THE EFFECTS OF LABELING ON HEALTH BEHAVIOR AND TREATMENT PROGRAMS AMONG NORTH AMERICAN INDIANS

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The effects on health status of poverty and lack of access to services are well known, and until recently major efforts were being made in this country to better the health of the nation's poor by inaugurating federally funded programs to improve living conditions and help pay for medical services. Cultural factors influencing the acceptance of modern medicine by, or impeding the delivery of health care to, ethnic minorities have also received considerable attention in the research literature. Yet it is in this area that the least effort has been made to implement recommendations based on research findings.

A wealth of anthropological literature convincingly demonstrates that societies around the world define illness in many different ways and that some of these definitions vary radically from those used by modern medical practitioners. The behaviors thought to be appropriate to the roles of patient and healer also vary widely among cultures. The lack of calibration of cultural definitions is a source of difficulty for modern medicine in most underdeveloped nations as well as among the many ethnic enclaves in modern Western nations. Less well studied is the process by which cultural definitions elicit behavior deemed appropriate from patients and health care providers. This process has been called "labeling" by sociologists studying social deviance.

Labeling theorists hold that no human behavior is inherently deviant but that social groups create deviance, and deviant behavior is that which is so labeled (Becker, 1963). Further, they maintain that a behavior labeled as deviant in one context may not be so labeled in others, and that all members of a society will commit acts considered deviant at some time in the course of their lives but will rarely be typed as deviant. Once individuals are labeled as deviant, however, their interaction with other members of the social group will force them to behave in the manner considered appropriate to the newly acquired role (Erikson, 1962; Lemert, 1951).

Labeling theory, or the interactionist perspective as it has also been called, was originally formulated to explain social deviance but was rapidly extended to include the domains of mental illness (Goffman, 1961; Scheff, 1966), physical conditions such as stuttering (Lemert, 1967), mental retardation (Mercer, 1981), hyperkinesia (Conrad & Schneider, 1980), and even sickness in general (Aubert & Messinger, 1958). Despite the fact that social deviance, mental disorder, and physical disease are very different from each other, the results of investigations...
in all of these areas exhibit a marked uniformity. Moreover, the boundaries of these domains often overlap due to the fact that they tend to change over time (Conrad & Schneider, 1980). Epilepsy and syphilis, for example, are physical diseases but each has a moral component, and alcoholism has only recently been removed from the domain of "badness" to that of sickness.

The extreme relativism of the labeling approach has been vigorously challenged because, although it explains how the role of the deviant is created and how subsequent deviant acts follow almost inexorably, it does not explain the original act which initiated the sequence of events. It is also difficult to see how a society can be completely arbitrary in its definitions of deviance and illness. Surely, such major forms of deviance as homicide are universally deplored and such easily recognizable syndromes as the grand mal seizure must be taken into account by all cultural systems. The merits and demerits of the theory as an explanation of all deviance need not detain us, however. What is important for the purposes of this paper is that the labeling perspective can help us understand many of the interactions between practitioners of modern medicine and the culturally distinct populations they serve.

This paper focuses, first, on problems that arise when the definitions of illness and appropriate behaviors for patients and healers of an American Indian society are so at variance with those of the modern health delivery system that physicians and Indian patients become confused and exasperated. Examples of this type of cultural dysfunction are called problems of "intracultural labeling." The second area of concern, "cross-cultural labeling," involves problems which arise when health practitioners misinterpret the behavior of Indians and, in so doing, create an erroneous definition of the Indian which then engenders either the behaviors "expected" of Indians as now defined or negative reactions, either of which is counterproductive and self-defeating.

In the discussion that follows, it will be helpful to keep in mind some of the salient features of the labeling process:

a) Sickness must be recognized and labeled as such before the individual can adopt the role of patient and receive treatment; b) in order for this to happen, health providers and their clients must share definitions of sickness; and c) aware that he/she has been labeled, the individual takes the shared understanding into account when relating to those around him/her.

The sick, for example, display behaviors thought to be appropriate for patients and, as Goffman (1961) has shown, those labeled as insane must learn to behave in the manner their caretakers expect of them. Once a person has been labeled, the question of how to relate to him or her is more easily resolved when cultural prescriptions exist (e.g., that sick people should be treated and evil people punished).
Labels are more apt to be accepted if a high-ranking person does the typing. People are more likely to accept a pronouncement by a physician than a lay person, for example. But, again, there must be an acceptance of the social hierarchy. Lay people must recognize the physician’s authority before they behave in the manner expected of them. Negative social labeling is more readily accepted than positive typing. People like to hear of the frailties of others and norms tend to be highlighted more by infraction than by conformity. Finally, people close to the deviance tend to normalize and accommodate it. Those at greater social distance are more ready to see the deviance as pathological or serious. Thus, wives learn to live with alcoholic husbands and resist the efforts of friends to help them to recognize the problem. Also, people of one culture or social group are quick to label an outsider as deviant simply because his lifestyle is different from their own. Because we live in a society that includes a multiplicity of social classes, geographic regions, and ethnic groups with different ideas about deviance, labeling most often has an ethnocentric bias.

The examples of intracultural and cross-cultural labeling which constitute the major proportion of the paper will be used to illustrate the implications a lack of understanding of these processes has for the success of health programs. A concluding section will consider the reasons few health programs serving Indians have implemented research findings, what new research efforts should be made in the future, and what prospects for success may reasonably be contemplated.

Intracultural Labeling

Indian societies often have definitions of deviance which differ radically from those of the dominant society in general and the medical establishment in particular. The examples presented here involve a physical disease which is taken by an Indian society as an indicator of social deviance, and two forms of social deviance which are themselves the consequences of labeling individuals as deviants. In each instance, the medical establishment’s definition and method of treatment are at variance with Indian perceptions.

Epilepsy Among the Navajo

According to traditional Navajo belief, sibling incest causes grand mal seizures. A study of Navajo epileptics, identified in 1964 and followed for 10 years, was undertaken to determine whether epileptics were labeled as deviants and suffered thereby, and whether indigenous methods of diagnosis accurately identified epileptics and distinguished them from hysterics with pseudoseizures (Levy, Neutra, & Parker, 1979). Subsequently, between 1979 and 1982, a comparative study of Navajo, Hopi, Tewa, and Zuni epileptics was undertaken to see whether
Navajo epileptics fared worse than their Pueblo counterparts whose societies did not imbue seizures with such negative connotations (Levy, 1987; Levy, Neutra, & Parker, 1987).

Navajo epileptics generally led difficult lives. Female epileptics were sexually exploited, gave birth to illegitimate children, and were raped more often than a group of women with pseudoseizures. Some 30% of female epileptics had pseudoseizures in addition to their epileptic seizures, a feature not found among Pueblo epileptics. Between 1964 and 1974, three patients died: one from exposure after drinking, another from suspected foul play, and the third by suicide. Male epileptics tended to drink heavily and were frequently aggressive and violent. Although it was difficult to know whether their drinking was excessive as compared with other Navajo men of the same age, a larger than expected number never married and were unable to keep a steady job. Over 30% of the patients with grand mal epilepsy had actually committed incest with a true sibling or with a "clan" sibling. In the case of the women, the incest appeared to result from a self-fulfilling prophecy as the epilepsy had started several years prior to the incestuous act. One male had forcibly and repeatedly committed incest with his younger sister some years after the onset of his seizures.

By casting the epileptic in the role of social deviant, Navajo society actually created unfortunate outcomes not consequent upon the epilepsy (as defined by modern medicine) alone. By contrast, the Pueblo epileptics were able to lead relatively normal lives. None of the Pueblo groups defined the generalized seizure in as negative a manner as did the Navajo, nor did they give any salience to convulsions in their disease classifications. If the untoward careers of Navajo epileptics were the result of impoverished living conditions or of general ignorance and resistance to treatment, similar observations should have been made among Pueblo epileptics. Navajo epileptics were found to have social and emotional problems more often that the Pueblo epileptics. Moreover, these problems were more severe and appeared at an earlier age. Only Navajos were diagnosed as psychotic. Only Navajos were involved in homicide or homicide attempts, and only Navajos made serious suicide attempts. There was a tendency for Navajo women to have persistent hysterical reactions whereas only one Pueblo male had a hysterical reaction and this was limited to a few episodes.

