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HEALTH CARE AND HEALTH CARE SEEKING STRATEGIES

Introduction

This study upon which this chapter is based was designed to replicate Kleinman's research on family-based popular health care in Taiwan (1980) among the Puyallup Indians. The research methodology and data analysis methods were created to be as similar to those used by Kleinman as possible.¹ The data illustrate what being sick among the Puyallup entails. Further, the research gives us an interesting example of how the process of acculturation and the availability of "prepaid" medical care affect the health care seeking process.

Taiwanese and Puyallup involvements in traditional medicine are embedded in two strikingly different cultural contexts. The Taiwanese are practicing traditional medicine within a supportive cultural situation that allows traditional beliefs and behaviors to thrive. The Puyallup are a sub-culture within a broader American system which historically prohibited the continuation of traditional Puyallup health care practices. In Landy's (1974) terms, the traditional Taiwanese curing roles are, thus far, both adaptive and emergent in the face of Western medicine, whereas the traditional Puyallup curing roles have been virtually attenuated through negative sanctions and legal action.

Further, the financial arrangements for paying for health care are remarkably different for the Taiwanese and the Puyallup. Family finance resources are the ultimate factor in determining the quality and availability of care in Taiwan. Thus, health care in Taiwan suffers from inequalities based on the larger socioeconomic inequalities that are characteristic of that society's social system. While the Puyallup are members of one of the poorest subcultures on or near the urban Puyallup Reservation, they have access to a "prepaid" medical system guaranteed for them by their treaty rights (Kimball, 1979). However, in many cases, the medical system which is actually available to them does not meet all of their needs.

Research Methods

In July of 1979, a list of the nearly 700 individuals enrolled in the Puyallup Indian Tribe was obtained. The number of enrolled individuals has significantly increased since that time due to a continuous enrollment drive. A letter was sent to each of the 146 families that resided in the greater Tacoma area notifying them that an interviewer would call, or appear if no telephone number could be located, to request permission to conduct an interview concerning sickness in their family.² One of the authors (George

Guilmet) instructed three female interviewers, two of whom were Puyallup themselves, how to conduct standardized interviews. These interviews were designed to assess the patterns of symptoms, diagnoses, treatments and health care seeking behaviors present in each family in the previous month.³ All interviews were completed by the end of August 1979 by these three individuals.⁴

Not all of the families on the Tribal list could be located and some family members did not wish to participate in the study. Eighty of the 146 families on the tribal role who resided in the area, or 55%, participated in the research. The nature of the 45% who could not be located or did not choose to participate in the study is unknown. It is possible that some of those contacted were more traditionally oriented and did not wish to divulge spiritual or herbal healing to outsiders, even other Puyallups. It is also possible that many of those who could not be located were of lower socioeconomic status and therefore displayed the higher rate of change in residence typical of this group.

The white interviewer stated that she experienced a great deal of difficulty in acquiring permission to conduct interviews because she was non-Indian and a stranger. People told her that they did not want to be bothered with another survey and were tired of others studying them. She said she sometimes knew people were home when she went door to door, but they would not answer. She went to each residence at least three times. The two Puyallup researchers had a hard time believing that the white researcher was having so much trouble completing her part of the research. Yet, the white interviewer's data were equal in detail and quality to the Puyallup interviewers' data. However, she collected a smaller percentage of the interviews (25%) than the Puyallup researchers (37.5% each).

For each of the families who participated in the study, one of the heads of the family were interviewed along with various other family members who were present at the time the interview took place. Usually, the mother or grandmother were interviewed, although in a few families where no such individuals resided or were present, another responsible adult was interviewed. Each interview covered the same set of questions concerning family health beliefs and health care. Answers were recorded on questionnaires by the research assistant who conducted the interviews. All interviews were conducted in English, the language in use among the Puyallup.

