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UNIVERSITY OF OKLAHOMA

GRADUATE COLLEGE

POWER AND PERSONHOOD: HEALTH CARE DECISION-MAKING IN A PLAINS INDIAN COMMUNITY

A dissertation

SUBMITTED TO THE GRADUATE FACULTY

in partial fulfillment of the requirements for the

degree of

Doctor of Philosophy

By

Deborah Bernsten
Norman, Oklahoma
2001

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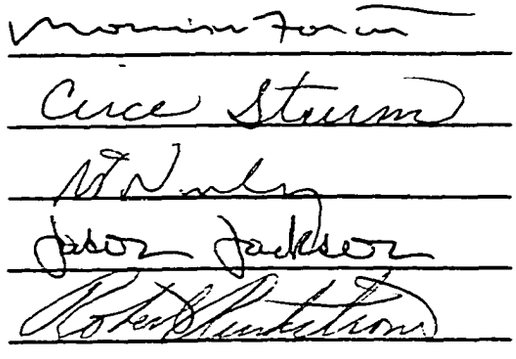
DECISION-MAKING IN A PLAINS INDIAN COMMUNITY

A Dissertation APPROVED FOR THE
DEPARTMENT OF ANTHROPOLOGY

BY



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Acknowledgements

It has been seven years since I was first introduced to the Dithkalay people; that introduction has inextricably altered my life. I owe my introduction to the Dithkalay to the Chair of my committee, Morris Foster. His constant encouragement (and occasional nudging) has taught me much about anthropology and the connections between theory and practice. Throughout my years of fieldwork and the writing process, he gracefully balanced being both mentor and friend. To the other members of my graduate committee: Circe Sturm, Michael Nunley, Jason Jackson, and Robert Rundstrom, I also am indebted. Each has contributed to my thinking in critical ways.

It is difficult to express my indebtedness to the Dithkalay for allowing me to be a part of their lives both professionally and personally. Even now, each time I return to the community I feel their warm friendship and hospitality. For their support and assistance in this project, I would like to express my gratitude to the members of the tribal Business Committee, the Tribal Administrator, and the Directors of the Dithkalay Culture Committee. I also want to thank those individuals who agreed to be interviewed and who participated in community focus group discussions. Most especially, I want to extend my appreciation to the women and elders of the Dithkalay community for their tolerance of my early indiscretions. With patience and understanding they encouraged me to learn about the community in the Dithkalay way. Regrettably, I cannot acknowledge individuals or the community if I am to preserve their anonymity.

For specific quotes I have chosen pseudonyms for the individuals involved. I have two reasons for this. First, I realize as an outsider that I am privy to

information that would not be discussed in the context of day-to-day interactions among the Dithkalay themselves. This is particularly true regarding the relationships I developed in the course of confidential conversations with male members of the community. Best explained, the term "respect" is used among the Dithkalay to express an overarching theme governing the appropriate behaviors and social interactions one uses on a daily basis in the community. It refers to the culturally defined limitations or social boundaries governing both conversational exchanges and reciprocal relationships between people based on factors such as gender, age, and status. Having learned and adopted the Dithkalay's ethic of respect, I see no reason for abandoning the community's governing principle now.

The second, and perhaps more important, reason for retaining the community's anonymity comes at the request of the Dithkalay themselves. Health related decisions, behaviors or the state of an individual's health are sensitive issues and are, therefore, governed by the principle of "respect." The Dithkalay place great value on individual autonomy and the rights and/or obligations of family members in the decision-making or acting-on process of health care. Given these culturally defined parameters, the Dithkalay who assisted me in my research recognize the potential for socio-political ramifications within the community resulting from disclosure. In that spirit, the identity of the Dithkalay will remain anonymous.

Finally, I want to thank my husband, Scott, who both supported my endeavor and maintained the home-front during long periods of separation. Without his patience and encouragement, this project would not have come to fruition.

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Abstract

This study employs a critical interpretive approach to investigate health-care decision-making and the practice of medical pluralism in a Plains Indian community. Data are from a four-year ethnographic experience, community-based focus group discussions and individual interviews. An analysis of the community's discourse of health shows that their health-related talk is shaped by four major themes: the conceptualization of the human life cycle as cyclical, intra-family responsibilities, bounded cross-gender relationships, and a quadpartite worldview. Health-related dialogue then serves as a medium for verbalizing, mediating, and at times, manipulating the illness experience and its perceived outcome to conform with community-specific cultural understandings. Members of the community view the various medical traditions as fluid and are constantly being negotiated and re-negotiated through dialogue. Paramount to their practice of medical pluralism is that both indigenous etiologies and biomedical perspectives, the available resources, decisions, and treatments form a dynamic and interrelated system that empowers both the individual and the collective group. Thus, the community's discourse of health and their practice of medical pluralism is not just about the re-making or re-constituting of the self (associated with an illness experience) as it is a transformative process that restores the individual within his or her physical, psychological, and socio-political worlds of experience.

Chapter One
Situating the Research and Establishing a Theoretical Base

My grampa, he, well he had that medicine, strong medicine. He uses it to help his people. He wanted to care of them. He knows that he's got the talent. He had a golden eagle fan - the one that got brown tail. But he don't do it inside, he don't do it in a teepee or house. He do it away from public view. If a person is, you know, if a person can't handle their body, they could need help with it. He had kind of medicine. He spread that hide, I'll use this one over here. That hide it's buffalo, buffalo robe for buffalo medicine. He sits here facing east, he sitting on the west side. Sits on west side and faces east. The person sits in front of him and faces east. He's got all his, ah...his medicine on the right side with him. It's on the robe. He brings his medicine with, his equipment. And, uh, he got all kind of medicine inside. One is hoof rattle...a buffalo, you know.. It's large you know. One hoof is big, three smaller hoofs...well, it's a hoof with four parts. He's got it tied with buckskin you know, about this long. Maybe shorter. It's got a handle 'bout that long. Sometimes he holds it with a black kerchief. You know kerchief? Like a black scarf. He puts his hand on him and sings. And he's got paint and he paints..Indian paint, different colors. I forget now, the names. It's not red..yea [chuckles]... pink. And he's got his pouch. It's...ah...ah round, it's tied up like with shoe lace. It's got these holes in it, and he opens it up and put stick in it. He wets it with his tongue, ah...the stick. And he touch where the pain is. Paints in the pouch but sometime, he uses his finger, like for on your face or head. Say you got mostly, say severe headache, he fix it. He touch the spot. He got bunch of herbs. He's blind, so he smell, you know they got, roots, herbs got different scent. He uses different and separate stuff for different illness. He helps 'em control their body. You know, what's wrong with them. He's got to seek the source that's interfering with their body. Some peoples...some weaker than others. He carry it up here... hill. I seen it when I was about eight years old. No maybe nine or ten. That's when I know and I watch him. When he was old, I pretty close to him. He never did practice on me. But people knew it. He had strong medicine to help everybody.

Allan Colbert (November 1995)

The elder's narrative was accompanied by Indian sign language that emphasized certain portions of his story. In doing so his recollection of the event in essence became a dramatic performance (c.f. Goffman 1959). His description of what he had observed alluded to the historic longevity of the practice; it seemed as though "buffalo medicine" pre-dated the Native American Church (although I was required to revise that assumption later on in my field experience). Nevertheless, given the elder's age the curing or healing ceremony that he described represented the persistence of an indigenous practice into the twentieth century.