Pueblo parents were more supportive of their epileptic children and avoided treating them as different in any way. Navajo parents, on the other hand, frequently withdrew support and preferred to keep the epileptic child isolated from the general community. The characteristic style of the Navajo parent was withdrawal and hostility. One boy related that his parents would leave home for hours whenever he had a convulsion.
In light of these findings, it would be reasonable to expect Navajos to respond positively to a regimen of antiepileptic medication which would control the seizures and make possible for the family to escape community censure. This, in fact, was not the case. Neither Pueblo nor Navajo epileptics were well maintained on medications, and seizures tended to recur frequently as a result. From this, however, it would be incorrect to conclude that a more carefully monitored treatment program with a comprehensive educational component would achieve greater compliance. Each group was noncompliant for very different reasons although the absence of case registers, organized follow-up procedures, and even the semblance of educational activities were distressing features of the services provided all these tribes.

The Tewa Pueblos lacked knowledge of the disease and there was little communication between care providers in the hospital and in the villages. It was thought that a program designed for the general population would probably achieve excellent results among the Tewa. The Zunis who were poorly maintained were from homes disintegrated by alcoholism. Neither years of education nor degree of belief in traditional medical practices influenced compliance, and the hospital was only a short distance from the main village. No epilepsy program which did not take the alcohol problem into account could hope for success in this context. Noncompliance among the Hopis appeared to be the result of the tendency for traditional Hopis to see all illness as caused, in part, by a lack of will on the part of the patient. Thus, while a child would be brought in for emergency treatment during or immediately after a seizure, maintenance was a problem because continued use of medication was seen as a personal weakness. Obviously, for a treatment program to have any success among the Hopis, considerable effort would have to be made to disassociate drug regimen from ideas of personal worth without destroying the sense of personal responsibility. Among each of these groups, however, the treatment program achieved the best results when working with the family of the epileptic child.

The Navajos present a rather different problem. As with the Hopis, a traditional definition of illness is the proximate cause of noncompliance and only the most acculturated and educated parents administered medications well to their children. However, whereas the Hopi belief that an individual is in some sense responsible for his or her own health has a positive component on which the sensitive counselor can build, there is little in the complex of Navajo belief and attitudes associated with seizures that can be turned to advantage. An educational program which sought to replace Navajo belief about the cause of seizures would be especially prone to ridicule in the face of the known cases of incestuous epileptics in the community. Moreover, the scattered settlement pattern of the Navajo makes continuous contact with the parents difficult to
maintain. With the exception of the highly acculturated, the only Navajo children who were well maintained were those in the federal boarding schools where school personnel took the responsibility to administer the medications.

Success is more likely to be attained among the Navajos by a program which places a high priority on efforts aimed at school-aged epileptics. Therapy groups should be formed by bringing these children together for a few days each month. This would help break the children’s sense of isolation by bringing them into contact with fellow sufferers. Recreational activities would require the idea that a normal life is possible despite the epilepsy once patients take it upon themselves to use medications to control seizures.

Suicide and Alcoholism Among Hopis and Shoshone-Bannocks

Suicide is one of the most studied forms of social deviance in the Western world. Ever since Durkheim’s (1951) classic study of suicide in 19th century Europe, suicide has been perceived as the final act of the despondent, the sick, and the socially isolated. Although today suicide is most often thought of as a symptom of psychological disorder, this was not always the case. At one time, and still today in many Catholic countries, suicide had a large moral component and the offender could not be buried in hallowed ground. Alcoholism has also come to be defined as a disease, either a physiological addiction or a psychological dependence. Whereas the alcoholic was once defined as weak and immoral, he or she is today able to adopt the patient role and receive treatment rather than salvation. The examples of suicide and alcoholism discussed below show that modern treatment methods in the form of suicide prevention and alcoholism programs run into difficulty when the Indian society defines the deviance as a form of badness rather than sickness, and when the distribution of suicide in the Indian population differs radically from what the health provider is led to expect.

Very different distributions of suicide and alcoholism have been found among Hopi and Shoshone-Bannock Indians, which indicates that conventionally designed suicide prevention and alcoholism programs will not target the populations at risk. In the 1960s and 70s, Shoshone-Bannock suicide rates were over 10 times the national average (some 100 suicides per 100,000 population) (Dizmang, Watson, May & Bopp, 1974; Shore, Bopp, Waller, & Dawes, 1972). Especially high were the age-specific rates for the 15-24 year age group. A suicide prevention program and facility were started by the Indian Health Service, and subsequently, the National Institute of Mental Health (NIMH) provided funds for the tribe to conduct research and to develop a program evaluation activity.
The prevention program concentrated its efforts on working with teenagers who had made suicide attempts and gestures and, because several adolescent suicides had occurred in off-reservation jails, with police and court officials in the neighboring towns where these suicides occurred. The assumption was made that Shoshone-Bannock youth were having a difficult time adjusting to "modern" society and that the jail suicides represented a reaction to the disorienting nature of the contact situation.

The research revealed that none of the completed suicides had a history of having made attempts or gestures. Conversely, none of the attempters had ever gone on to actually commit suicide. Suicide attempts were clustered within two or three extended family groups. Suicide, homicide, and fatal car accidents were found among eight family groups with the largest proportion concentrated in only three of these. Alcoholism, by contrast, was distributed rather evenly throughout the reservation population. A search of federal reports going back into the 19th century revealed that the majority of suicides had always been committed by individuals from only three or four family groups, and that every 20 years or so some of these surnames would disappear from the records only to be replaced by new ones. It seemed likely that the pattern of labeling certain families as deviant and, somehow, segregating them from the community proper was an old one. These families served as scapegoats and boundary markers for the community. Some disturbed and rebellious adolescents in each generation would, presumably, marry into the deviant families while those members of the deviant families who resisted the deviant label might move away from the reservation.

There was a clear indication that the suicide prevention program would have to spend less effort working with the suicide attempters and more getting to know the deviant families intimately. Until more knowledge of these families was available and techniques for working with them could be devised, a program aimed at general counseling of troubled adolescents was recommended. The ethical question was also raised whether, in a population of only 2,000, concentrating efforts on the already labeled families would do anything more than spotlight the fact that these families were different from others and thus reinforce the labeling process.

A parallel situation was found among the Hopi Indians, where suicide rates had climbed steadily since the mid-1950s and deaths from alcoholic cirrhosis were far higher than the national average. Attention of the Hopi tribe was drawn to the problem when people became aware of the fact that the age-specific rates for the 15-24 year age group had increased at a greater rate than that for the other age cohorts. Because excessive drinking was almost invariably associated with the suicidal act and because the most publicized cases involved youths with
some education who had grown up in the least traditional villages, Hopis and Indian Health Service personnel alike saw the problem as the direct consequence of acculturation and the state of anomic produced by that process.

Initial research findings seemed to confirm this impression (Levy, Kunitz, & Henderson, 1987). Suicide and death from alcoholic cirrhosis occurred most frequently in the off-reservation border towns, were frequent in the non-traditional villages, and were conspicuously absent from the traditional villages. When the data were scrutinized more carefully, however, a rather different picture emerged.

While suicide rates had been increasing and were far higher than the national average, rates in the rural, non-Indian populations of the surrounding counties were rising at the same rate. It also appeared that drinking and social problems were generated at about the same rate in the traditional villages as in the progressive, acculturated villages. The traditional villages, however, expelled their deviants before alcoholic cirrhosis developed and before the deviant's career was terminated by suicide or homicide.

The individuals at risk for these forms of deviance were the children of parents who had made deviant marriages. Traditional Hopi society, in contrast to most other Indian societies, was tightly structured, demanding submission of the individual's will to that of the community. Competition between individuals or social segments was disvalued because it was highly disruptive. Internal cohesion was enhanced by village endogamy and, within the village, by the tendency to marry a person of comparable economic and, in consequence, ceremonial rank. Any breach of these rules of endogamy created conflicts of loyalty and competition between families of differing status. Yet, with the exception of intertribal and intervillage marriages which were strongly disfavored at all times, there were circumstances which often made interrank marriages desirable. During periods of economic expansion—wet years increased agricultural production—families of high rank sought to increase their manpower by marrying their daughters to energetic males of lower status. Later, during dry cycles and the consequent economic contraction, these lower status individuals and their natal families sought to maintain their reflected status and share in the agricultural product by laying claim to prestigious ceremonial positions these men often held on behalf of their wives' kinsmen. In sum, predictable lines of internal dissention and conflict appeared during hard times. These structurally anomalous families were, and still are, subject to considerable community-engendered stress. At least one of the parents and all of the children were treated as deviants and suffered thereby.

