged an armed but peaceful occupation of the Cascadia Facility in October of 1976 (Puyallup Indians, 1976). After a second occupation of the facility by the Tribe in June, 1980, Judge Tanner of the Federal District Court ruled that the Cascadia site belonged to the United States Government, that it had been held in trust for the Puyallup Tribe, and that the transfer of the property to the State of Washington in 1961 was invalid. A "somewhat" orderly transfer of the site to the Tribe was accomplished in September of 1980.[2]

The efforts of the Puyallup Tribe to reestablish medical care for their people and the other American Indians and Alaska Natives who migrated to the greater Tacoma area existed throughout the period of controversy over the Cascadia facility.[3] In the late 1960's the Tribe organized a Social and Health Concerns Committee. During the same time the first Indian Health Service funded dental trailer began to appear at the Tribe. The trailer was parked in the Tribal Cemetery as this was the only ground available to the Tribe at that time.

The Puyallup Tribe began to operate the first "self- determination" Indian medical clinic in the nation, The Indian Community Clinic, in 1976 on a Tribal site adjacent to the Cascadia facility.[4] The beginning was the establishment in 1974 of a Well-Child and Women's Clinic one afternoon a month in a mobile trailer behind the current Elder's building. The first Community Health Representative (Fay Dillon) worked in this clinic. The next development was the hiring of a physician (Tim Byers, M.D., in April of 1976 for half a day, twice a week) and a nurse. The physician's position became full-time later in October 1976. The pharmacy was established in the same year. Connie McCloud completed training and started as a women's health specialist in 1976. The present Clinic building was built, and the present Dental-Administrative building was remodeled in 1976. Both were put in use in the same year. By April of 1978 the Clinic facilities included: a waiting room/reception area, a records room, a central staff room, a laboratory, six exam rooms, a treatment room, a storage room, a pharmacy, and an X-ray room. The staff consisted of two full-time physicians, two registered nurses, a pediatric nurse practitioner, a women's health care specialist, a lab technician, a lab assistant, a pharmacist, a pharmacy assistant, two medical clerks, and a receptionist. The Clinic was managed by a Clinic Director.

The mental health facilities at the Puyallup Tribe began in 1975 in the Indian Community Clinic with Indian Health Service funding.[5] Robert Houk, M.D., practiced one day a week. John Bopp, from the Indian Health Service Traveling Health Service, provided intermittant care, as did Joanna Thorpe. Mental Health moved to a mobile home by the current Elders building in 1976. They shared the trailer with Central Records and Nutrition.

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As other trailers were acquired, Mental Health received its own trailer. Between 1977 and 1979 Dr. Houk, Lou Matheson and Director, Vickie Sears, comprised Mental Health. They were funded by a start-up grant from the National Institute of Mental Health. An ongoing National Institute of Mental Health grant, funded by way of the Good Samaritan Mental Health Clinic beginning in 1979, allowed Vickie Sears to hire two more counselors in 1979. Mental Health experienced an almost complete turnover in staff in 1980. However, staff stability improved after the move to its present building following the return of the Cascadia facility to the Tribe in the Fall of 1980.

The Puyallup Tribe initiated an Out-Patient Alcohol Information and Referral Program in 1976 in another trailer near the present day Elders building.[6] Being housed in a trailer to the rear of the medical clinic presented some problems that were detrimental to treatment. Leo Whiteford, Manager of the Substance Abuse Treatment Center, the current title of the facility, reports that clients who needed help were reluctant at times to enter the alcohol program for fear of being discovered. The location presented a large amount of patient traffic in the immediate area. The trailer house was far too small causing group sessions to be cancelled. Problems of confidentiality arose because of inadequate insulation for sound.

When the Tribe reacquired the entire Cascadia complex in the fall of 1980, a building formerly entitled the Phoenix House by the State was opened to use by the Substance Abuse Program. This site was an excellent environment for an in-resident facility. This program, along with the existing out-patient services, the combination being known at the time as the Indian Family Alcoholism Program, experienced a high level of staff turnover and management-treatment problems for a time. However, positive changes began in May and June of 198l that brought nationwide recognition to the existing Substance Abuse Program. The Program was selected in February 1983 to be a model alcoholism program for the Portland Area Indian Health Service Region.