Interviews followed a standard format using the methodology of Kleinman (1980). That is, each family was asked to recall all sickness episodes in the preceding month. Interviews asked family members to (1) recall and describe each sickness episode no matter how minor; (2) name the sick person and his/her age and relationship within the family; (3) describe the treatment decisions that had been made and give reasons for those decisions; (4) list all initial symptoms and diagnoses, and the changes in these symptoms and diagnoses; (5) list all treatments that had been given and the practitioners who had been consulted in the sequence they were

chosen; (5) explain the reasons why persons outside the family were contacted; (6) rate the perceived severity of each episode at its onset and at the time of the interview; and (7) describe the conclusion of each episode. Tables 2 through 6 summarize the findings. In addition to this quantitative data, the interviews provided qualitative ethnomedical descriptions of health beliefs and practices. The latter data will be discussed as well.

Results

A result of 168 sickness episodes occurred during the previous month among the 276 family members in the 80 families interviewed. Ninety-nine (36%) of the family members were children (under 16 years of age); they accounted for 26% of all sickness episodes. Only 16 (6%) of the family members were elderly (over 60 years of age); they accounted for only 5% of the sickness episodes. One hundred and sixty-one (58%) of the persons in the families were other adults (16 to 60 years of age); they accounted for 69% of the sickness episodes. Other adults displayed a comparatively high sickness rate; see Table 2. While the rate per child was 0.44 and the rate per elderly person was 0.50, the sickness rate per other adults (0.72) was strikingly higher. We will discuss this finding later.

TABLE 2
Sickness episodes in month preceding interview

	Number	Percentage	Rate*
Total sickness episodes of family members	168	100%	0.61
Sickness episodes in children	44	26.2%	0.44
Sickness episodes in elderly	8	4.8%	0.50
Sickness episodes in other adults	116	69.0%	0.72

*Sickness episodes per person per month.

TABLE 3
Analysis of 80 Puyallup Indian families interviewed in 1979

	Number	Percentage
1. Composition of population surveyed:		
Family members reported on	276	100%
Children (under 16 years of age)	99	36%
Elderly (over 60 years of age)	16	6%
Other Adults	161	58%
2. Families' Income:		
Less than \$8,000 per year	21	26%
\$8,000 to \$15,999 per year	39	49%
\$16,000 to \$23,999 per year	14	18%
\$24,000 per year or more	6	7%

The lack of elderly persons in the sample prompted one of the interviewers who was particularly interested in the problems of the elderly to remark: "Where are they? Where do they live? How are their needs met? I would seriously consider this an area for further research." The truth is, there are very few elderly, using the standard definition, among the Puyallup. According to the 1980 United States Census, only 6.0% of the American Indians and Alaska Natives in Congressional District 6 are sixty years or older compared with 15.7% for white residents in the same area. The percentage of individuals over sixty years of age in the eighty households included in this study was 6.0%; see Table 3. Because of the small percentage of individuals who live beyond sixty years of age, the Puyallup Tribe defines an elderly person as anyone over 45 years of age for funding and service purposes. This has caused some problems with funding agencies, but the majority have now accepted this practice in most cases.

Sixty-eight percent of all sickness episodes were first treated in the family, and 44% of all sickness episodes received their only treatment from the family. Eighty percent of children were first treated at home while 88% of the elderly and 63% of other adults were first treated at home. Further, 50% of the sickness episodes in children only received family treatment, while 38% of the elderly and 42% of other adults were only treated at home. These results, shown in Table 4, contrast in many significant ways with those obtained in Kleinman's Taiwan population as we will discuss later.

TABLE 4
Sickness episodes only or first receiving treatment from family

	Number	Percentage
Total sickness episodes <i>only</i> receiving family treatment	74	44%
Total sickness episodes <i>first</i> receiving family treatment	115	68%
Sickness episodes in children <i>only</i> receiving family treatment	22	50%
Sickness episodes in children <i>first</i> receiving family treatment	35	80%
Sickness episodes in elderly <i>only</i> receiving family treatment	3	38%
Sickness episodes in elderly <i>first</i> receiving family treatment	7	88%
Sickness episodes in other adults <i>only</i> receiving family treatment	49	42%
Sickness episodes in other adults <i>first</i> receiving family treatment	73	63%