It is important to recognize that the deviance has its genesis in traditional society and reflects the stresses of that society more than of anomic disjunctions due to rapid change. At the same time, one cannot assume that the process of
accommodation to the dominant society is having no effect. Agriculture and its fortunes no longer power the marriage patterns of Hopi society. Instead, contacts made in school and at work are the contemporary sources of disapproved marriages. The values and perceptions of the older generations continue to be strong, however, as evidenced by the fact that the proportion of deviant marriages is not, as yet, increasing in the traditional villages.

Experience with the Hopi alcohol program convincingly shows that a treatment program which intervenes after the labeling process has done its work and the drinking problem is far advanced cannot undo what has already been done. In one instance, a family of drinking women became sober, however, the villagers continued to treat them as deviants. The family's relationships with their neighbors did not improve and they soon resumed drinking. The requisite prevention program faces several constraints. It cannot focus attention on the adolescents at risk, for that, as in the Shoshone-Bannock case, serves only to reaffirm the deviant label. In like manner it cannot identify itself primarily as a therapy program, for that too would limit its appeal to those already recognized as deviant. Nor can it present itself as a program addressing stresses engendered by traditional Hopi or the dominant society. To do the former would alienate all but the most "progressive," while to do the latter would deny that the path to ultimate adaptation is in the modern world. In sum, to be successful, a prevention program must attract deviant and nondeviant youth alike, provide counseling, enhance support networks and increase community awareness of the problems facing the adolescent generally without becoming identified in any way with the treatment programs currently extant or with any single theory as to the cause of Hopi social ills. Certainly the standard treatment and prevention programs designed for the larger, more anonymous, White society are not what is called for. Perhaps only wilderness adventure programs like Outward Bound or even Vision Quest can hope to fulfill these requirements (Levy & Kunitz, 1987).

The examples discussed thus far have dealt with problems that arise when cultures differ in the ways deviance is defined. The task facing the health care delivery system is one of discovering how the other culture works and then devising programs that take these differences into account. Research should not only pay attention to studying the beliefs, values, and attitudes of Indian communities, but special effort should be made to conduct epidemiological studies, because there is every indication that patterns of deviance and disease may differ considerably from what is found in the general population. In the following section, attention will be focused on interactions between Indians and non-Indian health professionals because, as we have seen, people of one culture label those of another and these labels often tend to be negative.
Cross-Cultural Labeling

How Anglo-Americans have perceived Indians in the course of the nation’s history has determined both the treatment accorded them and the behavior expected of them. The image of the Indian held by the dominant society has changed profoundly since the 18th century. The dominant image during the periods of initial settlement and westward expansion was that the Indian was a savage foe who, like the wild terrain, had to be conquered and tamed. Urbanization and industrialization coincided with the closing of the frontier and the confinement of Indians to reservations. By the end of the 19th century, as much of the eastern establishment began to realize the price that was being paid for continual expansion, the nation turned nostalgically to the rural "paradise" it had lost and the Indian began to be thought of as the pitiful remnant of a vanished race. The idea of the noble savage who once had lived in harmony with nature but had been debauched and degraded by civilization led, during the 20th century, to the belief that the Indian was deserving of the nation’s charity. Regardless of the rationalizations used to justify the treatment of Indians, whether based on the idea that their societies or their racial stock were less evolved, whether they were romanticized or merely regarded as unfortunates, the Indian has always been seen as somehow inferior. Those more favorably disposed might claim that this inferiority was not immutable but until the desired transformation took place the Indian could not be treated as an equal.

Throughout the nation’s history, behaviors seen as degenerate have been a constant element in discussions about Indian policy and programs. Alcoholism, sexual promiscuity, and lack of resistance to disease have all been seen either as the consequences of, or the reasons for, the Indians’ inability to succeed in Anglo-American society. Since the 1950s, and coincident with serious efforts by the federal government to improve Indian health, there has been a change in the nation’s ideas about the nature of social deviance. This change has been called the "medicalization" of deviance and madness and has involved redefining these aberrant behaviors as diseases rather than as moral failings or possession states (Conrad & Schneider, 1980). In sum, what was once in the charge of the church is now controlled by the medical establishment. Already the object of the nation’s compassion, the American Indian is increasingly being defined as "sick." Federal funding on Indian reservations, from being virtually nonexistent prior to the New Deal when a major effort was made to improve reservation economies and to give tribes more autonomy, has increasingly been spent on health, education, and social services. Today, an educated Indian wishing to remain on his reservation has almost no choice but to prepare for a career in these areas.
If the image of the sick Indian is still in the process of developing, the image of the deprived Indian is ubiquitous. While there is no doubt that Indians have been deprived of sovereignty and economic self-sufficiency, and are presently less well placed in the national society by almost any measure, the notion of deprivation carries with it the implication that there is an absence of vital elements. Thus, if an Indian does not have a formal education, the Anglo behaves as if the Indian’s intellectual abilities never matured. He or she is, in fact still a child. If Indian children have not had the same developmental experiences as White children, then they must be emotionally and intellectually impoverished rather than just different from White children. Liberal and humanitarian ideals and intentions notwithstanding, it is virtually impossible to actually treat someone as an equal deserving of respect and consideration if that person is perceived to be a cipher.

The purpose of the foregoing paragraphs has been to provide a context in which to place the dominant society’s current view of the American Indian. Although conservatives believe that the Indians have reached their present state because they have been kept dependent on the federal government and liberals view it as the consequence of destroying traditional culture, both agree that the current state of affairs leaves much to be desired. The question of crucial importance is, however, whether Indians can behave in any way other than as inferiors and incompetents so long as the dominant society, at every level, persists in seeing them as such.

Although much anthropological research has investigated the area of cultural differences in a nonperjorative way, there has been little done specifically to discriminate between the effects of cross-cultural labeling and those of harsh living conditions, malnutrition, and the like. In consequence, much of the following discussion must perforce rely on anecdotal illustration more than on the findings of quantified research.

You Can’t Say That in Navajo

One of the most persistent popular expressions used by non-Indians to refer to Indian languages is "the Indian dialect," which implies not only that Indians do not speak a fully developed language but also that all tribes speak some variant of the same language. Even among health professionals there seems to be a tendency to believe that if there is no single word in, for example, Navajo that precisely translates an English term or concept, then there is something incomplete, perhaps even deficient about the Navajo language. This misapprehension is clearly born of ignorance, but the negative connotation derives from the perception of things Indian as being somehow less than things White. It is doubtful that similar inferences would be made about German or French. In the early 1960s, research done in the Tuba City hospital on the Navajo
reservation revealed that the language barrier was sufficient to make communication between health personnel and Navajo patients dangerously inadequate. Subsequently, an interpreter training program was developed which was to serve as a model for similar programs to be established in all reservation hospitals (Levy, 1964). All non-Indian personnel who used Navajo employees to interpret for them were asked to enroll in the program with the Navajo who usually worked with them. Thus, a dentist and a dental assistant would be trained together as a team. The goal of the project was to make non-Indians aware of the complexity of Navajo and of their own imprecise use of English, in addition to developing better interpreting skills among the Navajo staff. One problem and its solution must suffice as an example of how negative labeling by non-Indians produced noncooperative behavior on the part of Navajo patients and their families.

At the time of the program’s inception only 3% of deaths occurring in the hospital resulted in autopsies. Because hospital accreditation demanded a considerably higher rate, there was some incentive for the medical staff to support a program which promised a solution to this as well as several other problems. By physicians’ accounts, Navajos refused permission to conduct a post mortem because they were superstitious about the dead and nothing one could tell them seemed to change their minds. Moreover, families of the deceased seemed unwilling to accept the physician’s condolences, reacting to his expression of concern by leaving the hospital as rapidly as possible. According to the Navajo employees there was no way to say "I am sorry" in Navajo and the literal translation of autopsy as "to cut into the body to find the cause of death" only served to further agitate Navajos. Both the Navajo and Anglo staff were content to leave it at that: Navajo just didn’t have the words to convey the physician’s meanings and Navajos were ignorant and unwilling to accept modern ways because of their mistaken fears and beliefs.

