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Introduction

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The articles in this volume represent a diversity of academic and practical interests which reflect our varied perspectives on health, illness, disease, and mortality. Conditions of health, illness, disease, and even death are socially constructed, based on the perceptions held by members of social and cultural networks, but are not determined.[1] Such perceptions vary intra- and interculturally. As the authors in this volume make clear, history, politics, language, economics, religion, and personal experience influence our thoughts and actions concerning health and care.

If all these factors come into play, how might we define health? Medical anthropologists, historians, and sociologists as well as health policy administrators tend to define health in contrast or reference to illness.[2] The World Health Organization declares health to be "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[3] One American Indian elder from southern Arizona, a retired housekeeper who suffers from chronic knee pain, explains that "healthy means that you're not sick. You're able to work, to do for yourself—everything." In his article, "The Embodiment of a Working Identity: Power and Process in Tarahumara Ritual Healing," Jerome Levi assures us that this conception of the self as able and productive is not idiosyncratic. However, Levi and other authors in this volume reveal that American Indian lay views of health do not always embrace this definition of health in opposition to illness.

Health is often expressed as a balance among body, mind, and spirit/soul[4] which is obtained and maintained through culturally appropriate responses to actual and/or perceived events.[5] Raised practicing both his tribal and Catholic religions, a Southern California Native American in his thirties says that health includes "the spiritual, physical, and the mental—you get a good mixture of all those [if you] believe in something higher than yourself." Health is also felt to be influenced by the interactions between people

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and natural elements, since humans originated from and with the assistance of beings of the natural world. These ideas about health are founded in American Indian oral narratives as well as historical and cosmological teachings that are shaped within sociocultural contexts.

According to oral traditions, during primordial times beings were immortal, and the first peoples of earth were in a state of health. Due to jealousy, treachery, or poorly controlled consciousness, one or more beings used his or her powers unwisely, resulting in the illness and death of one or more of the first beings. This is true today just as it was in centuries past. In the interdependent scheme of the cosmos, certain beings give their lives for others; for instance, deer or salmon may offer their lives so that others may be nourished. Although mortality occurs, healing powers also come into existence. Poison plants exists but so do healing plants, representing negative and positive power. These ideas form the foundation of American Indian cultural perceptions of health, illness, and mortality throughout the continent.

As in the past, contemporary states of health among American Indians may be jeopardized by a disruption in the integration of the body with either secular or sacred social connections. When secular and sacred ties are disturbed,[6] ill health may ensue. Reactions to disharmony may occur days, weeks, months, years, or generations after the event. What may be considered a health problem or illness among certain individuals or groups might be ignored or viewed as an observable physical or behavioral distinction in others. Certain people may consider sadness, disrespect, a cough, or tooth loss as impairments or dysfunctions, while others may perceive them to be nothing more than distinguishing markers.[7]

Inherently linked to biomedicine, disease is usually described by health professionals as a purportedly objective, decontextualized,[8] and measured physical change in the structure or functioning of the body.[9] Certain American Indian lay individuals and communities recognize disease as a condition diagnosed by a clinical health professional. For example, among members of certain Southern California tribes, lupus and diabetes—defined, diagnosed, and legitimized solely by medical technologies and personnel—are called diseases.[10]

Death also may be defined in a variety of ways. Clinicians, biogeneticists, religious leaders, and members of different ethnic groups may all consider death to occur at distinct stages and under different circumstances.[11] In this volume, Edward Castillo, Donna Akers, Troy Johnson and Holly Tomren eloquently describe and analyze the ways in which extreme spiritual anguish accompanies and aggravates bodily death. Indeed, among the Choctaw during the period after forced migration to Indian Territory, spiritual death may have taken place even as physiological life continued. Perceptions of the afterworld are also varied. Death of the body does not necessarily imply extermination of the soul.[12] Having passed from the secular world, the soul may still retain power. For this reason, the dead continue to influence the health of their ancestors and others. They are still part of the spiritual world and are honored through memorial services, meals, and stories. According to many Native people, spirits can cause disease and death, or they may contribute to health and well-being.