Fifty percent of all sickness episodes were referred to professional practitioners. Forty-eight percent of sickness episodes in children received treatment from professional practitioners, while 62% of sickness episodes in elderly and 50% of sickness episodes in other adults received such treatment. Using a different methodology in the early 1960's, Levy (Kunitz & Levy, 1981) found an even higher rate of referral to professional practitioners, whether native practitioners or physicians, among the Navajo. Of 77 instances of "illness" recognized by the patient (or a responsible adult in the case of minor children), 67 (87%) resulted in a decision to seek treatment from professionals outside the home. These 77 instances of "illness" occurred over a two year period among a group of 106 kinsmen of all ages who lived some 20 miles from an Indian Health Service Hospital. Kunitz and Levy note that this remarkably high proportion of decisions to seek help from professionals may be an artifact of the research design, which allowed subjects to define the point at which "illness" occurred rather than asking about the appearance of symptoms. In the present study, we asked informants to recall all episodes, even those that they would hesitate to call sickness, for example, scrapes and bruises. The differing methodologies probably contribute to the differences in referral rates between Levy's and the present study. If Levy's data is converted into an "illness" rate equivalent to that calculated for Kleinman's and the Puyallup data, this becomes even more clear. The "illness" rate among the Navajo was 0.030 illness episodes per person per month. This is a fraction of the sickness rates observed in Taiwan (0.57) and among the Puyallup (0.61). It appears that minor "illness" episodes were not reported by Levy's Navajo informants.

An interesting finding of this study is that not one sickness episode among the Puyallup was reported to have been treated by a folk practitioner. Indeed, if this study accurately reflects current Puyallup medical behavior, we must conclude that traditional secular and sacred medicine and more recently introduced forms of religious healing are both entirely absent from Puyallup culture. Not one informant disclosed the use of either of these practices. The entire focus of their medical thinking was either on family remedies, which appear to have very little continuity with traditional Puyallup culture, or, on referral to Western practitioners. The implications of and possible exceptions to this finding are discussed below.

Family income relates in interesting ways to sickness rates and health care seeking behaviors; see Table 5. First, the rate of sickness generally increases with increasing family income. This is an unexpected result until one considers the nature of the data. We are dealing with reported sickness episodes, thus, human perception is involved. What may be defined as a minor sickness in a family with a higher income, may not be considered sickness in a poorer family. Being poor brings with it a certain level of pain that makes a minor sickness not a memorable event, but simply a normal state of the world.

A second interesting aspect of family income is the nearly identical rates of referral to professional practitioners for families with incomes less than \$8,000 per year and those with incomes greater than \$24,000 per year. It appears that the availability of free medical care at the Puyallup Clinic enables poor families to seek professional practitioners when they are needed. It is interesting, however, that the middle income groups in Table 5 display referral rates half as large as those at the extremes in income. Perhaps time available to visit a professional practitioner is a factor, the middle income employed being too occupied in routine tasks and jobs to seek advice for sickness as often as the other groups' members, and their spouses being home without transportation. The Tribal clinic is not open on weekends and only one night a week after working hours. In contrast, the members of all but one of the families with incomes greater than \$24,000 per year reported the employed members of the household to be either a manager, planner, a smokeshop owner or a supervisor; positions with greater control over time of work and increased opportunities for visiting a practitioner. A large number of the other adults and elderly in the families with incomes less than \$8,000 per year was, respectively, unemployed and retired. Hence, they too had greater control over their time.

TABLE 5
Sickness rate, referral rate and families' income

Families' income	Number of individuals	Number of sickness episodes	Sickness rate*	Referral rate+
Less than \$8,000 per year	72	31	0.43	0.71
\$8,000 to \$15,999 per year	140	85	0.61	0.36
\$16,000 to \$23,999 per year	47	27	0.57	0.33
\$24,000 per year or more	17	25	1.47	0.72

*Sickness episodes per person per month.

+Number of sickness episodes per month referred to a professional practitioner or practitioners divided by the number of sickness episodes per month.

Table 6 lists the various determinants of health care seeking behavior. With a few exceptions which will be discussed later, these factors are extremely similar to those elicited by Kleinman. Perceived severity of sickness by family members was the most important factor. On a scale of increasing severity from 1 to 10, 38% of those episodes initially perceived to be from 1 to 5 in severity were referred to professional practitioners, while 75% of those episodes initially perceived to be from 6 to 10 in severity were referred to professional practitioners.