To a non-Dithkalay outsider, such as myself, the various contexts in which the elder Colbert used the word "medicine" were both intriguing and confusing. As a form of oral history (c.f. Vansina 1985), his eyewitness account contained elements that seemed exotic - if nothing else because it was outside of the biomedical framework in which I was used to thinking.

Taken at face value, the elder's description of the buffalo medicine practices gave credence to the framework used in many early studies in ethnomedical research (Lieban 1973, Rubel and Hass 1996). Many early investigations of indigenous health associated culturally-specific or traditional medical practices - such as buffalo medicine - with a native religion or "belief" system as opposed to a medical system based on "science" (see for example Evans-Pritchard 1937 or Kluckhohn 1962). The term "ethnomedicine," coined by Charles Hughes, served as a referent for the "beliefs and practices concerning disease or illness which [arose] from indigenous cultural development and [were] not derived from the conceptual framework of modern medicine" (quoted in Ackernecht 1971:11). This framework established boundaries between ethno -

and biomedical practices. Specifically, ethnomedicine was viewed as separate from medical practices based on a "rational or scientific" medicine and was aligned with magical or shamanistic practices and performances (Rhodes 1996, Rubel and Hass 1996, also Turner 1990).

The limitations of using bounded arenas is further complicated when examining Colbert's reminiscences of his youthful observation. For Hughes (1968), the procedures used in medicine, whether grounded on science or beliefs, are delineated by those practices designed to remedy or alleviate ill health. But in the elder Colbert's narrative, "medicine" is both literal and metaphorical.

In its literal application, the practice of medicine is an act by a practitioner to alter the state of someone who is ill much as Hughes suggests. Accordingly, in many situations the Dithkalay use the term to symbolize or to gloss-over the complete description of a specific performance by a practitioner. In other contexts, medicine refers to the actual pharmaceuticals used and designed to bring about a curative effect. Medicine is also the word that the Dithkalay use when collectively referring to the various herbs, including peyote, foods, and other paraphernalia used in treating an illness. At other times, the present-day usage of the word medicine refers to biomedical treatments and health-related practices.

It is in the Dithkalay's metaphorical use of medicine that a strict application relegating "medicine" to a curative practice becomes more complicated. Medicine as metaphor relates to the reputation, authority or power of both a healing practitioner *and* to individual Dithkalay. Embedded in Dithkalay conversational talk, medicine confirms an individual's knowledge or skill;

knowledge and skills that may not be related directly to issues of health. According to the Dithkalay, some practitioners do obtain their knowledge through a vision quest or request. However, as a metaphor for authority or power, any individual can have strong medicine. For example, in the statement "I don't know what kind of medicine he has, but, boy, those rattlin' snakes took off," the term medicine refers to the perceived ability of the individual to protect others from harm. Thus, an individual who exhibits power or control over a situation also has strong medicine.

As I learned over time to interpret the dialogue of the Dithkalay an additional aspect emerged. The message or meaning of the word "medicine" can shift between past and present. At times, medicine referred to their traditional bundles. Similar to many other plains tribes (Lowie 1987) the Dithkalay maintained medicine bundles for the well-being of the community. The traditional medicine bundles were guarded and passed down through family lines. Dithkalay people believe the bundles embodied restorative powers for illness or for the mediating of social disputes. When an individual experienced ill health, s/he or a member of his or her family sought to use the healing power or medicine of the bundle. For assistance in resolving one-on-one or family-to-family disagreements, those involved usually commissioned the aid of a bundle-keeper. All entreaties for the power or "medicine" of the bundle were accompanied by four gifts and usually performed over four consecutive days. While the bundles themselves are no longer used in this manner, the relationship between social interaction and ill-health is still significant in the contemporary community.

In other contexts, medicine refers specifically to the socially-oriented, religious aspects of the Native American Church both as a past and contemporary practice. However, the Native American Church can extend beyond what we might define as a purely religious realm. On numerous occasions the medicine or power of the church is used as a means for illness resolution.

In toto, Dithkalay conversations reveal that in the contemporary community there exist a multiplicity of interactive arenas of health-related decisions and practices. One arena incorporates a variety of health care sectors: popular, folk and traditional (c.f Helman 1994). Another arena is related to the conversational interaction between people: same gender, same family line and/or same generation. Finally, there is the arena in which "good health" or "control over the body" is measured: individually, socially, and politically, by both individual Dithkalay and other community members. But what were the linkages between these various spheres? Given the geographic proximity of the local Indian Health Service clinic, why did these various levels coexist? In this same vein, given the importance of good health as a precursor for both social and political authority or power, why the persistence of ethnomedical treatments in the contemporary community? Not that they ought not to exist, but I wanted to know why they did and do exist. Most especially why did the Dithkalay continue to use peyote as a medicinal treatment? I readily understood the religious significance of peyote in the context of the Native American Church but I could not explain why the use of peyote also persists as a curative remedy.

To unravel these questions I established a number of perspectives. From the outset I would state that I view illness as a part of the human condition; all

people, both as individuals and as members of a socio-culture group, must address the onset of illness at one time or another. After living with the Dithkalay for over four years, I have come to see their responses to illness as cultural responses toward the *totality* of illness. Following the lead of both Good (1996) and Becker (1997), I use the term "illness experience" to encompass the totality of illness as an experienced undertaking that affects both the individual and those around him or her. Any analysis of the illness experience must include a concept of "health." I take health to be symbolic of a state of physiological, psychological, and social being. With this in mind, the discourse of health encompasses both positive and negatives states of being; good and poor health; wellness and illness. Because people construct the actual utterances that constitute the discourse, the discourse of health is a creative process that is expressed in numerous forms. The forms that people engage in a discourse of health include narratives or stories, one-on-one interactions, and conversational dialogue.

With these perspectives in mind I will explore how cultural beliefs about the illness experience coalesce with health-related decision-making and health care practices. In order to understand Dithkalay health-related behaviors I examine how Dithkalay health care decision-making was and is socially and culturally constructed. My interest in the decision-making processes associated with health was piqued by the desire to elucidate the linkages within and between the various health care systems that the Dithkalay use. In this dissertation I examine the role of culture and society as variables that influence Dithkalay health care choices, the engagement with ethnomedicine as a form of

native persistence, and the practice of medical pluralism in an indigenous community.

Entering the community

Throughout my four plus years of living with and among the Dithkalay, both elders and peers guided me in learning their perspectives regarding health and medicine and how their cultural understandings of those concepts were juxtaposed with what it means to be Dithkalay.

Beatrice: "The beginning and the end...well, it's a private thing. I remember my mother delivering Dithkalay babies. But we got shoo'd away. Somebody dying, people move away. In our culture, everyone leave, person needs privacy. If they had some kinda' sickness, you got to move away. You don't want to be around them. You might get it. Like I went to see the doctor and he starts telling me what's wrong. I say, don't say it, then I might get it."

Iola: "We don't get near people that have a sickness. Got to give them quiet. Tepee or, now house, we say don't bother 'em. Don't go near 'em unless you're family. Then only if she askes. It happens when things aren't done right. Like my sister, the doctor he says, she's got something. She says I don't believe 'em. She walks away. She lived long time after that.