By using an approach that sought to calibrate concepts rather than to provide literal, word-for-word translations, Navajos and Anglos were asked to define the concept of the autopsy. The physicians had taken for granted everyone understood that modern scientific medicine was based upon constant learning and that an autopsy was a way to discover new facts and expand knowledge. The Navajo staff confessed they had not known this, but thought that the physicians wanted to determine the cause of death to make sure they had not made a mistake. The solution was found by explaining to patients and their families the difference between modern medicine which was constantly learning and expanding and the Navajo system which was self-contained and complete. Once the context of the concept was clarified there was little difficulty getting Navajo families to understand and accept the reason for the request.
Translating "I am sorry" rested on the understanding that the word used by Navajos also meant "worried" and "anxious," but that its meaning was determined by the context in which it was used. Navajos have a kin-based society. As a general rule, those who are not kinsmen are not expected to have a personal interest in each other's affairs. When physicians said, "I am worried that your baby died and would like your permission to cut into the body to find the cause of death," Navajos could only take this to mean that the doctor was incompetent and was afraid he had made a terrible mistake. By instructing the Navajo interpreter to say "This White doctor knows how you must feel and he wants you to know that, because his life has been devoted to saving the lives of children, he too feels a sense of loss and is sorry this has happened," condolences were adequately conveyed. Within a year the autopsy rate rose from 3 to over 80%.

The point to be made is that interpreting from one language to another involves some understanding of the cultures of which each language is a part, but that the Navajo interpreters had never gone beyond telling the physicians there was no "word for that" in Navajo until a training program treated the Anglo and the Navajo as equal members of a team which had a common goal in the medical encounter. Not only did Navajo modes of communication have to be examined as important and complex elements in the process, but Anglo concepts had to be analyzed in the same manner.

At no level of the structuring of Navajo-Anglo interactions was there a context in which a Navajo could communicate with an Anglo and have his or her views taken seriously. The subordinate position of the Navajo was not only set by status as an Indian in American society but also by position in the medical hierarchy. Navajos who were pressed into service as interpreters were employed in lowly positions as janitors, nurses' aides, or driver-interpreters in the field health programs. These programs rarely demanded more than a high school education and the pay was commensurate with the skill demanded by the job. They were not employed or paid to be skilled medical interpreters yet the non-Indian staff felt no compunction about taking them from their assigned tasks without warning and asking them to perform as interpreters in what was often a delicate medical situation. The Navajos felt their medical knowledge, knowledge of the health programs, and their command of English were inadequate to the task and wondered what the doctors really expected of them.

Thus, at the personal level of interaction, the White staff operated as if interpreting was a simple affair not to be accorded any respect or extra consideration. At the institutional level this attitude was set in bureaucratic concrete. Despite the fact that there were, in the 1960s, about 8 times as many Navajo speakers as there were a century before when Navajos were put on their reservation, the official position was that Navajo was a dying language and there
was not and would not be a well-paid position of medical interpreter in the Indian Health Service. The interpreter training program was conceived of as a form of in-service training for Navajo personnel that would not even lead to promotions in the positions they held. The contract situation was so structured that the only behavior acceptable on the part of the Navajos was that described above—there is no way to say that in Navajo—a response that confirmed the view that Navajo is indeed a limited means of expression. In any event, no funds were provided to establish interpreter training programs throughout the reservation and, after a few years, the routines developed in Tuba City were no longer in use.

The example given above involved cross-cultural understanding at the most elemental level, representing the "tip of the iceberg" of the full range of medical contexts in which Navajos and Anglos interact. If the image we hold of the Indian does not allow for a language of an expressiveness and complexity equal to that of English it must, for the sake of brevity, be left to the reader's imagination to consider what happens when a Navajo refuses an elective operation or refuses to take medications for any of a variety of conditions. These and innumerable similar situations require some willingness to concede to the Navajos both a coherent system of beliefs and values, and a degree of maturity and intelligence to make appropriate decisions.

The Drunken Indian

Thus far we have seen how Indian definitions of disease determine the behaviors of those labeled as sick and how the dominant society's definition of the Indian determines Indian behavior which confirms society's preconceived notions. Let us turn now to a consideration of what happens when an Anglo disease category is inappropriately applied to Indians forcing them to adopt the sick role when, in fact, they are not sick. In the United States, concern about the "drunken Indian" has been with us from the earliest contacts between Europeans and Indians until the present time. From its being taken as evidence of the Indian's savage nature and later as evidence of his moral and social degeneration, deviant drinking has come increasingly to be used as an indicator of social pathology and evidence that Indians are sick and in need of more medical treatment programs. Yet research in this area suggests that the situation is nowhere near as simple as many health providers would have it seem.

Several points have been made in the growing corpus of work on American Indian drinking: (a) "alcoholism" is neither a well-defined nor well-understood disease even as it exists in the White population; (b) there are probably several different forms of alcoholism with a variety of causes; (c) the markers of "chronic alcoholism," as it is understood in the general population, are primarily behavioral and are not adequate to the task of identifying the same pathology in
other cultures; and (d) the various forms of drinking which, while not "alcoholic," nevertheless cause social and personal problems of some severity often have their origins in socially preferred styles of drinking and are not always attributable to personal stress or other psychological states. Reactions to such observations have frequently been vociferous in tone. Objections have taken two general forms. One sees the relativistic position taken by many anthropologists as a denial that there is any problem, social or otherwise. Anthropologists who point out that drinking styles found in other cultures are not deviant in those societies and that attempts to alter drinking behavior based on Western notions of alcoholism may miss their mark are often accused of talking a very real problem out of existence by exempting Indian cultures from the judgments of the dominant society. The critics of anthropologists' findings often try to have it both ways: Not only is the anthropologist denying the existence of the problem, by holding that Indian drinking styles are consonant with their traditional cultural values and expectations and even with their basic personalities, the anthropologist is also maintaining that the problem of alcoholism is a sign of defects in the Indian culture itself rather than a response to White domination. This is not the place to review the merits of the findings or the arguments in detail. It is important to note, however, that those research findings which do not confirm the image of the Indian as anomie, if not actually suffering from a real disease, are not readily accepted by the research community itself.

Little has been done to determine just how much Indian drinking behavior is the result of the labeling process, that is, expected by the dominant society. Historically, the use of alcohol by most Indian tribes north of Mexico is relatively recent: a direct result of contact itself. The most careful historical reconstruction of the development of Indian styles of drinking since the introduction of alcohol to the continent by Europeans concludes that Indian drinking is learned behavior (MacAndrew & Edgerton, 1969). During the early years of contact with alcohol, it produced a variety of reactions ranging from euphoria to distaste to stuporousness. The untoward effects, that is, violence and the lowering of inhibitions, were rarely seen. But soon, a more uniform pattern of Indian drinking emerged, one that included group orgies, drinking to stuporousness, boisterousness, aggressiveness, sexual promiscuity, and violence. This form of drunken comportment, however, was modelled after White drinking behavior. Indians were constrained to drink in almost all routine encounters with Whites because Whites themselves routinely drank at such occasions and it was soon learned that the only way to drive a hard bargain with Indians was by getting them drunk. White tastes and drinking styles changed over time, especially during the prohibition period, while those of the Indian, isolated on reservations, tended to remain static. Much that offends the sensibilities of Whites today is nothing more than an echo of their own forgotten past.
It is doubtful that contemporary Indian drinking can be attributed to the labeling process. Styles of drinking have become institutionalized and serve to enhance many of the Indians' own values. What does seem to have happened, however, is that many Indians have accepted the dominant society's explanations as to why they drink and, in consequence, have come to see themselves as confused, disoriented, and in need of treatment. If alcoholism is a chronic disease resulting from physiological or psychological dependence, then it is proper that the Indian should face the reality and work toward the solutions offered by alcohol treatment programs informed by our perceptions of alcoholism. If, however, much of Indian drinking is a matter of style, the alcohol programs will be of little use and will serve only to perpetuate the dominant society's definition of the Indian.