TABLE 6
Determinants of health care seeking behavior

Type and severity of symptoms
Course of sickness
Sick role
Specific sickness labels and the etiologies they implicate
Evaluation of specific therapeutic interventions
Age, sex, family role, occupation and educational level of patient
Family income, orientation to Western or traditional values, and past experiences with health care
Access to "prepaid" health care
Proximity to particular treatment resources
Nature of patient's social network and lay referral system

Compared with the Taiwanese, Puyallup home treatment methods are quite simple. By far, the most frequent family treatment involved patent medicines (39% of all sickness episodes), followed by minor first aid materials (10% of all sickness episodes). "Rest" was the family treatment of choice in 6% of all sickness episodes. Many patent medicines are available free at the Tribal clinic.

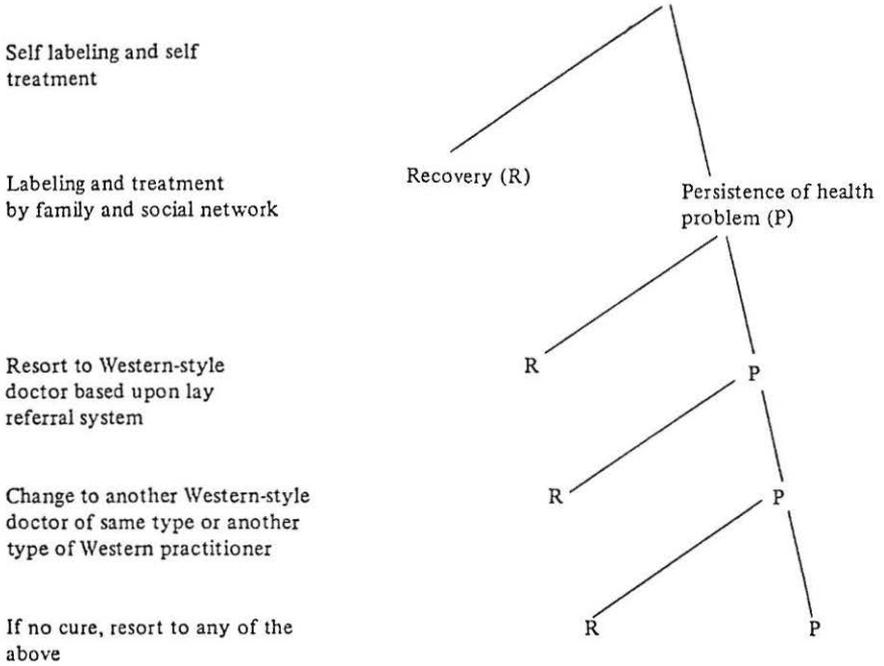
"Rest" is an important feature of the Puyallup sick role. A variety of minor sicknesses were cured by this method. Further, 8% of sicknesses in other adults and 2% in children received no treatment (no episodes in the elderly went without family or professional treatment). Informants in these cases responded to questions about family treatment with "nothing," "pain went away," "got better," etc. Both "rest" and inaction in the face of an illness episode are consistent with the common belief among the Puyallup that minor sickness will cure itself if left alone.

The rough hierarchy of resort (Schwartz, 1969) evident for adults and children observed by Kleinman also existed among the Puyallup. Most sickness episodes in other adults first received self treatment and most episodes of children first received family treatment. If this did not produce symptomatic relief or if the sickness did not remit spontaneously within several days, recourse was made to family members, friends, or professional practitioners. The difference between the Puyallup resort strategies and those uncovered by Kleinman in Taiwan is the relative lack of alternatives to Western medical practitioners in the former.