Women's Focus Group (April 1996)

My presence in this discussion was in the role of group facilitator in a focus group comprised of Dithkalay who reside in the area. The group consisted of eight women between twenty-five and seventy-five years old. My responsibility in this project was to present questions that would facilitate a discussion concerning privacy and confidentiality issues in the community. The

community based focus groups provided me with another, and somewhat unique, avenue for collecting data.[1]

Traditionally, anthropological research emphasizes both participant observation and the interview process, whether those interviews are either formally or informally conducted. My constant and continued presence in the community certainly afforded me the opportunity of being the participant observer. I have over time come to view this experience as comprising macro-level data. The collection of taped recordings with elders and/or heads-of-families provided a database of formal interviews of individual Dithkalay perspectives. Informal interviews were the result of assisting the women in preparing fund raising meals, organizing an elder honorary program, participating in the annual youth summer camp, and other community activities. I think of the information and insight collected at this level as micro-data. It was through community level dialogue in the focus groups that I could listen, watch and learn how culturally specific understandings were validated, negotiated, confirmed and/or manipulated. Less confined than the micro-level interpretation of an individual Dithkalay and relatively absent from my macro-level outsider bias, the focus groups became the basis for mid-level or bridging-level data.

In this particular focus group, the women spoke openly and freely about their use of traditional methods for healing. Some examples were linked to dreams that directed a subsequent behavior

> "Well, sometimes you can get a dream that'll help you. I got real sick once too...really sick. One day, well, I got sick. I must have had a dream that night. Something was talking to me. I never did see it. But I heard it. It was saying to me, you go get you a snapping turtle, cook it and eat it. Well, I didn't see it

> so...well, days went by and it's not getting better. So one day I say to my boy, You know where any snapping turtles are? He says what for? And I tell him I want you to go and find me one. Well, I say to him, please do it. So he goes over to my brother's. He's got a big sack, like the one we used when we was a kids. So he brings me one back. He says to me what 'ya gonna do now? You can't cook it in that little pot. So I tell him that when it was talking to me, in that dream, you know, well, I'm gonna cut it up and fry it. And sure enough, here I am.
> (laughter)
> I still believe in that today. Power can talk to us to help us with power, you know if you're willing to listen. 'Course some of these young folks. Sometimes they can't be quiet enough, long enough to hear it. I tell my boys that. Even today. 'Course back then, we used to eat them turtles all the time. Back then we kids go and get a bunch of them. Build a fire and get nice coals. Didn't know what health was then. We'd get long sticks. 'Course those turtles was heating up and they'd try to crawl out of the fire. We'd poke 'em back in with our sticks. When they was done, they were all black outside and covered with mud. We'd eat them right there, black an' all. Doesn't look like it hurt us too much, we're still here. (laughter). Maybe that's why we didn't have all this sickness back then. We was always eatin' those turtles.
>
> Women's Focus Group (April 1996)

Another participant related how a family member might decide to have a particular procedure done.

> After we lost our mother, well, Dad he got real sick. He had a massive heart attack. At age [XX] he had by-pass surgery. He made the decision himself. He prayed alot, asked to have the power to get better. He always had a strong faith. After he smokes and prays, then he comes and says to us...this is what I want to do. Our job, we show our support for his decision by assisting him. Elderly's need help. So I

> would go with him. Later on they run tests on him and they say he has cancer of the prostate. Prostate cancer. Again he does a lot of praying before talking to us kids. I guess he feels comfortable with me, going with him, cuz I can understand the medical. He decides though before he goes. He always wants to go on. He tells me, I'm not ready to be giving up yet.
>
> Women's Focus Group (April 1996)

Laden with culturally specific talk, these parts of the dialogue contrasted starkly with the women's discourse concerning the way(s) in which the women felt they were treated at the local Indian Health Service (IHS) clinic or at the Indian Hospital. Here, the talk was not flattering. A common thread was how "those folks patch you up with a bandaid and cough syrup and send you on your way." One of the female participants was a nurse employee at the local IHS clinic and to my surprise she did not come to the institution's defense. In many instances she concurred with the speaker's opinion of the situation. Throughout one two-hour period the women shared numerous examples that expressed their general feeling that the clinic doctors "got too personal." However, they were not speaking about any improprieties or physical breach in the physician-patient interaction. Instead, they were speaking about the physician's inquiries about their illness symptoms and, most particularly, about having to reveal their health histories.

The women verbalized their objection at having to reveal their health histories. Based on their childhood enculturation in the community and given the parameters governing health-related talk, revealing a past health history or a previous health-related decision is, from their perspective, "disrespectful." Inquiries into an individual's previous health-related experiences represents the

invasion of an individual's privacy and is considered a challenge to personal autonomy. As the women's talk revealed, their discomfort level with this aspect of the process was exacerbated when they were required to see a male physician. This was particularly accentuated if they were seeking assistance for a female-related health problem. The fact that scheduling procedures may govern the physician assigneded to attend them did not in any way ameliorate their embarrassment or distress. Additionally, the women expressed the "doubt that he [the physician] knows anymore than my Aunt Iola over there. He barely know what I'm talking about...he's not a Dithkalay woman." When I questioned the women as to how they responded to such a situation, the consensus was that "the only dignified and respectful thing to do is to get up and leave." Which they do regularly.

The Dithkalay women's objection to revealing or including previous diagnoses, treatments or histories conflicts with the standardized procedure of a biomedical paradigm. Western medicine emphasizes the taking of an individual's medical history and it is usually the first order of business when seeking a physician's aid. In a Euro-American framework, the individual medical history, as a set of collected and recorded facts, allows for a diagnosis based on scientific evidence. As such, the chart or medical history serves to comfort or bolster both physician and patient (Foucault 1975, Turner 1990).

Misunderstandings in the health-related interactions between native patients and non-native practitioners are not limited to the Dithkalay. That differing interpretations and responses in health-related dialogue are the result of differing cultural understandings is not surprising. How cross-cultural dialogue is successfully negotiated is consequential for most people, but most especially for

those who rely in part on a system where the health-care givers are consistently of a differing culture than the patient.

For anthropologists the word "culture" is almost synonymous with our profession. However, any cursory perusal of introductory anthropology textbooks will reveal as many definitions as the number of books examined. Constructing a definition for culture is the bane of any anthropology graduate student's career. To best explain what goes on in the Dithkalay community, the definition I use is: culture is any set of symbols, beliefs, understandings and behaviors that are shared by a group of people. Additionally, as this dissertation will illustrate, culture must be passed from generation to generation.

Even the Dithkalay use the word quite often, freely discussing their "culture" as a way of expressing their tribal distinctiveness. Because they live in close proximity to and interact with the members of two larger tribal groups, Dithkalay comparisons of their cultural practices with those of other native communities functions to distinguish themselves from their more numerous neighbors. In daily conversations it is common to hear "Well, you should have seen it. It may be the [blank] way, but it's not our culture. The Dithkalay way is..." And, of course, they use differences in culture and cultural behavior as the means for setting themselves apart from the larger Anglo society.

Recently, "culture," as a generalized term for labeling the ideologies and habits of a group of people, has found its place in the everyday language of the media. I knew from the day I entered the community that Dithkalay "culture" was unique and distinct from my own background. That the Dithkalay's way(s) of accomplishing tasks as different was immediately apparent in trying to accomplish my job as a researcher.