That a large proportion of Indian drinkers, in some communities at least, are not alcoholics is suggested by research conducted on the Navajo reservation (Levy & Kunitz, 1974). Over 70% of Navajo males surveyed on the western portion of the reservation reported drinking histories that would lead them to be classed as alcoholic or incipient alcoholic. Yet, at the time of interview, a larger proportion of this population were abstinent than was found in the general population by a survey using the same methods. After years of flamboyant and excessive drinking, Navajo men are generally able to stop without difficulty, a phenomenon that argues against the presence of alcohol addiction or dependence. A high proportion of these drinkers reported experiencing withdrawal symptoms. The withdrawal syndrome—tremulousness, hallucinosis, and delirium tremens—is usually considered a reliable indicator of physiological dependence on alcohol. Navajos, like sailors coming back on board ship after shore leave, experienced these symptoms because of the rapid cessation of drinking after having consumed large amounts of alcohol. Unlike the skid row bum who can almost always find a drink to stave off the shakes, Navajos have a style of periodic, heavy binge drinking which must be done away from the reservation where prohibition laws are still in effect. Whether they awaken in an off-reservation jail or at home, there is no alcohol available to permit tapering off.

To date, no means of distinguishing the normal Navajo drinker from the true alcoholic before the development of cirrhosis or brain damage has been discovered. An alcohol treatment program, in order to reach the few real alcoholics, must perforce treat all male drinkers—well over 50% of all males between 20 and 50 years of age—which is an economically prohibitive task. Perhaps even more ominous is the vision of a major portion of the Navajo labor force playing the role of patient, surrendering volition instead of actively seeking to change their living conditions.
A comparison of "wet" and "dry" reservations on the northern Plains demonstrated that, for a brief period after prohibition statutes were repealed, drinking increased but a new pattern soon emerged marked by a significant lowering of alcohol-related arrests and accidents (May, 1975, 1976). Without suggesting that alcohol-related research efforts to improve the performance of treatment programs be abandoned, there does seem to be room for efforts to improve self-image and change social habits. Those individuals who believe they are destined to be alcoholics because of forces over which they have no control have no chance of succeeding, while those who believe they have some control over their own lives have hope, as depressing as social and economic conditions may be.

In sum, Indian behaviors have been misinterpreted by the dominant society. These erroneous views: (a) guide the formulation of programs which have difficulty attaining their goals, (b) constrain Indians to behave in the manner expected of them, and (c) generally foster feelings of inadequacy and inferiority. There are, unfortunately, few studies which examine interactions between Indians and non-Indians directly. Yet it is important to know when Indians behave as they do—like "dumb" Indians, for example—that they are in situations where they think it is expected of them or their behavior is the norm in their own society. Without more detailed knowledge of cross-cultural interaction it will be difficult to modify the health delivery system in any significant way.

Prospects

After reviewing the attempts made by Indian Health Service to utilize applied research and implement culturally adapted programs, one can only be impressed by the fact that few of the research findings have any influence on program planning and that none of the innovative programs survived for more than a year or two. Thus, although much research on definitions of health disease among the various Indian population needs to be done, one must ask to what purpose the knowledge so gained will serve. This paper has focused attention on the labeling process and how, in the absence of well-executed research designed to expand our understanding of Indian realities, an erroneous and negative set of perceptions is used to inform our behavior towards Indians and our interpretations of what their behaviors may mean. The expressed intent of these research efforts has been to improve the effectiveness of health programs for American Indians by adapting and designing programs to conform to the needs of culturally distinct populations. That success in this endeavor has been meager is due only in part to the negative image of the Indian that seems to pervade the national consciousness and to the labeling process it engenders. Far more important have been the aims of federal Indian policy and the "culture" of the
EFFECTS OF LABELING ON HEALTH BEHAVIOR AND TREATMENT

medical establishment. In this context, it is instructive to review the history of this policy to assess what priority is likely to be given to the health and social needs of the American Indian at a time of great budgetary constraints.

The overriding goals of federal government prior to the publication of the Merriam report in 1928 were pacification of the Indians, their removal to reservations to permit the unhampered westward movement of the population, and the assimilation of Indians into the general population, this latter goal to be achieved through education and the ministrations of Christian missionaries. The process of assimilation was thought to be hastened with the passage of the Dawes Severalty Act in 1887, which began the process of breaking up the reservations and giving private allotments to individual Indians. Despite growing citizen concern about Indian rights after the 1870s, serious attention was not given to the deteriorated conditions of the reservations until the Merriam report made public the findings of a nationwide survey of Indian country. The inauguration of the New Deal and passage of the Indian Reorganization Act marked the beginning of a period characterized by increased funding for Indian programs and some attempt to formulate coherent policy.

From the 1930s until the years of the Nixon administration, while funding increased and programs proliferated, policy underwent a series of pendulum swings. The New Deal Democrats desired to promote Indian self-sufficiency and tribal autonomy by developing reservation economies, and tribally owned and managed enterprises. It was only by supporting ethnic separatism and self-sufficiency that the ultimate goal of assimilation could hope to be attained. Under the direction of the Indian Commissioner, John Collier, Indian languages were encouraged and teaching materials in these languages were developed. Curricula were adapted to serve the needs of particular reservations. John Collier was favorably disposed to the social sciences and initiated several large-scale research projects run by teams of anthropologists, educators, and physicians. Subsequently several of these anthropologists began careers in the Bureau of Indian Affairs. This period and the years immediately following World War II witnessed the rapid expansion of American anthropology, the emergence of "applied anthropology," and such new interdisciplinary fields of research as "psychological anthropology." The students of the anthropologists who were a part of this florescence are among the senior social scientists of today and are still imbued with the ideas of that time, namely, that federal policy should rely on social science research to guide it in making and executing policy. For many anthropologists, cultural pluralism is a salient value.

Despite the strength of this point of view within academe, it must be confessed that with the exception of the Kennedy and the first years of the Johnson administrations, the federal government has more consistently pursued policies designed to promote assimilation. Citizenship was granted to Indians in 1924.
In 1946, the Indian Court of Claims was established so that Indian claims against the government for lands taken from them could be processed expeditiously and the day hastened when the federal government would quit its special obligations and responsibilities. In 1949, the termination policy was formulated and, during the Eisenhower years, the termination of Indian reservations was begun and programs to relocate Indians in urban centers were funded. Efforts to dismantle the Bureau of Indian Affairs included assigning the responsibility for Indian health to the Public Health Service.

Although President Kennedy resolutely turned away from the termination programs and injected massive funding into reservation school systems and housing projects, the tide was never reversed. President Johnson, while pursuing the War on Poverty, came to feel that Indians were best served by being the same as other poor folk. Indian alcohol programs and community action programs were, wherever feasible, merged with the neighboring county programs. Public Health Service and Bureau of Indian Affairs were increasingly asked to contract services to private sector vendors in an effort to make the transition away from special Indian programs. President Nixon accelerated this process with the help of the ringing slogan, Self-Determination for American Indians, a policy which has also been called Indian self-termination. Indians themselves were asked to manage their own services under contract from the government. In this way the federal Indian bureaucracy could be decreased. When tribes made mistakes, the contract could be cancelled. The federal government would have discharged its obligations by providing funds; it would no longer be responsible for the viability of the programs themselves. It is noteworthy that neither President Carter nor President Reagan made an issue of Indian policy. As long as federal spending continued unabated, however, the shift toward a policy of assimilation was made palatable by well-funded services.

The original goal set by Congress for the Public Health Service was to bring the level of Indian health up to that of the nation at large. With this accomplished, Indians presumably could be served by the same delivery systems as the average citizen. Because many officials in the Public Health Service (PHS) had been trained in community health and preventive medicine and because so many Indian reservations closely resembled underdeveloped nations, it was natural that preventive and field health programs were developed during the first decade of PHS activities. Infant mortality and deaths from infectious diseases generally declined rapidly. Thereafter, priority was given to improving the quality of hospital services. Today, the utilization of social science research and the development of community health programs tailored to fit the needs of single tribes is a thing of the past and is likely to remain so. Tribes and private
health providers are encouraged to manage health services for reservation Indians and funding is provided by Medicaid, as well as by the Indian Health Service.

Given the current high cost of medical services, it does not stand to reason that much will be spent on research designed to adapt programs to the cultural needs of what can only be described as minuscule populations. Besides, it is well known that modern medical care produces rapid and significant acculturational change. For a government dedicated to a policy of assimilation, the integration of Indian medical services with those of the surrounding states is one of its most powerful tools.

What, then, justifies requests for funding of cross-cultural medical research? It can and should be argued that our knowledge of psychopathology and social deviance are best advanced by testing hypotheses generated in the larger society among dissimilar populations. Hypotheses which propose social factors as causal variables especially are in danger of false confirmation when tested in the same society which gave rise to them initially. In essence, the aim of future research must be to improve our knowledge generally so that the national health care system may be improved. That Indian tribes will ultimately benefit must be accepted on faith. It is ironic that Indians must, in future, be asked to cooperate with research efforts, the success of which is dependent upon the very cultural uniqueness that the nation has so resolutely and persistently disvalued.