As revealed in this volume, major health concerns of the past centered on medically identified infectious conditions such as respiratory ailments, typhoid, diphtheria, measles, smallpox, syphilis, trachoma, and tuberculosis. The authors also assess Native-identified problems including fevers and sickness of mysterious origins, sorcery, and forced migration from ancestral homelands and spiritual beings. Emotional torment, hunger, and the deterioration of tribal environmental, economic, social, and political resources all contributed to these dilemmas. Current health concerns are no less alarming and may be traced to local and national histories and policies. Clinical typologies include Type 2 diabetes, cancer, depression, suicide, stress, violence, and substance abuse, all of which plague the Native peoples of North America. The only contemporary indigenously defined illness in this volume, detailed by Levi, is described in English as a "loss of power" accompanied by pain and weakness. It may not surprise readers that these symptoms are often associated with the preceding listed clinical conditions. And even though a single individual may exhibit symptoms associated with a loss of power, his or her friends, family, and community members may also be at risk for this problem, not just the individual affected by the loss of power.

Native peoples in some regions may be in jeopardy because the loss of numerous community healers and shamans throughout the past century has decreased the ability to protect people. Fortunately, American Indian individuals and groups are not passive and fatalistic. They tend to take action and try to rectify ailments. Solutions, both grandiose and minor, are available. As many elders will tell, it is not possible to return to the "Old Ways." However, as Levi clearly delineates, it is possible and helpful to incorporate tribal traditional healing processes to treat contemporary woes. These therapies may not resemble all facets of those that took place twenty, fifty, or two hundred years ago, but like the Tongva who attacked an epidemic through the destruction of the sand painting as described by Castillo or those leaders who initiate social service and health care programs in their communities as discussed by Hassin and Young, American Indians are taking actions for positive purposes.

Clinical, Native, and popular therapeutic systems are all described in this issue. Under particular circumstances, certain people utilize one health system, whether biomedical, Native, Christian, or some other form. A person with a fever may take ibuprofen, while some individuals have developed syncretic systems, mixing health beliefs and behaviors much like they combine elements of different religions into one ritual. For instance, someone who has a fever may assert that it was caused by germs and must be treated through the joint use of rest, prayer, and aspirin. Other individuals may combine treatments from more than one tribal group, blending herbal treatments from two distinct regions, for instance.

Many people make use of multiple systems of health care, utilizing two or more parallel and seemingly distinct structures of health. Like the person who practices both Catholicism and her Native religion separately, this individual may declare that her fever was caused by germs and by the evil intent of another person. Sometimes the etiologies and associated prevention and treatment methods of a condition form cognitively separate domains.[13] When

a multiplicity of health systems exists, there are numerous points at which an individual and/or caregivers can make a usage choice, and so the health care decision-making process becomes quite complex.

The health-seeking process is not always sequential. A person may forgo care, then seek preventive measures, and later use two or three systems of care.[14] As Brooke Olson, Nancy Reifel, and Diane Weiner write, overall choice seems to be inextricably linked to cultural acceptability, economic and infrastructural access, and efficacy. Todd Benson, Linda Burhansstipanov, James Hampton, Martha Tenney, Jerome Levi, and Clifford Trafzer keenly observe that political structures greatly impact the utilization of health care as well as health status. These phenomena are not unique to Natives of North America—such situations are common throughout the world.[15] However, they are particularly acute in American Indian health strategies because of the pervasive domination of Euramerican governments over American Indian communities.

The authors of this work examine the ways in which people from various indigenous communities think about and practice health care within historical and sociocultural contexts. The writers also assess the impact of a variety of social, health, and political systems on the health of Native peoples. Conditions of health, illness, disease, and death must be analyzed and addressed in this manner. Expressed eloquently by Eric Henderson, Stephen Kunitz, and Jerrold Levy in their analysis of Navajo youth gang behaviors, maladies have histories and presents that must be examined in order to be deterred in the future.