Part of my assignment was to conduct interviews and construct family genealogies.[2] This naturally required identifying the various individuals who comprised a family line. The difficulty in this undertaking did not lie in a language barrier, per se. Like most American Indian peoples, English is the dominant language. English is virtually used everywhere, by everyone. The exceptions were certain ceremonials or blessings conducted by a limited number of elders who still speak the Dithkalay language.

Instead, the confusing component stemmed from the Dithkalay's socio-linguistic rules such as placing a taboo on "calling out" or using the names of deceased persons. Instead, speakers substitute a pronoun--he, she, his, her. Occasionally, the speaker may be more explicit by saying "this man/woman, here" subtly indicating the individual or in the case of documentation s/he may point to the referenced symbol on the genealogy chart.

Also confounding the preciseness necessary for genealogical research was the Dithkalay Anglo-cized form of bifurcate merging kin terminology. Cousins by blood are "brothers" or "sisters," although cousins through marriage remain "cousins." Applied on a multi-generational level, an individual may have, for example, as many as seven or eight persons called "grandpa" by incorporating his/her biological grandfather, his grandfather's brothers, grandmother's brothers and, perhaps, the former husbands and brothers-in-law of his/her biological grandmother. *Then,* one must factor in multiple marriages and, prior to 1920, multiple spouses. Over time I too adopted the Dithkalay's way of knowing who is whom by memorizing the various relationships of people in-and-between families. Today I can follow their everyday conversations even though they replace the direct reference of a person (i.e. using the person's

name) with a pronoun. While some younger members of the community sometimes may have to stop and think momentarily before articulating a relationship, Dithkalay children continue to be socialized along these lines.

An additional feature that appears in Dithkalay dialogue includes male references to "brothers" of a different sort. The adoption of this kin term is the result of a conscious and deliberate change in semantic usage by Dithkalay males. In these contexts, "brother" is a fictive kin term that replaces the previous designation of "friends." In their historic past, the male members of the two Dithkalay military societies were organized into pairs, called "friends." These society partners were obligated to each other much in the same way as biological brothers. However, based on one contemporary usage of the term "friends" in the larger Anglo society (referring to a close and homosexual relationship), Dithkalay males have deliberately replaced the term "friend" with the term "brother." Dithkalay men are very sensitive to any challenge of their masculinity. By replacing one term for the other, Dithkalay men have consciously chosen to emphasize the kin-related social relationship. The occasional use of the term "friends" by a male of the younger generation (15 to 30 years of age) is one of the very rare cases in which an individual's dialogue will be openly corrected.

Historic circumstance of the Dithkalay

Dithkalay ancestors practiced a lifeway typical of most nomadic Plains societies. Initially pedestrian, and later horse-mounted bison hunters, nomadic bands comprised of extended families traversed the Plains encompassing a range from the present-day American southwest to the Canadian border.

Horizontal cohesion for the bands into a tribal group was based on a shared language, social structure, voluntary societies and beliefs or ceremonial patterns. Until contact with the Federal Government there were no "chiefs." The spokes-person for tribal negotiations and inter-band activities was the oldest living male member of the extended family who had demonstrated his ability to guide and provide for the group. Characteristic of most band-level societies, political action or major decisions required a group consensus. Those who did not agree with a proposed plan of action were free to leave and join another band or to strike out on their own.

During the later-half of the nineteenth century the Dithkalay were confined to a reservation. At some point during their early reservation years a smaller group of linguistically-affiliated people joined the Dithkalay. Practicing a similar lifeway and ceremonial pattern, they united with those Dithkalay already confined. The merger of these two groups is not documented in historic records, most likely the result of the federal government's attitude toward all Indian peoples at this time; if an individual declared him/herself as Dithkalay, then Dithkalay he/she was and belonged in the designated reserve. Little, if any, consideration was given to indigenous territorial land occupation or group affiliation. However, Dithkalay elders know and can identify living community members whose "peoples came up from the south."

Data concerning the Dithkalay is scanty for the reservation period. Agency and military correspondence, written solely by white outsiders, necessarily concentrates on the more aggressive activities of other larger tribes and federal efforts to contain them. I would suggest that the Dithkalay's small population inhibited their military participation at this time. Numbering less than

400, Dithkalay band leaders may have adopted a more conciliatory stance as a strategy to ensure that Dithkalay encampments did not suffer military attack. More importantly, the necessary annuities would be provided. Data suggest that pre-reservation Dithkalay band leaders maintained their traditional leadership roles throughout this period.

This pattern for family composition and of authority within the extended group exists at present. In the contemporary community, extended families constitute the socio-political units. The Dithkalay refer to their extended families as "households." In situations requiring the input of tribal members the members of each extended family rely on the male head-of-household (usually the oldest living male) to be the voice in the matter. However, unlike their ancestors, contemporary Dithkalay cannot pick-up and leave in the face of inter-family conflict. It is perhaps this reality that has led to one of the governing themes of the contemporary community - that of "respect."

The weather in this area, both extreme and unpredictable, is a major factor. Winter often brings plummeting temperatures accompanied by wind gusts up to forty or fifty miles per hour. In the more rural areas people are often confined to their homes for periods of time because of ice-covered roads. During the summer, drought is a constant threat and daytime temperatures can stay between 100 and 110 degrees for days on end. There is always the threat of tornado activity or sudden devastating thunder storms. Creeks and washes can fill with run-off in a matter of minutes, only to become thick reddish sludge as soon as the sun reappears. In spite of government attempts to manipulate the environment, in 1890, only a small portion of the reservation was under successful cultivation. (ARCIA 1890).

Ignoring this reality and driven by the government's concerted attempt to assimilate the Dithkalay into the larger Anglo society, their lands were subject to allotment in severalty. With allotment, government annuities, including rations for the elderly and disabled, were discontinued. Deviating from the federal government's general policy of having the local Indian agent assign allotments to individuals, the local agent permitted the Dithkalay to select the location of their allotments. A study of the allotted lands reveal a somewhat unique pattern which I examine in greater detail in Chapter three. One hundred fifty Dithkalay allotments were completed and the surplus lands were opened for settlement.

Many Dithkalay lost their lands, generally the result of selling it based on an immediate necessity for cash. In the case of Angus Carroll's blind grandfather, a surgery that potentially could restore his eyesight precipitated his need for money; he sold his allotment to a white farmer. Most of the Dithkalay who were able to retain their allotment did so by leasing their land to nearby White cattle ranchers.

An inter-tribal business committee was formed shortly after allotment because non-natives sought the leasing of commonly held native lands for grazing and agricultural development. In the Solicitor's opinion, leases, as contracts, required the consent of both parties. So a business committee was formed to represent the affiliated communities to administer their joint economic interests. Tribal delegates to the committee were selected in separate tribal general councils, by stand-up vote and supervised by the agency representative. However, the committee was far from an independent association or self-regulated. As an independent political body, the committee was operative

only insofar as the Commissioner approved of their actions and usually approval was based on the local agent's recommendation.

Census data prior to the reservation era indicate a relatively stable, albeit small, Dithkalay population. The earliest formally documented census comes from 1879-80. According to this census the Dithkalay comprised eleven bands with a total population of 244. Like most indigenous groups, during the reservation period they experienced numerous epidemics of measles, influenza, and, of course, tuberculosis. The community's population nadir came about following the influenza epidemic of 1918 that affected both native and non-native mortality rates.