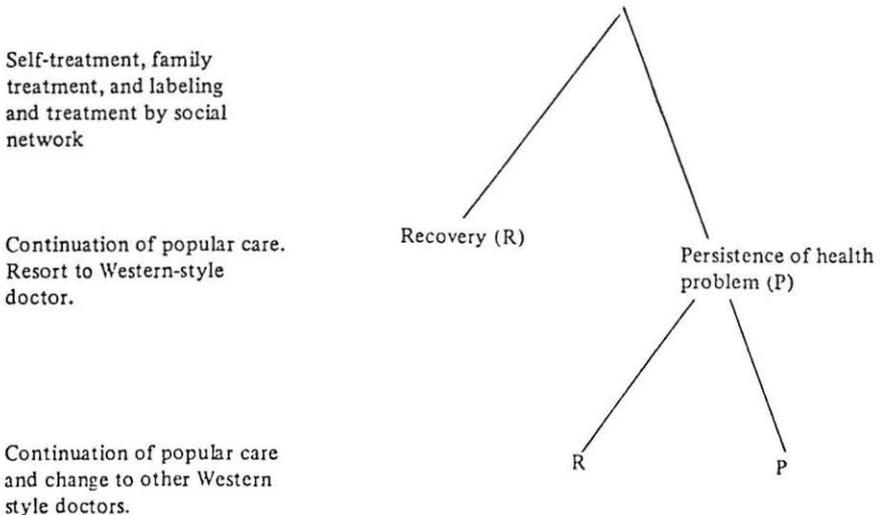
Three types of health care seeking behavior were disclosed by this study; hierarchical resort exclusive type, hierarchical resort mixed type and hierarchical resort direct type (see Figure 1). We have labeled the first two Type B and Type C to be consistent with Kleinman's terminology. Both occurred in more elaborate forms in his population. Hierarchical resort direct type (Type D) did not occur in his population. Kleinman's Type A, simultaneous resort, did not occur among the Puyallup with any measurable frequency.

FIGURE 1
Patterns of Health Care Seeking Behavior

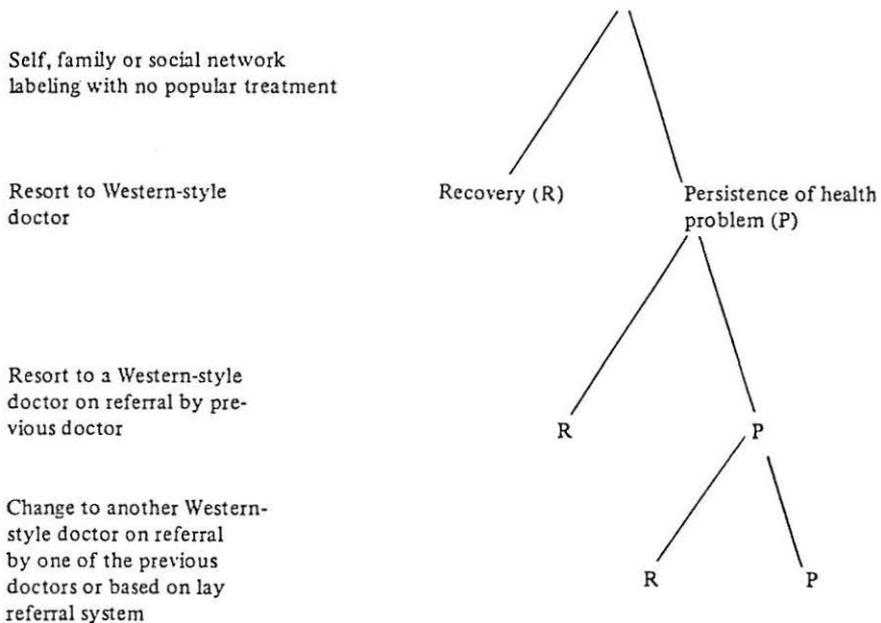
Type B: Hierarchical Resort, Exclusive Type
Usually an acute but non-life-threatening sickness in an adult



Type C: Hierarchical Resort, Mixed Type
Usually a chronic or recurrent sickness in an adult



Type D: Hierarchical Resort, Direct Type
Usually a serious childhood or adult sickness



Discussion

Let us now compare the Puyallup results with those obtained by Kleinman in Taiwan. It will become clear that Puyallup Indians rely less on family health care and more on Western doctors than the Taiwanese. We will argue that this result is due to two factors: (1) the relative absence of traditional folk medicine among the Puyallup and the continuation of folk medicine as a common alternative to Western medicine among the Taiwanese; and (2) the availability of "prepaid" medical care among the Puyallup and the relative absence of the same among the Taiwanese.