In addition to the above services, the Puyallup Tribal Health Authority, the current name for the entire Puyallup health care system, currently offers a Community Outreach Program, a Nutrition Program, an Elders Program, and a Children's Services Program. Each of these have a developmental history that originated in the revitalization period that began in the late 1960's. Space and time limitations force us to relate these histories in another place. However, it is clear that the goal of the Puyallup Tribe from the beginning of the revitalization movement was to provide holistic-comprehensive-preventive medical, dental and psychosocial support services to their Tribal members and their larger American Indian and Alaska Native community.

The Puyallup were regarded by neighboring tribes as generous and hospitable. That is why they bear the name Puyallup, which translated as meaning "add more" (Hunt, 1916, p. 23). In the past Indians came from the north, south, and east traveling in quest of game, fish, and various

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vegetable foods. They usually stopped with the Puyallups for a replenishment of their supplies, asking merely for enough to carry them to their destination. The Puyallups not only gave what was asked but added more. This tradition continues today in the modern context through their health care facility.

Broader Medical Context

Kleinman (1980) has made it clear that a cross-cultural study of medicine must start with the appreciation of health care as a system that is social and cultural in origin, structure, function, and significance. "In the same sense in which we speak of religion or language or kinship as cultural systems, we can view medicine as a cultural system, a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal arrangements" (Kleinman, 1980, p. 24).

A corollary of this position is the recognition that the aboriginal Puyallup health care system could only be understood in relation to traditional Puyallup culture. The main element of Puyallup culture underlying healing was their spiritual approach to the world. Most natural things possessed spiritual power: animals and people, trees, as well as such entities as water and thunder (Smith, 1940b). Martin notes that this spiritual orientation influences traditional practice in two ways (1981). First, the healer is concerned with the relationship of the patient to his/her surroundings: spouse, family, neighbors, and village. Second, he/she emphasizes ritual in the healing process incorporating social relationships in a curative ceremony. The reason for the ceremony is the belief that disease and illness are the result of a lack of harmony, balance, or equilibrium between the sick person and his/her surroundings. Martin concludes that this is similar to the modern psychosocial approach to sickness which includes attention to the patient's family and support system.

Despite the rather extensive literature on the social, political, economic, and psychological functions of traditional American Indian and Alaska Native healers (Bergman, 1973b, 1974; Hallowell, 1941; Handelman, 1967; Jilek, 1971, 1982; Morgan, 1931; Murphy, 1964; Nieuwenhuis, 1924; Opler, 1936, 1946; Whiting, 1950), *few medical practitioners realized* the function and significance of traditional health care systems until recently.

Western medical practitioners have rarely been sensitive to the underlying nature of the biomedical model upon which Western clinical practice is formulated. Kleinman describes the effect of this lack of sensitivity on modern medical research:

> The ingrained ethnocentrism and scientism that dominates the modern medical and psychiatric professions (both in developed and developing societies) follows the paradigm of biomedical science to emphasize in research only those variables compatible with biological reductionism and

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> technological solutions, even if the problems are social ones. (1980, p. 32)

Another bias of health professionals in contact with indigenous health care systems was the tendency to restructure indigenous health care delivery by copying the idealized model of professional care prevalent in technologically advanced societies (Kleinman, 1980). This fictive view which overemphasizes the roll of professional practitioners does not correspond to the actual situation in technologically developed society where 70% to 90% of all illness episodes are treated solely in the family context (Hulka et. al., 1972; White et. al., 1961). Further, Western professionals frequently make the mistake which Polgar (1963) labels the fallacy of the empty vessels. That is, practitioners assume that nonwestern people do not have established health customs and thus are empty vessels waiting to be filled with whatever health program is being advocated.

Finally, there has been a long standing tendency of clinicians to treat healing as if it were a totally independent, timeless, culture-free process to be understood either as an isolated special case or by comparisons with clinical practices in psychoanalytic therapy, hypnosis, biofeedback, or the accepted clinical methods of the time (Kleinman, 1980). Consequently, clinicians have not regarded healing, the most basic of all health care processes, as a core function of health care systems to be studied in its own terms within specific social or cultural contexts. Rather, they have made simplistic reductions or superficial comparisons to fads such as brain washing or occult forces.