During the 1950s, federal termination policies did little to assuage Dithkalay concerns regarding government's attempt to eliminate its responsibilities to the community. The Dithkalay were against termination, although many, especially those who remembered or had heard about the allotment negotiations from family members, believed termination was inevitable.

Of all the programs overseen by the Bureau of Indian Affairs (BIA) in conjunction with termination, the relocation program had minimal participation by Dithkalays. While there is some evidence for out-migration, most Dithkalay who participated returned to the community within short periods of time. More importantly, their minimal participation may have been related to previous attempts by Dithkalays to participate in the larger, Anglo economy. Those who participated in relocation were young men who had families, the majority of them having been in the service. Following World War II, some had relocated to economically developing areas (such as the burgeoning airplane industry in California) only to find their native status restricted access to jobs, and if they

obtained jobs, employment was short-lived. Unaccustomed to nuclear family living conditions, most had returned to the community.

However, in contrast to the minimal or selective influence of relocation, was the effect on the community by the BIA Indian Adoption Program. Started in conjunction with the Child Welfare League in the late fifties, the project authorized non-native state and federal employees (usually the agency social worker) to decide when to remove children from their homes. With this authority a number of Dithkalay children were referred to the League and sent to established adoption agencies throughout the United States. On numerous occasions Dithkalay tribal leaders appeared in court to argue for their cultural practice in which relatives raised these children. But as most relatives were unable to meet state guidelines, particularly those restrictions concerning living standards, the efforts of tribal leaders in this aspect continued to be unsuccessful until the passage of the Indian Child Welfare Act in 1978. The community's consternation, especially that of elders, over the loss of these children comes to the surface in a number of contexts, usually accompanied by concerns over how the adoptees might establish tribal affiliation and, if so, how they might (as adults) be properly integrated into the community.

While the threat of termination subsided with the end of the Eisenhower administration, a two-million dollar partial settlement of the lands held jointly by the tribes once again intensified tensions in the joint business committee. One faction of the larger tribal groups sought to disband the intertribal affiliation. The proposed split was a source of concern for Dithkalay tribal leaders. Realizing that any equitable division of their commonly held lands was impossible (each tribal group would want the most productive portions), Dithkalay leaders argued

for maintaining the political bloc that the tribal affiliation provided. In addition, there was the sensitive issue of separate tribal identity. Under the formal organization of the affiliated tribes the collective membership comprised "those members having blood of the [other groups] or Dithkalay tribes, including their captives and their descendants." Now individuals had to select a particular tribal association.

Ultimately, the faction supporting separation was successful in "pulling out." With separation, the Dithkalay formed their own business committee. In a General Council, consisting of all Dithkalay tribal members over the age of eighteen, the Dithkalay adopted a Constitution establishing themselves as a separate and distinct tribe. Under the Constitution, elections for the five business committee positions; Chairman, Vice-chairman, Secretary, and two Committee members are conducted every two years by ballot. During the course of my fieldwork, I had the privilege of observing the workings and decisions by three different business committees. There was constant pressure on these tribal officials to provide for their constituency and to work for the benefit of the tribe as a whole. Most of the time, they were very successful.

Community life

Today the Dithkalay occupy a thinly populated rural region of the southern plains. It is an economically depressed area so some younger adults commute to one of two larger towns for employment. One town is about thirty miles south, the other about forty miles north. Local tribal governments, including their own, are the major employers of Indian people in the area. Today some rely on their share of land leases as their economic base. Although a limited number do have

a more sizable income, the result of oil, they are few. Consequently, the majority have an annual income that is below the government's established poverty level of $16,000.[3] Yet, despite the forced changes in their traditional economic or subsistence pattern resulting from American expansion, life in the contemporary community expresses a persistence of traditional Dithkalay ways.

Following World War II, the Dithkalay experienced rapid population increases, similar to population increases observed in other developing societies or countries. Today, fifty-one percent of the Dithkalay are eighteen years or younger.

In some sense, these statistics do provide support for those who argue that a burgeoning population is the direct result of declining infant and child mortality rates the result of increased medical care, mobility, and modernization through technology. By this syllogistic argument, population decreases will eventually follow as the extended family loses importance and as individualization is emphasized (Caldwell 1976). But underlying this argument, as an approach to controlling population growth, is the implication that indigenous peoples will abandon their traditional cultures in favor of "westernization" and individualization (Ibid). Rightfully so, proponents of this approach have been criticized for a decidedly Euro-western perspective. More to the point, life in the Dithkalay community argues otherwise.

In the contemporary community many of the variables that would in the past have influenced mortality rates or health outcomes are either limited or non-existent. All Dithkalay homes are heated, have running water and indoor plumbing, and through the extended family and kin-term network, none go hungry. Similar to other Indian groups, food, especially as a meal, is an arena

for social and political discussion, symbolizes the connectedness between families and/or other tribal members and reaffirms the reciprocal relationships of the participants.

Nonetheless, early in my fieldwork I learned that Dithkalay beliefs concerning the physical body and its state of health governed a multiplicity of day-to-day practices, including the perfunctory and standard Anglo greeting: "How are you?" For the Dithkalay, this inquiry is much more complicated because it is imbued with understandings about the appropriate and inappropriate ways for inquiring as to the status of an individual's health. Just as Dithkalay children learn, so I was taught. It did not take too many non-responses or re-directed replies, such as "it is good to see you" before I understood that a direct answer to this question implied a relationship between individuals. By interacting with Dithkalay women I came to understand the rules governing who talked to whom about a community member's illness, including one-on-one inquiries.

The other constraint on daily interaction is related to proxemics. As in many other Plains Indian communities, the Dithkalay are relatively reserved in greeting another person. If the greeting of another person requires a handshake (usually a non-native), this generally is a loose, hovering slide over the out-stretched palm of the other person. Physical contact between the genders, say in the form of publicly hugging another, is virtually non-existent. Within the same gender, and only in the absence of a male presence, women may hug each other especially if they have not seen each other in a long time.

Male Dithkalay are far more reserved. Even in acknowledging the presence of another male tribal member, the male-to-male greeting is usually in

the form of sign language. This takes form in a hand movement at the waist line. The hand signal is that of an open, flat hand, palm down movement, which flutters in an alternating clockwise and counter-clockwise manner. According to Dithkalay elders, the sign is literally translated to mean "what's up?" During this non-verbal greeting Dithkalay men tend to leave a space of about one to two feet between themselves and the other male participant. However, given the gender distinctions between males and females (which I more fully discuss in the following chapters), cross-gender greetings require a far greater distance than those within the same gender. More important to my research is that the distance between people increases significantly if the one of the participants believes that the other is ill or if there are visual indications that his/her health is jeopardized.

These cultural rules governing daily interactions were necessary codes that I needed to learn to participate appropriately in the community. While all community members were willing to "teach" me and to overlook my early-on infractions of culturally prescribed parameters, the initial learning process brought forth more questions than understanding.

For example, more than once I was asked to drive someone to the local IHS clinic, but each time the request came from a female, usually one who was older than I and whose daughter or niece was unavailable. Yet I had numerous close interactions with male members of the Dithkalay community: Why did men not request my services?