With the exceptions of Akers, Castillo, and Levi, the writers in our volume analyze clinical categories of illness. As academics we might ask ourselves why there is currently a fascination with and focus on clinically defined health categories? Is it because we are doing our research and writing in English, the language of clinical health in the United States? Is it because American Indians currently have a greater tendency to be diagnosed and cared for by clinical practitioners than by Native providers? Is Type 2 diabetes more prevalent than "loss of power"? Are health professionals and lay people more apt to request a study of diabetes than of loss of power, asserting that the former is more damaging than the latter? Is it because after decades of investigating so-called cultural illnesses, we as academicians prefer not to reveal the perceived sacred, ritual, and private health beliefs and practices of American Indians? Or, in a more cynical vein, are there more sources of funding to examine suicide and cancer than to investigate soul loss? These may be unanswerable questions. We must ponder these inquiries and ask if and why these predicaments have value.

All of the authors in this work strive to shed light on information that has been ignored, underreported, misclassified, and obfuscated. The works in this volume are all original, and they contribute significantly to the developing body of research by and among contemporary Native peoples of North America. In his original essay, "The Embodiment of a Working Identity: Power and Process in Tarahumara Ritual Healing," Jerome Levi deals with a curing ceremony that a leader underwent in 1989 among his people, the Rarámuri

(Tarahumara) of northern Mexico. Levi argues that his research demonstrates that the body is a "house of the souls" as well as an active agent of Rarámuri personhood. The body, he argues, requires serious scholarly study in terms of ritual healing. Levi shows that through the physical body, the people empower themselves and bring forth strength, vitality, energy and health. He provides a comparative study of healing ritual and a firsthand, detailed description and analysis of one such ritual.

In his provocative essay, "Blood Came from Their Mouths: The Response of the Chumash and Tongva Indians to the Pandemic of 1801," Edward Castillo links the spiritual beliefs of two California Indian peoples to disease, death, and cultural resistance. He examines the Tongva and Chumash Indians of the Los Angeles basin and adjoining northern coastal region. During the era of the Spanish mission system, Native Americans often interpreted epidemics as manifestations of their culture, finding causes and solutions within their own cultural frameworks. During an epidemic in 1801 at Mission San Gabriel, Tongva viewed the sickness and death as an internal, Native phenomenon created by two *Ta.xkw.a* (Indian doctors or medicine men). The disease may have been diphtheria, but Tongva leaders learned that a local captain had hired two Indian doctors to create a sand painting on Catalina Island to kill his opponents. After the people killed the two medicine men and their assistant, the epidemic ended among the Tongva. Diphtheria also ravaged the Chumash at Mission Santa Barbara, Santa Ynez, and La Purisima Concepcion. During the height of an epidemic in 1805, a Chumash woman dreamed of a Native deity named Chupu (Earth Mother) who instructed the people to save themselves from sickness by refusing or renouncing Christian baptism. Castillo links the armed resistance of the Chumash against the Franciscans and presidio soldiers with Native spiritual beliefs that significantly influenced the course of events between the two peoples. He maintains that Native religion played a significant role in response to European diseases and that Native spiritual beliefs tied many people together as a natural cultural response to biological threats brought by the Spanish.

The correlation between Native spiritual beliefs and health is also a theme found in Donna Akers' essay, "Living in the 'Land of Death': The Choctaw Occupation of Indian Territory." Akers argues that the forced dispossession of Choctaws from Mississippi was far more than political and economic. Rather, the Choctaws saw the forced exile from their homes as a spiritual uprooting to a place they called "The Land of Death," that is, the direction or place where the dead lived after ending their lives in Mississippi. Like many Native Americans, Choctaws considered their homelands to be sacred and marked by Nanih Waiya, a sacred mound that was built after the people had completed their migration to Mississippi and that took generations to build. The Bookbearer enjoined the people never to surrender their homelands and left a legacy of beliefs and rituals that bound the people together and with plants, animals, water, and places of the south. When the United States forced the Choctaws to move to Indian Territory, the government created a catastrophic situation for the people because they had been told never to surrender their homelands. Furthermore, the government forced most

Choctaws into present-day Oklahoma, a dangerous place where spirits of the dead traveled low to the ground or resided permanently. As a result of this forced relocation, the Choctaws suffered disease, starvation, suicides, murders, and a general anomie that dislocated the people for generations.