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References


Discussion

Dr. Trimble: I think Jerry’s paper is in many ways right on target. I was a little disappointed that you really didn’t tackle the whole labeling process as it exists in anthropology, sociology and social psychology, and I’ll do that for you. What I’d like to do is fill in gaps with some hypothetical constructs that come out of the field of labeling theory and symbolic interaction, and person-by-situation interactionism in the field of social psychology.

In a very interesting text entitled Moral Passage, the sociologist, Augustfield, refers to labeling theory as behavioral expectancies of a person judged deviant. These expectancies are really derived from the perceived normative structure of a group. So these judgments have different implications for how one interacts with those who are judged deviant than those who are doing the judging. Augustfield summarizes by saying deviance can be classified as repentance, the ill, and the enemy. I think what we’re talking about here is the ill—I’m not so sure we’re talking about repentance.

Another recently published text, titled Social Control of Mental Illness, (Horowitz, 1982) does a nice job of summarizing labeling theory as it applies to the field of mental health and physical illness in general. Let me share three pointed statements.

One, "Professionals are much more likely to label behavior as deviant than are lay people." He cites a number of studies to substantiate this point. In one study psychiatrists and clinical psychologists were asked to review a series of case studies, randomly interspersed with individuals who "were normal" and those who were judged mentally or emotionally incompetent. The ratio was 14 to 1. That is, for every one lay person who identified a particular individual as emotionally disturbed, fourteen psychiatrists did likewise. I think this issue bears serious examination relative to the whole health care delivery system as it exists in Indian communities.

Point number two, among lay people, Horowitz says, "The tendency to label people as mentally ill varies directly with the relational and cultural distance between the observer and the actor." I’ll come back to this point, but what we mean by relational distance is that people who perceive themselves as being close to one, or a part of the same network, or part of the same extended family, for example, are much more likely to normalize the description of an individual. The farther away you are from that kinship system, the farther away you are from that social network, the greater likelihood to impose more pathology on the description of the person’s behavior. Again, I thought this was an extraordinary, interesting finding that bears examination.
Horowitz says that the labeling process shows that there are indeed sex, social class, and ethnic variations as to who is marked, how that person is marked, and subsequent influences of the marking process. By "marking," we are implying that marking and labeling are somewhat synonymous. I think marking has a more active implication.

Just recently, social psychologist Ed Jones published a fascinating book titled *Social Stigma*. He asks: "Why do people feel imperiled by the process of stigmatization, and why do stigmas in and of themselves imperil?" and then he proceeds to try to answer this question.

In many ways, the process of labeling is a process of stigmatization. I just came back from a fascinating conference in Hawaii. There's growing concern about the spread of a phenomenon that occurred several decades ago in the Marshall Islands where individuals who were influenced by radiation are now giving birth to children with birth defects. The attribution is that the radiation exposure has caused these individuals to produce these "deviant-looking children." As a result, the Marshalese have stigmatized any descendents of those who were exposed and are not having anything to do with them.

The same phenomenon is occurring in Palau. There is a recent upsurge of leprosy and the stigmatization process that is occurring with it. More importantly, in the area of Washington I live in, there is a tremendous increase in the use of sorcery. Individuals who have been witched, or have been hexed, are in a sense stigmatized, and somehow everyone in the community knows who has been witched, and as a result stays away from them.

Looking more closely at Jerry's paper, I have identified six areas I think are worthy of more serious examination. First of all, there is the role of marginality in the labeling process. The more marginal an individual is perceived to be relative to his affiliation with his or her tribe, the more variation in the labeling of that individual as deviant, sick, or ill. Those individuals who desire to be seen as Indian, or accepted as Indian, especially mixed-blood individuals, are likely to fall into these categories. They will understand the rules and norms and might internalize some of the requirements associated with being seen as deviant.

Secondly, as I pointed out, there is the role of stigmatization, and what the consequences are of stigmatizing the afflicted person.

Third, there is a congruence of belief on the self and on the other individuals. Congruence refers to the extent to which I believe the label that has been affixed to me enables me to understand what it is I'm experiencing, and how that affects my own self-perception, my own self-concept, and how it affects the concept that others have of me.

Of course, if we are going to deal with congruence, we have to deal with categorization. Perhaps I should also put the words creation of experiences and creation of expectancies in categorization.
I alluded previously to the notion of relational distance and how that affects the normalization of labels and the stigmatization process. It also feeds on the clinician’s effort to discern whether or not there is something that is or is not pathological. I’m reminded of Robin Room’s article on the ethnosomatics of alcohol and alcoholics. In his article he asks the question, "What are we really studying when we’re studying alcoholism across cultures?" By definition, in one culture alcoholism may be A, in the other culture it may be B.

This leads into the sixth heading under "group boundaries." Marked individuals, in a sense, tend to be on the fringe of group boundaries. They may or may not be discerned or described, stigmatized, or labeled as deviants until they approach that boundary. Hence, you have a close interrelationship between relational distance, because in communities, you obviously have different people who are part of the same clan, or part of the same family, and also subscribe to these boundaries in terms of how far one can go before they are labeled accordingly.

The seventh area for comment refers to commonality of the condition. The more common the phenomenon, the greater amount of deviation that’s required for it to be marked, stigmatized, or labeled accordingly. So the more common a phenomenon within a particular group, or within a particular clan, or within a particular network, or an extended family system, the less the likelihood of its being stigmatized or labeled as pathological or ill.

I want to move to treatment. I would have liked to have seen Jerry outline a specific plan of research, much like Norm did in their paper. Linda Aronson and I just finished a study where we interviewed 25 informants, half of whom had seen an Indian doctor or shaman, and the other half had seen a conventional mental health practitioner in the greater Seattle area. One of the things we’re looking at is the kinds of symptoms that led an individual to see one or the other healer. With five of the informants we uncovered a very interesting phenomenon. If they went to an Indian doctor, as the Coast Salish are more likely to refer to them, they might see that individual because of a stomach complaint, but they wouldn’t refer to it as a stomach complaint. They would instead refer to that stomach complaint as a spirit residing in the abdomen. On the other hand, when the very same informants sought treatment for the very same problem from a physician or a counselor, they would describe it as an anxiety reaction. In other words, they learned the labels that got them in the door to get the treatment they felt they needed.

Secondly, we were interested in the perceived effectiveness of the treatment. We were not necessarily surprised to find that all of the informants who sought assistance from the Indian doctor claimed that they were better, whereas only half of those who received help from the mental health counselor claimed that they had improved as a result of the treatment. I think what we need to do when
talking about the labeling process is to recognize that there is an inability today, in a lot of Indian communities, for the traditional healing system to treat imposed forms of deviancy. One of the things that we've learned is that among the Coast Salish, the traditional form of healing cannot deal with things like alcoholism and particularly substance abuse. It doesn't fit within their native world view. On the other hand, they recognize that the treatment available on the outside is also not responsive to, nor does it deal with, nor does it include an Indian perspective. Here you have so-called deviant individuals for whom there is no available treatment. Both worlds are struggling to understand this form of behavior. The system in both cases is not flexible enough to handle the categories that could presumably deal with the problem.

Jerry was on target when he said, "Why are we labeling Indians as sick?" Towards the end of his chapter he was referring to the fact that the image that the White man had towards the Indian in many ways affected policy.

That thesis is put forth by the Michigan historian, Robert Burkoff, in his book *The White Man's Indian*. I would strongly recommend that for your reading, because he very carefully documents through historical analysis how policy was shaped by imagery.

I want to emphasize the point that you were making about the severe economic constraints that are already being felt in Indian communities and the fact that these are seriously impacting the health care delivery system. There is, from my observations, an increase in social disruption and social disorganization in Indian communities these days. I also have noticed an increase in non-Western forms of illness and a tremendous increase in the use of sorcery. I'm not sure what this means, but I think that it's making the process of improving health care delivery that much more impotent. I also believe that it places the marginal Indian, the urban Indian, in a complicated situation in terms of understanding where he or she fits within the flow of activity back and forth between Seattle and Bellingham, Washington, or Denver and the Pine Ridge Reservation in South Dakota.