Understanding what "health," in both its positive and negative state, means to the Dithkalay seemed like peeling away the layers of an onion. I could easily grasp that good health encompassed notions of well-being,

understandings about illness prevention and a positive physiological or psychological state of being. However, Dithkalay conversations about health were not explicit in expressing these notions. Instead, health-related conversations tended to be illusive and open-ended. The Dithkalay's pattern for talking about health contrasts sharply with the dialogic interactions in American society. In the discourse of health Anglos concentrate on openly acknowledging and discussing the alteration in a person's physiological state. Most often the dialogue, even in its most mundane form, includes references to symptoms, diagnoses, and treatments. For example, it is quite common in the larger Anglo society that conversations among participants at a baby shower will turn in the direction of what I would dub "war stories." Essentially, these are renditions of the story-teller's previous experience during pregnancy and/or labor. Often, these stories are told in great detail and include elaborate descriptions designed to guide the expectant mother through what is a normal process of life. In general Dithkalay women do not engage in such conversations. Instead if the expectant mother has questions or experiences difficulty she may seek out the advice or assistance of her aunt or a sister on a one-to-one basis.

Like many native peoples, quality health care for the Dithkalay community can be problematic. In the final treaty confining their ancestors to a reservation, the provisioning for health care was included as one of the treaty stipulations. Thus, in its early form biomedical health care was provided by agency doctors, hired by and duly compensated under the auspices of the Department of the Interior, later on the Bureau of Indian Affairs.

Today, the Indian Health Service (IHS) is a part of the larger Public Health Services system. IHS clinics and its practitioners often have limited facilities and

on-site diagnostic resources are few. The local IHS clinic used by the Dithkalay is no exception. In situations that call for the expertise of outside personnel, natives must wait for referrals to these specialists. Called contract health services, the delay between the initial scheduling of the appointment and the actual visit to the physician-specialist can be as long as three months. Limited services at the local level also mean notoriously long waits for care. Even on a daily basis people with a scheduled appointment may wait up to six hours before seeing a physician. A further impediment is that the physicians often lack experience working with native patients or are of other ethnic groups themselves; language and communication difficulties ensue, frustrating both the patient and the physician.

Nevertheless, it is unfair to cast these health care providers as uncaring. Fraught with many administrative and financial difficulties, the practitioners I talked to at the local clinic expressed how "most of the time [they] feel as though [their] hands are tied," the result of policy constraints, regulations and funding.

For most public health care recipients, availability is limited to those individuals who meet some sort of established requirement(s). Usually the qualifying criterion are embedded within other federal policies. For example, some non-native individuals whose annual income falls below the established poverty level are entitled to public health care. But validating income levels and determining any potential health care benefits may fall to the Department of Children and Family Services, not to Public Health Service officials. Similarly, the availability and quality of biomedical health care provided the Dithkalay is embedded in other federal policies; policies specific to Native Americans. Defining who is entitled to IHS privileges becomes a murky issue, mostly

because the qualifications for determining eligibility get clouded with the larger question of: Who is an Indian?[4]

Indian Health Service eligibility requirements demand that recipients be able to demonstrate membership in a federally recognized tribe. This often entails tribal restrictions on or the determination of blood quantum. In 1988, during their annual General Council meeting, by majority rule the Dithkalay voted to change their tribal membership blood quantum from one-quarter to one-eighth.[5] Some who supported the amendment cited the need for change so that IHS services would be available to their children and/or grandchildren. But, even though the Dithkalay altered the eligibility requirement, it is not retroactive. Specifically, any Dithkalay born prior to 1988 must still demonstrate a blood quantum of one-quarter. Only those Dithkalay born in 1988 or afterward can become a member of the tribe and have accessibility to Indian Health services based on a blood quantum of one-eighth. Consequently, the ultimate determining for tribal membership and its attendant health care eligibility is no easy matter. At times this disparity leads to heated discussions among the Dithkalay themselves regarding who has rights under federal government treaty obligations.

The local IHS clinic is but one of a number of biomedical options that the Dithkalay have at their disposal. While the local clinic is centrally located to serve a number of tribes whose members reside in the surrounding area, less than a one-hour drive away is an Indian Hospital. The hospital was built in the early twentieth-century with the specific intention of providing more comprehensive health care to the local Indian population.

Discussions about the hospital and its current operations also inspire the ire of community members. Many Dithkalay quickly point out the hospital was built using Indian monies. Specifically, it was constructed using the four percent accrued interest funds due the reservation tribes for the loss of their lands. Yet within the last two years, the services provided at the Indian Hospital have been extended to include other non-native public health recipients. Most Dithkalay, especially young adults, view this policy change as "just one more example of the federal government's attempt to do away with us Indians."

In addition to the clinic and hospital also readily available is a vast array of biomedical treatments in their most mundane form. The local Wal-Mart Superstore stocks its typically large collection of various remedies and pharmaceuticals available to the general public for curing everything from the common cold to sleeplessness.

The persistence of indigenous Dithkalay health related treatments is not due to the lack of biomedical resources. In fact, the Dithkalay's use of the local clinic suggests that biomedicine, with its differing etiologies and practices, is but one option available to them. Discussions concerning health care availability or the local clinic inevitably turn into a dialogue concerning the government's responsibility as a provider based on treaty agreements. Elder community members adamantly demand that the "medicine chest" included in their treaty be modernized, continued and confined to Indian use only.

The fact that Dithkalays do avail themselves of biomedical resources means paying attention to how biomedical etiologies are interpreted by the Dithkalay. It also means giving consideration to the variables influencing the use of biomedicine as an option in the process of health-related decisions and

behaviors. The relative availability of and recourse to a variety of health care options led me to questions about: When in an illness experience does an individual select to use one or more of the remedies available for resolving ill health? My initial observations in the community did not reveal any pattern for immediacy of care except in the case of accidental injury. In the absence of an identifiable pattern I was led to other questions such as: Are specific illness symptoms associated with a particular health care domain? And if so, do Dithkalay emic classifications use a hierarchy of resort for illness resolution as reported by Lola Romanucci-Ross (1977) in middle Melanesia? The Dithkalay do distinguish between episodic and chronic illness. But even within these two larger categories, their use of a particular health-related resource does not appear to be the result of a perceived illness causality. An additional question to be addressed then, is: Are Dithkalay health-related options merely aspects under the umbrella of medical pluralism?

Until very recently, there was a tendency on the part of biomedical practitioners to view native peoples as categorizing symptoms and exercising a hierarchy of resort for resolving illness. In this view (as outlined by Helman 1994), the first avenue in illness resolution relies on popular remedies such as over the counter items or by seeking and acting on the advise of family and friends. Secondary measures count on ethnomedical remedies, what Helman labels the "folk" category. When the foregoing attempts do not produce the necessary results, then natives seek biomedical assistance. This sequel means natives use biomedicine "when they have no choice." Given this scenario it is not too surprising that in the past this hierarchy was used by some biomedical

providers to justify ineffectual results or a poor illness outcome in minority populations.

Two assumptions are involved in applying a hierarchy of resort when, in fact, it is not practiced. Both may have serious ramifications for Indian peoples. The first assumption is that biomedical remedies are viewed as the only correct course of action for an illness resolution. Those patients who do not follow the physician's instructions exactly are often viewed as "non-compliant." This is true for many patients, not just native peoples. Like most individuals in a similar situation, the Dithkalay resent incorrect judgments concerning their behavior. Based on my experiences both in the local clinic and in a number of smaller hospitals located in towns throughout the area, it appears that, in situations involving cross-cultural interaction, issues of compliance are exacerbated.