A similar situation is analyzed by Clifford Trafzer in "Infant Mortality on the Yakama Indian Reservation, 1888–1964." Trafzer describes how the government relocated fourteen distinct tribes and bands onto a small land base known as the Yakama Reservation in central Washington State, where people died of many diseases. During the seventy-six-year period from 1888 to 1964, the modal age of death on the reservation was infants under one year of age. He shows that the infant mortality rate on the Yakama Reservation from the 1920s into the 1940s was many times higher than that of whites and nonwhites in the United States as well as that of people in Washington. Infants died primarily of pneumonia, gastrointestinal disorders, tuberculosis, heart disease, and syphilis. Trafzer maintains that while bacteria and viruses cause most infant deaths, conditions on the reservation—poor housing, lack of traditional food, depression, inadequate public health and medical care, and powerlessness—contributed significantly to high infant mortality. And though it is possible to quantify the numbers of deaths, it is not possible to measure the degree to which housing, food, depression, medicine, public health education, and so forth contributed to these deaths. On the Yakama Reservation, nearly a third of all deaths during the era from 1888 to 1964 were those of children under six years of age. This is not uncommon among populations throughout the world, but it is disturbing nevertheless.

In her work, "In the Fall of the Year We Were Troubled with Some Sickness," Jean Keller also deals with childhood deaths. She traces the deaths of individual students in 1904 who suffered and died from a typhoid epidemic at Sherman Indian Institute located in Riverside, California. Keller details the case histories of each student and discusses the circumstances surrounding the epidemic. She offers a critical analysis of Harwood Hall, the school superintendent who failed to report the deaths or epidemic in his correspondence with the Office of Indian Affairs, referring euphemistically to the epidemic as "some sickness." Keller's article is one of the first scholarly examinations of Sherman Indian Institute and inaugurates a larger research plan to examine medicine, health, disease, and death at the government boarding school.

Todd Benson explores Indian health during the era of the 1920s when the Office of Indian Affairs launched a dangerous campaign to eradicate trachoma among Native American populations. In his essay, "Blinded with Science: American Indians, the Office of Indian Affairs, and the Federal Campaign against Trachoma, 1924–1927," Benson addresses the problem of trachoma, a debilitating eye disease in which tiny red blood vessels form in the conjunctiva or lining of the eyelid and surface of the white of the eye. Trachoma spread through tears, infecting hundreds of Indians. Unable to control the disease, the medical division of the Office of Indian Affairs chose a radical surgical procedure known as grattage to eradicate the disease. When this procedure failed, medical doctors working for the government began per-

forming tarsectomies, the removal of the tarsal plate underlying the conjunctiva. Even when administrative and medical officials realized that the radical procedures did not work, they continued to operate on American Indian patients in order to curb the tide of trachoma.

Not all health professionals working on reservations were as calloused as policymakers for the Office of Indian Affairs or the surgeons performing tarsectomy. Nancy Reifel provides insightful research into reservation field nurses and their fight against poverty, ill health, smallpox, and tuberculosis. In her essay, "American Indian Views of Public Health Nursing, 1930–1950," she focuses on two Sioux reservations, Pine Ridge and Rosebud, discussing the role of field nurses and the responses of various Lakota people to white field nurses. The oral histories provided in this path-breaking essay will be useful to anyone interested in health among Native Americans during the early twentieth century. They provide an American Indian voice seldom heard with regard to the efforts of field nurses to stem the tide of disease and death on reservations during this period. The use of oral interviews with Native peoples is a hallmark of Reifel's essay as well as that by Diane Weiner.