The medical community has just begun to realize the relationship between traditional healing beliefs and practices and the maintenance of health among American Indians and Alaska Natives (Manson, in press). The Indian Health Service now allows some patients to be treated by culturally appropriate healers when the patient's symptoms or standard interventions indicate that Western approaches are not effective. An increasing number of private practitioners are referring patients from diverse cultural backgrounds to traditional healers in similar situations (Jilek & Jilek-Aall, 1978). Culturally based referral to alternative practitioners not only serves the patient, but also supports the maintenance of the world view of the patient and his/her community, a first step towards the reintegration of the individual and his/her cultural heritage. Such progess is being directly threatened by the current trends toward limitiation of care through budget trimming and the imposition of a stratified system of health care within Indian communities, even to the point of eliminating care for some individual family members through "racial purity" guidelines.

Traditional healing still is only marginally integrated into treatment practices in the United States even today. To be sure, breakthroughs in antiseptic surgery, bacteriology, vaccines, and the diagnostic use of X-rays dramatically improved the reliability of Western health care during the nineteenth and early twentieth centuries (Starr, 1982). The orientation of

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Western practitioners became a powerful force due to the enormous increase in prestige they experienced due to the rising popular confidence in science characteristic of the nineteenth and early twentieth centuries. Thus, medicine in the minds of most Westerners was tranformed into a legitimate domain of specialized experts. Most other health-care practitioners were excluded from practice.

However, the successes of Western psychiatric treatments have not been nearly as dramatic. Even the development of powerful psychotropic drugs has shown limited success in the *cure* of emotional disorders, especially for individuals from diverse cultural backgrounds. It is perhaps ironic that mental health researchers are now turning to traditional patterns of curing that were once outlawed to help populations relatively insensitive to Western therapies (Jilek, 1978, 1982).

The power of Western practitioners was further amplified due to the generous financial backing they received from capitalistically derived philanthropic foundations (Brown, 1979). Perhaps most importantly, the waves of introduced contagious diseases which ravaged the Puyallup, combined with the reservoir of environmentally-caused health problems initiated by the disruption of their traditional culture, progressively increased the dependence of the Puyallup on Western biomedical technologies and those who provided them. Traditional Puyallup medical knowledge and technique were poorly equipped to deal with recently introduced contagions.

As a consequence of the biases and forces operating in Western medicine, American Indian and Alaska Native healers were viewed as crazy witch-doctors who prevented patients from seeking adequate care (Jilek, 1971). Initialy, they were thought to be mentally ill people whose cultures enabled them to act out their particular psycho-pathologies in a prestigious role. Only recently has a small portion of the medical community incorporated the traditional American Indian or Alaska Native healer into mainstream practice as auxiliary psycho-therapists (Manson, in press).

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Impact of Western Medicine

Because of the baises and forces that dominated the medical profession during this period, the traditional health care system of the Puyallup, well documented in Smith (1940b), was discredited by Western authorities, and the Puyallup were forced to accept a health care system modeled after that in Western culture. Using Landy's (1974) terminology, the traditional healing role of the Puyallup was "attenuated."

The historic pattern of consequences of this biased orientation of Western medical practitioners on the Puyallup is of critical concern. Based on a research project on current Puyallup health care and health care seeking strategies by Guilmet (see Chapter III), it is clear that the traditional holistic support for health in Puyallup culture has been impacted and replaced for the most part by a dependency on a series of fragmented

interventions provided by Western medical practitioners with strictly biomedical orientations. By holistic we mean socially organized responses to sickness that constitute a special cultural system, the health care system, which functions to treat the whole person in all of his/her social, cultural, biological, and psychological aspects. The Puyallup refer an extremely high rate (50%) of all sickness episodes to Western practitioners when compared to other cultures; yet the medical staff displays a superficial understanding of the causes of sickness in Puyallup culture. The turnover rate of physicians at the Tribal clinic is extremely high; 33 doctors have worked at the small clinic between 1976 and 1984. Most doctors serve only a short time to fill or partially fulfill their commitment to the federal government which has financed their education. This pattern is typical of most Indian Health Service facilities (United States Senate, 1974).

Further, the Puyallup almost never become involved in non-Indian alternative healing; for example, chiropractors, naturopaths, health food store advisors, lay therapists, non-Indian religious healers, or other ethnic folk practitioners (Chinese herbalists or acupuncturists, *curanderos*, etc.). In a time when alternative healing is flourishing in our society in ethnic and mainstream sectors of the health care system, it is impressive that the Puyallup do not participate in this society wide phenomenon. Due to their particular ethnohistory, the Puyallup are largely isolated from other forms of alternative practice as well as from their own traditional healing system.