That reminds me of a story. Most of you remember the takeover in South Dakota by the American Indian Movement (AIM). A lot of the FBI men who were sitting in the trenches 24 hours a day waiting for something to happen would every once in a while confide in the local Indian people that they were seeing visions of Indians on horseback, seeing ghosts, and so forth. They were frightened by all of this, so much so that several of them were very, very reluctant to spend the night in the so-called foxholes. One of my shirttail cousins laughed when she heard that, because she said, "We see that all the time around here." I bring up that story, because I think it has a lot to do with the so-called labeling process, and the familiarity that a particular cultural group has with a phenomenon versus the lack of familiarity that another has with it.
**Dr. Schulz:** Joe, I assume, much of what you say assumes a distinction between self-labeling, or internal labeling, and external labeling, or outsiders labeling others? To what extent is that distinction made in the literature and applied to this particular situation?

**Dr. Trimble:** I don't know.

**Dr. Schulz:** The labeling and interactionists' literature make a lot of these points. As far as I have seen, there is no real work focusing on labeling and Indian health behavior across the board. But you could take examples, as Joe did, of the Pacific Islanders coming to Los Angeles and having forms of behavior that are considered normal there, suddenly labeled because their behavior is considered deviant here. There are plenty of examples like that in the sociological literature, but a focus on health in another culture, across the theoretical spectrum, I wasn't able to find works doing that.

**Dr. Manson:** I'm intrigued with the issues of labeling and the potential fruitfulness of examining that phenomenon at several different levels. I recognize the importance of looking at it in terms of the external labeling process, at a macro policymaking level; but I feel less potent in doing anything about that. I am intrigued by simultaneous resort hierarchies in terms of help-seeking behavior and going to a variety of different alternative health care providers. It's not unique to Indian communities. We see it in White middle-class culture with respect to visiting simultaneously a chiropractor and an allopathic physician as well as a herbalist. I'm intrigued by this process and the negotiated definition of the phenomenon that brings these people together.

**Dr. Levy:** Can you give an example so I'm sure I'm understanding you?

**Dr. Manson:** Well, let's take Joe's example, the individual presenting to the health care provider in describing their illness as anxiety, or perhaps in physical terms, to an Indian doctor. What's intriguing are the different categories used linguistically to make sense of that experience, and understanding what the prime motivating factors may be. In the latter case, it might be for seeking solutions with respect to ultimate cause and etiology. With respect to the presentation to the professional health care provider, it might be the amelioration of immediate acute pain. I'm interested in that process, the discourse that goes on, the languages that people use for describing the phenomenology of the experience, because it seems to me that we know very little about that, but that it is extremely important to understanding the help-seeking process.

You mentioned seeing visions in schizo-affective disorders or auditory-visual hallucinations, which are a very salient element to diagnostic criteria. It is, however, normative in many cases among Indian people to have these types of experiences. The difficulty is the negotiated definition about what is normative
and non-normative and what that implies for diagnosis and subsequent treatment. It strikes me that we know very little about them, but that they remain very important.

**Dr. Mohatt:** On a practical basis, that raises a question the literature on healing has brought up about ultimate causes. As western medicine has moved further and further away from helping individuals deal with ultimate causality, people don’t get better. People have a more difficult time getting well, and it raises the question of what medical practitioners can do, particularly with cultural groups whose people instantaneously want some help with that kind of question. They can’t turn into priests, but there are certainly ways in their practice that they can be much more effective by helping people deal with those kinds of issues.

**Dr. Guilmet:** Regarding the sociology of deviance, be sure that you look at the role of the actor and activity. Just a little too much emphasis was put on this in the power of the institutions. Individuals have a lot of power if they know these rules.

**Mr. Whited:** It could possibly be the only power they have in the situation. You see yourself as pretty powerless when you’re talking to the various levels of treatment we’re talking about, the Indian doctor from the spiritual end of knowledge, and then the medical doctor wearing his white frock with all the technology and machinery. That places the individual who is seeking care at a distinct disadvantage in that the amount of power and ability to manipulate the provider is a very real consideration. We see that all the time in our clinic, people coming in and trying to get the doctor to buy into their view of what is wrong with them, and if that doesn’t work, they will try another one. They go from provider to provider to provider, or use different attacks with a different point of view, trying to reinforce their power and affirm that their definition is true, or accurate, and that they actually have an idea of what is going on with them.

**Dr. Levy:** What I’m hearing is of broad potential research interest. I’m a researcher, I want to know everything there is to know about a phenomenon, including how much an individual influences something and how much the institution constrains. The interest of social science research in the area of health and behavior is boundless.

And then we have the interest of the practitioner who says, "Look, I’m dealing with the following kinds of things, what button do I push to get this patient to comply? Don’t give me all this theory stuff, just tell me how do I talk to a Navajo so he will do what I want him to do?" I’m sure that if we got down on our hands and knees and put our eyes very close to the ground, we might get an idea of the Indian’s perspective of what he needs out of the health system. There is very little research done on that.
There is also the interest of taking an agenda to Congress, to individual Congressmen, to start getting support, to see what are the priorities. Pure research doesn't exist in a vacuum, and I think we have to take the expansion of pure knowledge, the needs of a delivery system, the real needs, and the priorities at the national level, and see how a research agenda would be served. One of the things we are getting into now with depression with Navajo aged is the significance of symptoms that are not expressed verbally as opposed to ones that are, and discovering a cultural tradition going back into the myths that only certain types of symptoms of affective disorders are verbalized, the others are always implied. This could take me a lifetime. And so we somehow have to work on points that are of benefit to the treatment program, take into account the national constraints we are working under, and still serve pure research interests.

Dr. Bloom: You're leaving out informing the tribal council.

Dr. Levy: Well, I think on the last sentence before my envoi in the paper I discussed that briefly. We are going to be asking American Indian groups to cooperate with research that is going to be very intrusive. Long interviews about all kinds of sensitive areas, symptomatology and behavior are going to serve the advancement of national health interests. They are valuable to us because of their cultural uniqueness, and yet this is the very thing that we have been aiming at destroying for 200 years.

Dr. Bloom: Let me say it this way. What are you doing with the epilepsy and incest finding? That's a very interesting finding that seems to me should be discussed within the community.

Dr. Levy: Well, the community knows it, it was the White man who didn't understand it.

Dr. Bloom: It's a negative health concept that can be changed from within the community.

Dr. Levy: What was done is that Al Hiat, in the Indian Children's Program, outlined in a very general way what should be done in the epilepsy treatment program in these different tribes. In other words, we suggested ways to move to increased compliance and better psychological outcome for the Navajo kids that were suitable to that group. The question is, once that's done, why is it never implemented? This is where you come up against the institutional constraints. You see with Navajos that they have labeled these people as incestors. You don't go in and say, "Don't do this, this is very negative." They will show you twenty cases where the incest was done. They are being the empiricists, we're being the theoriticians.

You go to the Hopi and say, "Who are the Hopi kids who are committing suicides and drinking?" Not the ones who are torn apart by conflict with the White world. These are the kids who are the children of parents who made cross-clan marriages, a very old deviant pattern within a complex Pueblo society.
It's not good therapy to go to a community that is now very concerned about suicide and alcoholism, and say, "Look, you can't blame this on the White man, it's you, it's your own traditional culture." That becomes immaterial. These findings are the research findings which help you understand how to create a treatment program.

You may think Indians want truth, but I believe Indians are human beings, and they are just like us, they don't want to know the truth any more than we do. And believe me, we don't want to know the truth very often.

Dr. Kunitz: That's not true.

Dr. Levy: These are very delicate issues that have to be approached in a much more operational way. The demand of the Hopi would be for a program that did no labeling. You are not going to say, "We are going to take the kids who have already started drinking." You have to make a program that is open to all youth, because these kids were already labeled at birth. You don't want to reinforce that. You can't talk about suicide, this is going to be a youth adventure, outward bound program, open to all. The program is for everybody and does wonderful things. The counselors will know what they're looking for, or who needs support, and the pattern may be changing very rapidly. In another generation, this pattern of deviance may be gone and a new one may have replaced it. So you want to be able to make the support accessible without labeling the kid.

The tribe has committed itself to a juvenile delinquency program. The label is there; you persist in letting the community go ahead saying, "Aha, he's in the treatment program." But why does the tribe do that? Because the professional world says, "This is what you need, you guys are sick. Look at your suicide rate, look at your alcoholism. Get down on your knees, you qualify for a treatment program because you're worse than anybody else."