In her innovative contribution, "Ethnogenetics: Interpreting Ideas about Diabetes and Inheritancy," Weiner constructs a work that employs original field research with interpretations. She deconstructs the terms *genetics* and *inherited* with regard to cross-cultural discourse between Native American patients and health providers. In a very real sense she deals with four "bodies," including the body of Native people with diabetes, the body of medical-health providers, the body of Native communication, and the body of communication of the medical-health providers. Weiner points out that data regarding perceptions about inheritance help researchers understand the causes and nature of diabetes as well as illustrate the cultural misunderstandings that arise between and among health providers and Native patients when discussing diabetes.

In her work, "Applying Medical Anthropology: Developing Diabetes Education and Prevention Programs in American Indian Cultures," Brooke Olson offers practical advice to tribal leaders, health providers, and policymakers about dealing with diabetes. After providing brief overviews of diabetes and genetic considerations about the disease among Native American populations, Olson suggests specific strategies for dealing with diabetes education and prevention among Native cultures. She argues that effective programs depend on understanding the cultures being served, since there is a vast difference among diverse tribes. Traditional health beliefs, concepts of the body, Native exercise and games, storytelling, and native foods are all topics discussed and analyzed by Olson. These are powerful components of an effective diabetes education and prevention program among Native peoples.

Felicia Schanche Hodge and John Casken offer "Pathways to Health: An American Indian Breast Cancer Education Project." Their research details practical and culturally sensitive steps by which health care providers might implement a breast cancer educational program for Native American women in California. Using a community-based approach, the scholars worked with six focus groups of California Indian women to produce educational materi-

als, including an informational video for Native women, a breast cancer treatment guide, a resource directory, workshop curricula, and a video for health care providers. Among the many findings in this work is the discovery that California Indian women regard early detection of breast cancer as a low priority in their lives in comparison to the needs of their families. The authors also point out that one of the problems associated with breast cancer and other forms of cancer among American Indians is the lack of accurate data regarding cancer among Native populations.

This is the major theme of another work found in this volume. In their essay, "American Indian and Alaska Native Cancer Data Issues," Linda Burhanssitpanov, James Hampton, and Martha Tenney point out the great need to develop cancer programs among Native Americans as well as the problem of obtaining reliable data in order to assess epidemiological trends among Native populations with reference to cancer. Overall, there is a general underreporting of cancer incidences, deaths, and survivals for Native Americans, the result of which has been the inability of health professionals and Native peoples to recognize increased cancer rates throughout Indian country. The authors argue that while New Mexico, South Dakota, and Alaska have access to better databases, other states do not.

Most scholars would agree that in order to provide effective health education and prevention programs, communities and professions must have a baseline of accurate data on the health problem. This is certainly true with regard to diabetes, cancer, and suicide as demonstrated in works featured in this volume, but it is also important in dealing with another health problem that has emerged among Native Americans: the rise of youth gangs on Indian reservations. Eric Henderson, Stephen Kunitz, and Jerrold Levy combine their research to offer "The Origins of Navajo Youth Gangs." The authors argue that youth gangs among the Diné emerged out of the nineteenth century, after the United States forced thousands of people on a "Long Walk" to the Bosque Redondo for a four-year exile in eastern New Mexico. The Navajo War and forced removal in the nineteenth century were catastrophic to Diné men who had previously proven their ascendancy to adulthood through raiding ranchos for horses, cattle, and sheep. This component of Navajo culture largely ended after 1868 when the people returned to their homelands, but some males continued to organize into adolescent male peer groups. Today, officials of the Navajo Nation estimate that sixty youth gangs exist on the reservation, groups that originated in the 1970s. The authors argue that although these gangs have antecedents in the last century, changing demographic, economic, and social conditions on the reservation during the 1970s contributed to the rise of modern Navajo gangs. They maintain that membership in a gang is one way in which Navajo youths may make the transition from childhood to adulthood. Using a theoretical framework advanced by Terrie Moffitt, the authors examine the emergence of modern gangs that are intimately connected with alcohol and drug abuse as well as other antisocial health-related behavior.