When the traditional healer's role of the Puyallup diminished, a major contributor to individual health and social order diminished in importance, a fact seldom appreciated by representatives of Western culture. The traditional healer was a prime contributor to dispute resolution, the integration of marginal individuals into mainstream culture, and the maintenance of spiritual values. No outside force, medical, political, or religious, has thus far been able to replace the holistic functions of the traditional healer.

In contrast, the traditional curing roles of other cultures, such as the Taiwanese (Kleinman, 1980), have thus far been both "adaptive" and "emergent," again using Landy's (1974) terminology, in the face of Western medicine. Continuity in traditional systems occurs in these cases because the traditional medical activities occur in a supportive cultural situation which allows traditional beliefs and behaviors to thrive. Less cultural disruption occurs in these situations due to the coexistence of traditional and Western medical systems.

The Puyallup experienced the transition from a small-scale hunting and gathering society to a marginal subculture within an urban-industrial society within a period of little over one hundred years. This transition was accompanied by the introduction of literacy, concepts of individual land ownership, the establishment of a cash economy, and the replacement of a holistic cultural system by a fragmented contact culture heavily dependent upon a short-term, short-sighted, bureaucratic support system. However, no change was any more dramatic than the attenuation of traditional healing

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roles and the rapidly engineered dependence of the Puyallup on outside medical traditions. Traditional healers, especially shamans, were also spiritual leaders in the community charged with the responsibility of restoring harmony to the community by mediating disputes concerning both spiritual and secular issues. Once the power of these shamans was perceived by their groups as having been lost or diminished ("proof" of this was seen in their inability to stem the pernicious effects of both newly introduced diseases and newly powerful outside authorities), the normative and ethical system of the community was torn apart. As a result, individuals were no longer bound by the traditional values that typically provide solidarity for a face-to-face community. Instead, individuals began to live in a bicultural world marked by weakening ties to tradition and attempts by individuals, especially the young, to become accepted in the society brought by outsiders.

The difficulties in this culture-change situation were perhaps most strongly felt by the young. How could youth have pride in themselves it they could not feel pride for their parents, grandparents and other family and friends? Many young people tried to adopt the ways of the outsiders but soon found that they were not generally accepted, being ostracized due to their "savage" ancestry.

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Moreover, "Indian doctoring" (referring to the continued practice of traditional Indian health care by shamans and other native healers) was, as noted earlier, outlawed by the Superintendent of Indian Affairs of Washington Territory in 1871. Two segments of the contact population were particularly influential in instituting this law: doctors and missionaries who were assigned to the Indian reservations. Both believed that traditional practices were not only ineffective but primitive and dangerous. The impact of this decision is not appreciated by outsiders even to this day. The Western heritage has taught some that it is possible to dissect cultural systems into discrete entities and treat each as a separate unit. The reality in small scale traditional societies is much different (Amoss, 1978). Healing is but one part of a larger philosophical system that includes what is labeled religion, economics, politics, and medicine. Sanctions aimed at limiting one aspect of a holistic system affect the entire metaphysical web. Traditional healers were responsible for dispute resolution, the integration of marginal individuals into society, and the establishment and interpretation of the meaning of existence for all culture members. Indeed, in a society less dependent upon bureaucratic roles and institutions than contemporary industrial forms, traditional healers were necessary for the maintenance of daily social order.

The ability of individuals to adapt to new subsistence patterns, occupational roles, marriage forms, family power structures, and the presense of alcohol was significantly decreased by the declining importance of the traditional healers and the philosophical world view they represented. Other cultures, like those in Taiwan and the Peoples Republic of China (Kleinman, 1980), have managed, because of greater political autonomy,

to assimilate Western medicine while allowing traditional medical beliefs and behaviors to survive. A comparative study using Kleinman's methodology, found that this kind of biculturalism in the area of medicine resulted in far less disruption for the Taiwaneese than that experienced by the Indians of southern Puget Sound (see Chapter III).