At one point during my field research I had the opportunity to briefly discuss my investigation with a relatively new, but interested, acquaintance. Having provided a brief overview, the individual said,

> "But now, seriously...Isn't it that they really don't want to be cured by the Whiteman? But when their medicine man fails; well...no one wants to die, so they go where they should have gone in the first place."
>
> Anonymous (non-Indian), May 1996

These misinterpretations, and therefore, miscommunications between peoples, are important issues to all Native North Americans who are required to negotiate the patient-provider relationship within the biomedical sphere.

This attitude is not only reminiscent of the boundary between biomedicine and ethnomedicine but it also ignores the history of the institutionalization of

biomedicine. One of the first and strongest critiques disputing the preeminence of Western medicine comes from the work of Foucault (1973,1975). His historiographies illustrate how biomedical institutions are culturally constructed. The past ten years has seen numerous critiques regarding the objectivity and science of biomedicine (see for example Hahn 1995, Rhodes 1996). These criticisms illustrate that biomedicine is not unlike the realm of ethnomedicine. Biomedical etiologies, treatments, and patient-practitioner interactions are the product of specific historical and cultural processes that took place within Euro-western society and cross-cultural interactions.

The second assumption in applying a hierarchy of use is that the various care alternatives available meld together creating a complex, whole system, the parts of which are in some manner prioritized. Baer (1995) recognizes medical pluralism as the process of subsuming the various sectors of health care into an over-arching totality. Here, medical pluralism involves relationships among subsystems where biomedicine enjoys preeminence and attempts to exert dominance over subordinate medical subsystems.

Listening to the talk among community members about health and observing the subsequent behaviors of individuals argues against the idea of the separate medical subsystems dissolving into a single, complex, yet complete plural system among the Dithkalay. Quite the opposite, on numerous occasions the Dithkalay use a multiplicity of different resources simultaneously to resolve the same illness. This, of course, then leads to the question: What of human agency? If the boundaries of the varied sectors or alternatives are fluid or overlapping, then somehow those boundaries are being negotiated and/or manipulated. This means that the cultural boundedness of medical systems

becomes a question to be addressed. If the Dithkalay are an example of how health-related issues are dealt with in an indigenous community, then ethno and biomedical etiologies, perceived illness outcomes and the attendant health-related decisions and behaviors of individuals are not as cut-and-dried as might be thought.

Until very recently, the health status of Native Americans were the bivouac of the Indian Health Service and prior to its inception, the Department of Indian Affairs. The bulk of their documentation and conclusions were based on a statistical analysis. A head count of sorts, the state of health for native peoples was based on illness outcomes; "X" number of reported cases for diabetes, "X" number of measles, etc.

The statistical summary used by IHS was an extension of its biomedical realm that operated within a framework of knowable "facts." Little, if any, consideration was given to the "medical aspects of culture [or] the cultural aspects of medicine" (Landy 1977:2). But, early anthropological interests in and about health as a field of study were precisely concerned with the those relationships: sickness and healing, culture and society.

The single earliest work that may be "designated" as the initial contribution to medical anthropology is that of William Rivers (1924) and his *Medicine, Magic, and Religion.*[6] Trained as a physician and interested in sociology, Rivers contended that indigenous health decisions and/or health remedies were not based on concepts of disease and illness causality; health-related behaviors were persistent practices that reflected a "primitive" belief system (Ibid: 49-69).

Following the lead of Rivers are the numerous works of Erwin Ackernecht, who also viewed indigenous curative practices as "magical medicine" (1946: 467). Even though he confined his interpretation of indigenous medicine to magical practices, Ackernecht, nevertheless, did much to advance an expanded view of the relationship between native health-related behaviors and culture. Ackernecht argued against the categorization of "primitive" medicine as an inter-culturally inclusive domain; there was "no single primitive medicine" (1942:506). Instead, Ackernecht contended that there were: 1) numerous and differing native health-related practices on account of, 2) the health-related behaviors of native peoples were related to specific historic circumstance and cultural beliefs which, 3) became incorporated as one aspect within the total contour of the group because, 4) the health-related practices served a function within the society (1945:427-32). Ackernecht's view that native health-related behaviors were primarily driven by cultural beliefs (a.k.a. magic), rather than concepts of disease or illness causality, strongly influenced anthropological studies of health throughout the 1940s and 1950s.

Scholarship on Native American Health

By the mid-1960s, there was a marked increase in interest among both medical and social scientists to explore and develop theoretical approaches about health. As a body of research emerged the field of medical anthropology developed.[7] Early investigations in the field tended to fall within two broader theoretical approaches; the focus was on either issues related to political economy or the investigated group served as an example for cultural studies.

As a body of work the political economy perspective is still useful for some accounts and for some areas of investigation. The approach, however, is inclined to focus on the state of native health in general terms. Consequently, indigenous peoples are treated as an aggregate. There is little separation or analyses of health outcomes as a result of cultural, geographical, or demographic differences. A political economy approach places an emphasis on examining the relationship between colonized peoples and colonizing governments, both historically and in the present. Using Pierre Bourdieu or Michel Foucault as a point for departure a number of these studies address the hegemonic or differential relations of competing medical systems.

A good example of this type of investigation is Jean Comarroff's (1993) work on body politics. In this work, Comarroff examines the interrelationship between British imperialism in Africa and the rise of biomedicine in Europe as historic process. For Comarroff, the rise of biomedicine in Europe resulted in a symbolization of the human body which allowed British imperialism to excuse an inequitable social order. Manipulated by the colonial regime the emerging European "sense of health as social and bodily order...[meant] natives [were the] embodiment of filth and disorder" thus justifying the domination of their African subjects (Ibid: 306).

Comarroff's analysis points to one of the weaknesses of using a political economy approach. By confining an analysis of the data to differential power relations, a political economy approach is inclined to point fingers at the colonizing powers as the sole source for the state of health among indigenous peoples. While the influence of external forces cannot and should not be excluded, there is an implied assumption in this approach that native peoples

were and are passive, submissive or apathetic victims who never responded, reacted or attempted to manipulate the political, hegemonizing processes at work. This, I and others think, is unrealistic.

My critique of a political economy approach does not in any way discount the need to examine and analyze differential power relations or the utility of investigating the ramifications of unequal social and political relations in health outcomes. Certainly when applied to American colonial attitudes and policies, the symbolization of the human body as healthy or unhealthy is analogous to British colonial attitudes. Codified in federal policies the production of a healthy physical body meant disciplining and controlling Indian social activities in the name of sanitation and disease control. Along with social behavior, the "otherness" of Native Americans revolved around their use of native medicine(s) and their "medicine men [who] are ignorant, superstitious sometimes cruel, and resort to the most grotesque of practices" (ARCIA 1890: xix). The symbolic image of Native Indians, riddled with consumption, tuberculosis or some other epidemic disease - the direct result of their social behavior - produced a particularly strong, albeit inverted, self-image for Anglo Americans. Therefore, the creation of a healthy Indian exonerated policies to re-define and re-make Native Americans.

More recent inquiries using a political economy framework are the direct result of collaborative undertakings between Native peoples and the researcher. In the last decade, more and more anthropologists have gradually moved into an advocacy relationship with the peoples they study. The recent anthology produced by Canadian anthropologists Waldram, Herring, & Young (1995) is an example of this kind of research. While I strongly believe in the guiding

principles of advocacy anthropology, it seems that here also too often the research has a tendency to avoid addressing how health outcomes vary by geography, economic opportunity and/or the socio-political structure within the studied community.