One of the themes developed by the authors is that gangs provide young people with a vehicle through which to feel mature, powerful, and in control of their lives. This is also a theme fully developed in "Self-Sufficiency,

Empowerment, and Community Involvement among Southwestern Indians." In this research, Jeanette Hassin and Robert S. Young argue that Native dependency on the dominant society has created destructive anomie among Native peoples and alienation from non-Indians. In order to correct this trend, the two scholars have launched a vigorous self-empowerment program to encourage Native American self-sufficiency through community involvement. Hassin and Young maintain that permanent change can occur within communities through self-determination and self-sufficiency, a two-tiered process involving one's personal health, direction, and action as well as a community level of revitalization. The authors provide firsthand interviews discussing views of the body, mind, pain, health, spirit, and other topics. This revealing piece of research offers suggestions for personal and communal action that will lead to empowerment and better health.

Certainly one's view of body, mind, spirit, pain, and empowerment have a great deal to do with reversing trends among Native Americans that can lead to suicide. This is a major theme found in "Helplessness, Hopelessness, and Despair: Identifying the Precursors to Indian Youth Suicides" by Troy Johnson and Holly Tomren, offering a detailed analysis of suicide, suicide stereotyping, and suicide prevention among Native Americans, particularly young males. Their research is at once contextual and theoretical, drawing on the works of James Shore, Philip May, Teresa LaFramboise, Beth Howard-Pitney, and other scholars who have studied suicide among Native Americans. Johnson and Tomren argue that among American Indian youths aged fifteen to twenty-four years, suicide is the second most frequent cause of death in the United States—nearly two and one-half times greater than that of other youths from all races in the country. Suicide has been an ever-increasing problem among Native American populations on and off reservations since the 1950s, and it is considered epidemic on some reservations. After deconstructing and analyzing suicide among Native American youths, the authors offer recommendations to families, health care providers, human services professionals, and others interested in curbing the tide of youth suicides. Among others, these recommendations include using a team approach to combat suicide, incorporating volunteers from among tribal elders, teachers, parents, and spiritual leaders.

Health issues have always been an important element of American Indian culture, and the topic is a continual theme in the traditional oral narratives of all tribes. Since the time of creation, there have always been destructive forces afoot, doing harm to the people depicted in ancient tribal stories. There has never been a time when negative, destructive, and dangerous forces did not exist or threaten Native communities or individuals with annihilation. Traditionally, oral narratives metaphorically depicted disease and death as monsters that consumed plant and animal people, destroying the natural environment and creating confusion among communities. Within the stories evil monsters continually challenged the people, but through the heroic efforts of individuals and communities, the people always fought back against the forces of destruction. This is an underlying theme of the research presented in this volume.

At the end of the twentieth century, Native Americans are taking a greater role in fighting disease, death, depression, and destruction among their people. They are engaging in this struggle with increasing knowledge, although many Native Americans would agree that knowledge is unevenly distributed and access to knowledge is based on one's unique abilities to comprehend.[16] Much of the work in this volume expands upon this theme. We also contend that an understanding of past and current health dilemmas enable us to engage not only in theoretical conversations about problems, but also offer possible solutions from academics who cross the fence between the walls of the university and the indigenous communities and lives of people whom we describe and analyze. We hope that these investigations of health inspire others to develop the means to ensure the health and welfare of future generations of all First Nations people.