The irony is that as high as Hopi suicide rates might be, they are no higher than the neighboring counties, and nobody is pointing a finger at the White people in Cochise County or any of the rural counties. These rural Arizonians are knocking themselves off at a very happy rate and nobody is worried about it.

Dr. Mohatt: I'd like to ask you a question about the suicide of the Hopi in terms of the cross-clan marriage. Was there something within the Hopi cultural framework that would allow that to be dealt with other than suicide to repair the infraction?

Dr. Levy: Yes. You could leave, and in the early days you see profiles of out-migration among the Hopi. The moment there were towns you left, you got out, so that the first comers to the off-reservation towns, like Flagstaff and Holbrook were deviant couples who had made these funny marriages.

Dr. Mohatt: But would that stop the suicide?
**Dr. Levy:** The suicide phenomenon is rather complex. The Spaniards came in 1680 or so, and being able to get at what a pristine Hopi life was with suicide is virtually impossible. They indulged in what we would call hidden suicides. They are very well documented in the ethnographic description, but the frequency is gone. If it's successfully hidden, what do you do? If you have a life insurance policy that says it won't pay off if you commit suicide and you want your wife and kids to have something, you engineer a car accident. Hopis would pay Navajos to kill them, they would say, "On a certain day, I'll be in my field with jewelry if you come and kill me." Nobody else knew he wore that jewelry back at home, but once he was dead, the family could say, "Oh, those vicious Navajos got him."

The only reason we're beginning to see suicide more now is that we've got a broadening of horizon, we have a Hopi newspaper and they are beginning to announce suicides. Before, when you talked to informants—take a tiny society of Hopis back in the 1930s—say they had 10 suicides per 100,000 a year, and you lived in a village of just 200 people and there was no communication across mesas, you would never know it. You would make your images of suicides to suit your own needs. With Navajos, the reasons they thought people committed suicide were the same reasons you and I would think: illness, old age, and so on. The actual pattern of suicide was so discrepant with what Navajos thought only because they lived very geographically dispersed; news didn't travel. Almost all the suicides were sex, jealousy, man-versus-woman kind of conflict, which Navajos didn't recognize. Their response was, "That's not why we commit suicide;" but that's why they did commit suicide. Never trust your informants without having quantified data under your belt.

I think also the Hopis are a part of the state of Arizona now and are responding to complex economic shifts. Why is Apache County suicide rate going up as rapidly as Hopi in the same years? All of the rural counties of northern Arizona behave as do Hopis. The sociologist is looking at the nation, and we talk to ourselves in our vacuum and say, "See, this is specifically an Indian problem." We don't know how much of it is Hopi and how much of it is regional. It's very complex.

**Dr. Ghodes:** I'd like to sort of get back to the everyday world of the clinic that you mentioned in the practice of medicine. We talked this morning a little bit about lifestyle disease, and it's clearly what we're dealing with. It's only a shift from the kind of infectious diseases where the health care system would control what was going on. The challenges are enormous and I think the value of the sociocultural research is going to be more perhaps than it was in the last few years, because we don't have the magic medical bullet. We have communication, we have patients, it's really the most important thing we do with many of these medical problems.
Now, when we label, if you will, a patient as having diabetes, that is an enormous label. That label carries with it a great deal of overtones. The patient has never heard of this problem. They come to you and you tell them they have diabetes. They have brought a number of beliefs, a number of expectations with that. We are dealing with those patients and communicating with those patients within their own coherent system of logic. But if we don’t understand that coherent system of logic and how it impacts on that medical problem, then we don’t communicate very well, and we are terribly ineffective. Then the patient goes on to develop kidney failure and get dialyzed at $40,000 a year. I think the point can be made that the end-stage consequences of some of these lifestyle diseases are very expensive. The research has value in its applicability to help us communicate better with patients and prevent the adverse outcomes that cost the health care system so much money.

I think one of the purposes of this conference is to look at where diabetes is an Indian issue and where it is a non-Indian issue. In this particular case, the diabetes that is the concern of the Anglo community is Type I diabetes, insulin dependent diabetes, and getting those adolescents to monitor their blood sugars, do their pumps and all that. That’s not the concern in the Indian community, those are not the relevant issues. The issues may be different from tribe to tribe as to what people’s understanding is about diabetes. But we’ve got to have that understanding, we’ve got to be practicing medicine, if you will, in that coherent system, rather than in our Anglo system.

Dr. Levy: Well, what has IHS done in the area of health education, of just educating in our definition?

Dr. Ghodes: Do you want a 5-minute answer, a 20-minute answer, or a 3-hour answer?

Dr. Levy: Whatever you think would get across a cogent answer. Do you feel that there has been a well-designed effort of bringing education down to the community just to see what can be done? What is the response to education for diabetes when it’s widespread and well designed, and forget about culture?

The first thing I would say is that when we demonstrated that you could bring information about trichoma to Indians in White terms, when it was done on a community-wide level, we had very rapid community response from Indians, a lot of cooperation, and trichoma rates began to go down.

Dr. Ghodes: I would just make a plea that we really need to understand more about where our patients are coming from, and more about how to communicate with them better, because that’s our tool.
Dr. Levy: Well, Tuba City did very nice things with Hopis: They utilized marginality. They took diabetic Hopis who were fairly well educated, had them work with field health nurses, taught them—they were already motivated—taught them all the maintenance things and the reasons, and then began having community discussion groups.

The maintenance levels worked out very, very well. A lot of the problem was that people don’t explain things to us when we go to the hospital. Here you’ve got somebody coming and talking to us, and a Hopi who is always in the village we can go to for the questions who is well informed. That seemed to work. It’s no longer being done, as far as I know, because the nurse was transferred, or transferred herself. There doesn’t seem to be a mechanism in IHS to take the successful program experiment, institutionalize it, and spread it throughout the system.

Dr. Ghodes: Well, part of the problem is that there is not a mechanism in the medical community in the United States in general. What button do you push, so that people who are practicing medicine in the IHS context, are being trained and are coming out of the greater medical community in the United States? That’s one of the barriers, but again, you are in the position of telling us what the barriers are, what is the sociology, if you will, of the medical community where we can make a difference.

Dr. Pine: Presenting educational programs in the Western model, I can’t speak as far as IHS experience is concerned, but from experience in providing services to nine different reservations, it doesn’t work. It’s been tried, and we’ve had people pulling their hair out by the roots with the frustration.

Dr. Levy: I worked five years with IHS and I can make a bet of the kinds of things you encountered. You take a picture, you don’t want to have contaminated milk, so you want to talk about fly vectors. You don’t sit around having Navajos who don’t understand the language, you bring a poster, right? I bet your groups had a lot of posters, a lot of audio-visuals.

Dr. Pine: Plenty of them.

Dr. Levy: Here is a glass of milk this big and here’s a picture of a fly this big on the same sheet of paper. Now, you’ve got to watch out for flies, because flies contaminate milk. And the Navajos sit back and say, "Gosh, yes, I can understand you White people have a lot of trouble with flies, but we Navajos, you must understand, our flies are very, very tiny."

Dr. Dinges: Jerry, let me suggest that, again, we do not operate in a vacuum with respect to a rich literature on health belief models, health utilization, and health decision-making models that respond to and are sensitive to cultural issues. Kleinman, Chrisman, and a whole host of people have dealt with these
issues. I would agree that a step to good health education is to examine beliefs and decision-making processes. If used well, these models can increase compliance, adherence, and effectiveness of treatment.

Dr. Levy: The problem, if you get into it and you want to train the clinician what button to push, give him all this research, and when this particular patient comes in, he’s never the average. You’ve made a normative description, beliefs, and you haven’t taken into account all the individual variations.

Dr. Ghodes: We’re not that bad, give us a break.

Dr. Levy: I’m oversimplifying it, but I have had a lot of doctors say, "What do I say to a Navajo to get him to do such and such, what’s their belief?" I say, "Well, their belief is that it’s all caused by witchcraft in this particular case." The next guy comes in who has those symptoms and he says, "Oh, I know that you want to see your doctor, because it’s caused by witchcraft." The guy comes running out, and he says, "Look, I’ve got a B.S. from Northern Arizona University, what do I want this doctor telling me about witches for?"