The overall sickness rates in Taiwan (0.57) and among the Puyallup (0.61) were very close, although the sickness rates according to age varied strikingly between the two cultures (See Table 7). Children and elderly displayed less sickness among the Puyallup, but other adults experienced a far greater rate of sickness. These data can be interpreted in the following way. Other adults among the Puyallup experience almost three times the rate of sickness as other adults among the Taiwanese due to comparatively high rates of alcohol and drug abuse, family dissolution, unemployment and other effects of long term poverty and discrimination among the Puyallup. For example, the Puget Sound Service Unit of the Indian Health Service maintains that a conservative estimate of the percent of the Indian community that has serious problems with alcohol abuse is

25% (Kimball, 1979, p. 343). Thus, the minor illnesses of childhood are less frequently reported among the Puyallup than among the Taiwanese because being a Puyallup brings to life a certain level of pain that makes a minor sickness not a memorable event, but a normal state of the world. Kunitz and Levy note a similar phenomenon among Navajo Indians:

Physicians and nurses have often commented on the fact that Navajo parents seem remarkably unaware of their children's symptoms and appear uncaring and callous...we think it has something to do with the tendency for poor people living in harsh conditions to react only to the most obvious signs in others and to considerable pain of their own. We have had occasion to discuss this idea with a few articulate Navajo women, all of whom said that they just do not react and sometimes hardly notice when their children have running noses, coughs, fever, diarrhea, or loss of appetite. They only become concerned when the child can hardly move - despite the fact that they are good observers of their own symptoms (1981, p. 369).

A second effect of the extremely high rate of sickness among Puyallup other adults is the low sickness rate reported among the elderly. It appears that those few Puyallup who live past the age of sixty years of age either live a comparatively stable and drug and alcohol free life or they are resistant to sickness. Nineteen percent of Kleinman's sample were elderly versus 6% among the Puyallup.

TABLE 7
Sickness rates: Taiwan vs the Puyallup*

	Taiwan	Puyallup
Overall sickness rate	0.57	0.61
Sickness rate in children	0.91	0.44
Sickness rate in elderly	0.81	0.50
Sickness rate in other adults	0.27	0.72

*Sickness episodes per person per month.

Family treatment among the Puyallup continues to be important, but not nearly as prevalent as among the Taiwanese (see Table 8). For all age groups, fewer sickness episodes are treated only at home and fewer sickness episodes first received family treatment. This trend is especially clear for other adults, the population that faces the greatest sickness rate among the Puyallup.

TABLE 8
Sickness episodes only or first receiving treatment from family:
Taiwan vs the Puyallup

	Taiwan	Puyallup
Total sickness episodes <i>only</i> receiving family treatment	73%	44%
Total sickness episodes <i>first</i> receiving family treatment	93%	68%
Sickness episodes in children <i>only</i> receiving family treatment	58%	50%
Sickness episodes in children <i>first</i> receiving family treatment	88%	80%
Sickness episodes in elderly <i>only</i> receiving family treatment	86%	38%
Sickness episodes in elderly <i>first</i> receiving family treatment	100%	88%
Sickness episodes in other adults <i>only</i> receiving family treatment	91%	42%
Sickness episodes in other adults <i>first</i> receiving family treatment	88%	63%

The Puyallup referred a much higher percentage of their sickness to outside practitioners (see Table 9). This trend is most evident for the elderly and other adults. The Puyallup repeatedly stated that serious sicknesses should be treated by a doctor if they persisted more than a day or so. In contrast to the Taiwanese, the Puyallup said that they resorted exclusively to Western practitioners.

TABLE 9
Sickness episodes receiving treatment from professional or folk practitioners:
Taiwan vs the Puyallup*

	Taiwan	Puyallup
Children	42%	48%
Elderly	14%	62%
Other Adults	9%	50%

*The Puyallup exclusively used Western practitioners.

Two factors account for the above results: (1) the relative absence of traditional medicine among the Puyallup; and (2) the availability of "prepaid" Western care for many Puyallup. Let us discuss each of these in turn.