NOTES

1. See Arthur Kleinman, *Patients and Healers in the Context of Culture* (Berkeley: University of California Press, 1980); *The Illness Narratives: Suffering, Healing, and the Human Condition* (New York: Basic Books, 1988); Jenni Joe and Dorothy Miller, *American Indian Cultural Perspectives on Disability* (Tucson: Native American Research and Training Center, 1987); Veronica Evaneshko, "Presenting Complaints in a Navajo Indian Diabetic Population," in *Diabetes and Native Americans: The Impact of Lifestyle and Cultural Chan*ges *on the Health of Indigenous Peoples,* eds. Jennie Joe and Robert Young (Berlin: Mouton de Gruyter, 1994).

2. See Lesley Doyal with Imogen Pennell, *The Political Economy of Health* (Boston: South End Press, 1979); Robert Hahn, *Sickness and Healing: An Anthropological Perspective* (New Haven: Yale University Press, 1995).

3. World Health Organization. WHO Definition of Health from the internet, 1997–1998 (http://www.who.int.aboutwho/en/definition.html).

4. For an excellent presentation of this description of health and wellness, see John Molina, "Cultural Medicine," *Journal of Minority Medical Students* (Spring 1997): 28–32.

5. See Robert Lake, Jr., "Shamanism in Northwestern California: A Female Perspective on Sickness, Healing, and Health," *White Cloud Journal* 3:1 (1983); Carol Locust, *American Indian Beliefs Concerning Health and Unwellness* (Tucson: Native American Research and Training Center, 1986).

6. For instance, the majority of accidents and injuries have observable secular causes. Nonetheless, some acts that befall a person may also be traced to social and/or religious violations. A person may state that a child cut her foot on a loose rock while bicycling without shoes. This event may be analyzed as a circumstance of visible causal relations. Yet it may also be attributed to the improper social behavior of the child or her kin.

7. Jennie Joe and Dorothy Miller, 1987. See also Cecil Helman, *Culture, Health and Illness: An Introduction for Health Professionals* (Boston: Wright Publishers, 1990).

8. See Laura Nader, *Naked Science: Anthropological Inquiry into Boundaries, Power, and Knowledge* (New York: Routledge Press, 1996) for an analysis of scientific knowledge.

9. Cecil Helman, *Culture, Health and Illness: An Introduction for Health Professionals*,

86–89; See also Horatio Fabrega and Peter Manning, "Illness Episodes, Illness Severity and Treatment Options in a Pluralistic Society," *Social Science Medicine* 13B (1979): 44.

10. For more information on this subject see Diane Weiner, "Luiseño Theory and Practice of Chronic Illness Causation, Avoidance, and Treatment," Ph.D. diss. (University of California, Los Angeles, 1993).

11. See Robert L. Rubinstein, "Narratives of Elder Parental Death: A Structural and Cultural Analysis," *Medical Anthropology Quarterly* 9:2 (1995): 257–276; Margaret Lock, "Death in Technological Time: Locating the End of Meaningful Life," *Medical Anthropology Quarterly* 10:4 (1996): 575–600.

12. Richard Applegate, *Atishwin: The Dream Helper in South-Central California* (Socorro, NM: Ballena Press, 1977).

13. See also Leo Chavez, et al., "Understanding Knowledge and Attitudes About Breast Cancer: A Cultural Analysis," *Archive of Family Medicine* 4 (February 1995): 145–152.

14. Noel Chrisman, "The Health Seeking Process," *Culture, Medicine, and Psychiatry* 1 (1997): 351–378.

15. Susan C. M. Scrimshaw, "Adaptation of Anthropological Methodologies to Rapid Assessment of Nutrition and Primary Health Care," *Rapid Assessment Procedures: Qualitative Methodologies for Planning and Evaluation of Health Related Programmes*, eds. Nevin S. Scrimshaw and Gary R. Gleason (Boston: MA: International Nutrition Foundation for Developing Countries, 1992).

16. See Lowell John Bean, "Power and Its Applications," in *Native Californians: A Theoretical Perspective,* eds. Lowell John Bean and Thomas C. Blackburn (Berkeley, CA: California Indian Library Collections, 1976).