The Puyallup community population still experiences an average age at death nearly eighteen years lower than the Washington State mainstream (Seattle Indian Health Board, 1983). Much of this difference is due to alcoholism, accidents, suicides and violence--all expressions of the emotional stress experienced by individuals who have been stripped of many of their cultural traditions and forced into a schizophrenically bicultural existence. The chronic depression displayed by many Indian people can be at least provisionally linked with such potentially causitive factors as the frustration many experience upon failing to acquire upward mobility in American society; subjective feelings of rejection and discrimination because of the actions of many nonIndians toward them; guilt feelings stemming from collective and personal denial of their Indianness; and moral disorientation due to the fragmentation of their traditional cosmological system. An increasing body of psychiatric literature suggests that the deliberate integration of Indian healing theories and techniques with Western treatment strategies--especially in situations where Western approaches have proved uneffective--will have a positive effect on this type of depression.

The positive directions evident within Indian Health Service's pattern of care, the major progress made in improving the health status of American Indians generally, the rebirth of a holistic approach to medical care, all are jeopardized by the blind exclusion of some tribal members and not others from access to even the simplest of medical treatment and the wholesale reductions of dollar support for Indian health care. It is unfortunate that the decisions regarding the health futures of tribal peoples are being removed from the hands of the tribes themselves, completely disregarding tribal self-determination. It is even more unfortunate that these decisions are not even being made by medical practitioners with at least some familiarity and understanding of individual tribal needs. It is, indeed, tragic that these decisions with a life threatening medical impact are being made by politicians and bureaucrats with only the vaguest of understandings regarding the ultimate effects upon Indian lives and Indian health.

Indian Health Service was originally instituted to stem the impact of disease and injury upon tribal communities. IHS was originally put to work to keep Indians alive longer. It seems now, that because there are too many Indians that IHS has been targeted by Congress as having done its work too well. The population is too large; there are too many Indians; it costs too much money to keep these Indians alive anymore. Due to the epidemiologic changeover, the easily managed conditions are nearly controlled.

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It should be pointed out that the health status of unrecognized tribal groups, and those without the benefits of IHS medical care has been shown to be well below the health status of their surrounding non-Indian neighbors (Otis, Katz & Whited, 1981; Whited, 1979).

The first stage of the contact experience, the impact of introduced diseases, is beginning to approach a controllable state with the major contagious and infectious diseases under closer management. This is why the Indian population is growing and expanding at such a healthy rate. The problem now confronting IHS, the second phase of its job, is to address the epidemiologic transition which allows still lingering major differences in survival rates because of afflictions tied to the impacts of biculturalism with the inherent long term frustration and the inability to achieve upward mobility within the mainstream society of the United States (i.e., alcoholism, depression, violence, accidents, suicide, obesity, diabetes, and other eating disorders linked to depression). The second stage of the contact experience involves conditions which are not as controllable, as easily influenced, or even as completely understood within the biomedical community. The problems associated with influencing these conditions which do not fit neatly into the biomedical model are much more complicated in their epidemiology. "The Indian Health Service, for example, provides less than 1% of its annual budget for the treatment or prevention of the disease which the Secretary's [Secretary of Department of Health and Human Services] report finds responsible for 80% of our excess deaths" (Kauffman, 1986, p. 5).

The first half of the job is nearly finished assuming continued constant levels of support. IHS, however, points out that the per capita expenditures on Indians for health care has not kept pace with inflation and has in fact remained well below the nationwide per capita health costs for the average non-Indian American (National Indian Health Board Health Reporter, 1986a, p. 10). The average hospital stays for Indians also remain below the average length of stays for non-Indian Americans. Still, Congress and the Office of Management and Budget persist in pointing out that it costs too much to keep Indians alive.

In congressional hearings regarding the 1987 fiscal year budget requests the IHS Director responded to questions regarding the possibility of changes in IHS eligibility criteria:

> Since I've been director and prior to that time, it became clear that the demand on the system was far out-stripping any reasonable ability to provide care . . . My experience indicates that all of the questions about Indian health services are almost rendered moot until we decide who we're serving.
>
> As I see it, there are three choices under a constrained budget, including increasing the level of resources,

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> decreasing the number of persons served, or decreasing services. We have been rationing care since the beginning of IHS. In the past we have been excluding certain individuals from IHS care in a chaotic and haphazard way. We are seeking to bring some order out of chaos (National Indian Health Board Health Reporter, 1986b, p. 2).

The only reasonable, humane, and medically sound alternative offered by Dr. Rhodes is his first choice, to increase the level of resources. All clinical evidence not only suggests, but mandates that the increasing level of support be coupled with a larger emphasis on mental health care and alcohol prevention and treatment services.

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