The Puyallup displayed an elaborate set of traditional medical beliefs and practices at the time of first extended contact with Western

culture in 1833 (Morgan, 1979; Smith, 1940b). However, their traditional medical system rapidly changed upon the introduction of Christianity and Western schools (Smith, 1940a), the declaration of a ban on "Indian doctoring" by the Superintendent of Indian Affairs of Washington Territory in 1871 (Gunther, 1949), and the establishment in 1929 of the only Indian Hospital in the Northwest on the grounds of the current Puyallup Tribal Center. This hospital is no longer in existence. In Landy's (1974) terms, the traditional Puyallup curing roles were of the attenuated type while the traditional curing roles in Taiwan are thus far both adaptive and emergent in the face of Western culture. Not one Puyallup informant disclosed the use of traditional secular or sacred medicine, including traditional dietary practices followed for sickness. Also, no episodes of sickness were reported to have been treated by more recently introduced forms of religious healing. The data suggest that the results of the relative absence of traditional medicine among the Puyallup are two-fold; both a lower rate of family treatment and a higher referral rate to Western practitioners when compared with the Taiwanese.

The Puyallup also are not utilizing non-Indian alternative practices; i.e., chiropractors, naturopaths, health food store advisors, lay therapists, non-Indian religious healers or other 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, why are the Puyallup not participating in this societal wide phenomenon? The answer lies in the fact that the Puyallup are both isolated from other forms of alternative practice due to their marginal relationship to the larger society, and dependent upon the biomedical services provided in most cases without cost due to their particular ethnohistory. The Puyallup are isolated both from their own traditions and from many aspects of the greater society's health care system.

The second factor accounting for the lower rate of family treatment and higher referral rate to professional practitioners is the availability of "prepaid" Western care for many of the Puyallup in many situations. Health services were guaranteed for the Puyallup by treaty although non-reservation Indians face difficulty in maintaining these treaty rights. As a consequence, the Puyallup experience fewer economic constraints on their referral decisions than do the Taiwanese.

The various determinants of health care seeking behavior among the Puyallup were presented earlier in Table 6. Only two differences were observed between these determinants among the Puyallup and those observed among the Taiwanese. First, the patients' access to "prepaid" health care was important in determining many individual's health care seeking behavior. "Prepaid" care of this form did not exist as an option for the Taiwanese. Second, the Puyallup all live in the same general vicinity. Thus, rural-urban residence differences did not play a significant part as it did among the Taiwanese.

Three major differences exist between the health care seeking strategies of the Puyallup and the Taiwanese: (1) the simultaneous resort observed by Kleinman among the Taiwanese did not exist to any measurable extent among the Puyallup; (2) hierarchical resort, exclusive type and hierarchical resort, mixed type as observed and defined by Kleinman existed among the Puyallup in simpler forms; and (3) the Taiwanese did not display hierarchical resort, direct type as observed among the Puyallup. Consider each of these points in turn.

Kleinman observed that the Taiwanese displayed a pattern of health care seeking behavior which he labeled simultaneous resort. In this strategy, the sick person was simultaneously given popular treatments at home while at the same time being referred to a Western style practitioner, a Chinese-style doctor or Chinese pharmacy, and a *Tang-ki* or other sacred healers. This health care seeking behavior was usually displayed in the case of a serious childhood sickness. The Puyallup did not engage in this type of health care seeking behavior. Not one informant stated that folk practitioners either sacred or secular were consulted. Further, in the cases of serious childhood or adult sicknesses, informants repeatedly stated that the behavior of choice was to immediately consult a Western doctor. When this occurred, home treatments, if initiated, were usually discontinued in favor of the treatments recommended or prescribed by the physician.

Hierarchical resort, exclusive type and hierarchical resort mixed type, observed among the Taiwanese, both occurred among the Puyallup in simplified forms. Indeed, these resort strategies were used by the Puyallup for the same kinds of sicknesses as among the Taiwanese. That is, hierarchical resort, exclusive type was usually employed in the case of acute non-life-threatening sickness in an adult, and hierarchical resort, mixed type was usually employed for a chronic or recurrent sickness in an adult. The reason that these two resort strategies were simpler among the Puyallup was due to the relative absence of sacred and secular folk practitioners as an option within their health care system. The choices among the Puyallup were self-labeling and self-treatment, labeling and treatment by the family and social network, resort to Western practitioners, and change to another Western practitioner of the same or different type.

The Taiwanese did not display a form of health care seeking behavior prevalent among the Puyallup which we have labeled hierarchical resort, direct type. In this process, self, family or social network labeling occurred without popular treatment. Then, a Western doctor was consulted if the sickness was thought to be serious or if it persisted. If the doctor consulted did not cure the sickness, another doctor, a specialist, was consulted on referral by the previous doctor. If the latter physician did not effect a cure, a change was made to another doctor on referral of one of the previous doctors or based on a lay referral system. This health care seeking strategy was usually employed in the case of a serious childhood or adult sickness.

Conclusions

This research provides an interesting example of the effects of acculturation on family health care and health care seeking strategies. The traditional medical system of the Puyallup was profoundly changed upon contact with Western culture. Informants did not report one case of traditional family or folk practitioner treatment. We believe that it is no coincidence, therefore, that the rates of home treatment were smaller and rates of referral to professional practitioners were larger than among the Taiwanese, where traditional medicine exists as a common alternative to Western medicine. Future research could be conducted with other American Indian tribes and with other cultural groups in various types of acculturative situations to verify this conclusion.

There is reason to believe that the hierarchies of resort reported for the Puyallup do not reflect the complexity of health care seeking behavior that actually exists for many Puyallup and other community members. Indeed, several cases of participation by Tribal members in Shaker or Longhouse healing has been shared with the authors since the time of this study. The actual resort complexity may be, for some, similar to that described in Amoss (1978, p. 83) for a more isolated Coast Salish Indian group:

Differential diagnosis is not easy. When an illness cannot be cured by simple home remedies, the usual procedure is first to consult a white doctor. If his ministrations fail, the victim or his family will look for help "on the Indian way." AZ explained her decision-making process: "There's three things we have to help us, the white doctor, the Shake, and the *syó?wən*. If my kids is sick, I go to the white doctor first. If he can't do nothing, I take them to the Shakers; if they can't do nothing, then it's the *syó?wən*."

Thus, the Type B and Type C hierarchies of resort reported earlier would be much closer to those observed by Kleinman (1980) for a sub-population of the Puyallup. That is, they would include traditional resort options as part of the resort strategies.

Traditional medical practices or more recently introduced forms of religious healing may exist to a greater extent than expressed by the Puyallup families interviewed, but if they do, they were not divulged even to the Puyallup researchers. Ongoing attempts by the Puyallup Tribal Health Authority to reintegrate traditional healing back into Puyallup culture may have two effects. Individuals may begin to learn and use Puyallup and other American Indian traditional medical knowledge lost to acculturation, and individuals who may already be practicing traditional medicine or more recently introduced forms of religious healing may be more willing to divulge their behavior to outsiders. We were told by several Puyallup

individuals that people who are trying to practice traditional or religious healing are unwilling to discuss their behavior with strangers.

Because traditional medicine is infrequently reported, the Puyallup appear to have relied on patent medicines, minor first aid, rest, nothing, or resort to Western practitioners to effect a cure of sickness. The belief is common that all sicknesses should be referred to a Western doctor if the sickness is serious or persists. In the case of minor sicknesses, the Puyallup sometimes expressed the view that "it will get better by itself" or "leave it alone and it will get better."

Some resistance to seeking Western practitioners was expressed by certain individuals. One woman could not get her husband to see a doctor about his drinking problem. Another said that she had seen many doctors for her sickness but "they did no good." Another elderly woman said "some older people are afraid of going to the doctor." But, even in these few exceptions to the general acceptance of Western medicine, no one expressed alternatives other than nothing or non-traditional family treatment. However, we were told by an employee of the Puyallup Tribal Health Authority that a few of the Puyallup elders who use the facilities of the Elders' Program say they never use the clinic, just Indian medicine.

A second factor also contributes to the lower rates of home treatment and higher referral rates to professional practitioners among the Puyallup when compared with the Taiwanese: the presence of "prepaid" health care for many of the Puyallup in many situations. This factor has made it possible for the lowest income families to seek professional treatment when desired. Indeed, the poorest Puyallup families had a higher referral rate than either of the middle income groups and as high a referral rate as the highest income group. This kind of option for poor families did not exist in Taiwan and resulted in the lowest rate of referral for the lowest socioeconomic class. The void that was left upon the decreasing use of traditional Puyallup medicine has been filled in part by federally guaranteed access to Western medicine.