Other more generalized studies - including the impact of epidemic disease on North American native populations is well documented (Thornton 1987). That European-born diseases and government policies had devastating ramifications for Indian mortality rates was recognized and illustrated in anthropological studies beginning in the early 1960s (see for example Bruner's [1961] study of the Mandan and Hidatsa).

T. Kue Young's (1994) recent addition to the body of medical research among native peoples uses a biocultural approach. Weaving together factors of environment, epidemiology, and historical circumstance Young examines the interaction between these variables and provides insight into the processes leading to reported outcomes. However, as an analysis of the components that both constrained or ameliorated health outcomes it has limited applicability for explaining the processes of health care decision-making by either an individual or community. More pertinent to my research is what health decisions and outcomes mean to the individual or a community in terms of social and/or political interaction.

In contrast to the more-or-less generalized political economy studies is another body of literature; that of ethnographic studies. The roots of inquiry for many of these early studies lie with the idea of "deviant behavior" as suggested by Talcott Parsons (1964) and the focus is on the individual. Expanded on through innumerable "community-level" studies, much of the research and

explanations in this functionalist tradition concentrate on the idea of the illness experience as a form of social control.

One example of this sort of research is Beatrice Whiting's (1950) investigation of sorcery among the Paiute. Whiting's data on the Paiute's acquisition of supernatural power links illness with the misuse of supernatural power or inappropriate behavior. Individual illness may be explained as self-inflicted, the result of sorcery or ghosts. For the individual, illness causality may be attributed to the person's inappropriate behavior such as failing to acknowledge a spirit helper, losing the paraphernalia associated with the spirit helper or the stealing of power by someone else. If these criteria are remedied (or excused as absent) and the illness persists, then it is attributed to sorcery. Those accused of sorcery are generally individuals who have repeatedly violated social rules and behaviors. Thus, the accusation of sorcery, as the cause for illness, serves as a means of social control (Whiting 1977:210-18).

Based on his fieldwork among the Navaho, Clyde Kluckhohn (1962) reaches a similar conclusion. Kluckhohn summarizes how native understandings for illness causality, either stemming from inappropriate social conduct (i.e. "acting mean") or witchcraft serves as a sanction for controlling social interactions. In his analysis, Kluckhohn concludes that the fear of witchcraft accusations functions to maintain the proper relationships and behaviors between people.

What studies such as these have in common are strong structural-functionalist overtones. More importantly, these studies typically concentrate on describing the resolution of an illness experience, usually that of the individual. Consequently, the literature that attributes illness causality and

resolution as a means for social control assumes bounded and static native etiologies. While the responses and behaviors of the individual are important, I find this approach also limiting in explaining Dithkalay health-related decisions and behaviors. Because the Dithkalay use a number of health care alternatives - each having its own set of etiologies, means of diagnosis, and treatments - Dithkalay health-related behaviors are not static nor are Dithkalay care seeking behaviors confined to a single health care domain. Therefore, it seems more useful to look at how the experience alters the perceptions held by, interpreted, and acted on not only by the individual but also by others in the community.

Creating a new framework

More useful in bringing light to the situation at hand are the recent attempts to integrate both an analysis of the larger political economy with the health-related experiences of an individual. Current research that attempts to address and illustrate the connections between the individual and his/her society are closer to what I observed in this community.

In some of his later works Foucault turned his attention to the systemizing practices of social institutions as processes for objectifying the subject. Most pertinent to my project are Foucault's discussions of how the medical lens is given power through discourse (1975). It is the power of medical or other discourse that the "objectification of humans to subject" is produced (1983:208). Within this productive process, "dividing practices" separate the subject/human into oppositional categories (Ibid). In the medical arena, humans as subjects are objectivized into categories of sick or healthy. Via technical terminology or medical discourse unequal power relations are established and maintained. It is

through medical dialogue that the patient recognizes that s/he has become the subject; a subject for and of inquiry. In his final work Foucault (1983) studies the way(s) in which individuals assume and recognize themselves as subjects. Here, Foucault views power as the fluid and diffuse dialogue operating between the two opposing levels of objectivizing institutions (such as biomedicine) and humans as subjects at the individual level.

Foucault's influence is explicitly stated and forms the model for the "tripartite domain or three bodies" suggested by Margaret Lock and Nancy Sheper-Hughes in their call for a more critical-interpretive approach toward medical research in anthropology (1995:44-70). The perspective of Lock and Sheper-Hughes is that it is essential for researchers in medical anthropology to consider the three levels in which the "production, expression, and resolution of health and sickness" are created and re-created (Ibid:70). Lock and Sheper-Hughes designate the three levels for investigation as comprised of the individual body, social body, and that of the body politic. Concerning the individual body, Lock and Sheper-Hughes view this level as comprised of mind, matter, psyche, soul and self. In turn, the social body operates as a symbol for and a representation of culture and society. It is the regulation, observation and monitoring of control of the body that forms Lock and Sheper-Hughes' final level for analysis; that of the body politic.

As a model for inquiry, the levels that Lock and Sheper-Hughes delineate do help to refine and identify the various realms of interaction related to a state of health - good or poor. The significant contribution here is the addition of a culturally based level where states of health are expressed, which they define as the "social body" (1995:56-61). Defined in this manner their model bridges the

gap between the political economy approach of power relations and cultural studies focusing on individual behaviors.

While I agree with their approach and I use Locke and Sheper-Hughes' model for the purposes of analysis, as a model for inquiry it falls short of demonstrating or explaining ***how*** individuals, their social world, and the body politic interact with and on each other in health and health related issues. For this I turn to the recent work of Byron Good.

Good (1996), in my opinion, seems to take as his point for departure Bourdieu's suggestion of "the body as the locus of social practice" (1995). In doing so Good expands on the social construction and expressions of health as a "set of distinctive and interpretive practices" that can be used for cross-cultural comparisons (1996:87). Furthermore, Good argues that the experience of illness is an "experience in totality" affecting the individual, his or her family, and other community members (Ibid:117). Using discourse analysis Good examines the illness narratives of American patients to demonstrate how their accounts are structured in cultural terms.

In Euro-western health-related stories, according to Good, the plot of the narrative usually includes a serial account of the experience, recollections of previous experiences, and the various reactions by both the individual relating the narrative and of others involved with the individual. In turn the listener may have differing experiential or situational knowledge and, therefore, the rendition of symptoms or narrative may be interpreted differently. In this manner the varying interpretations and reactions to the narrative bring about a new predicament and only through resolution of the predicament is the story

concluded. In this vein, illness narratives are the medium for making and re-making social and political relations.

Using discourse analysis to examine the creative and productive power of language and health is not new. The late 1980's witnessed the documentation of numerous accounts of language and its power between patient and physician (see for example Kuipers 1989, Nuckolls 1991). However, most conclusions in this area reflect the earlier framework of the political-economy approach. Discourse analysis also has been used in ethnographic studies. Cohen's (1995) examination of the dialogue between parents and children regarding dementia and social status in India is an example of how the dialogic process defines and re-defines social relationships in a culture specific context.

My approach to the use of narrative and conversation deviates from the foregoing. I view myself as more closely aligned with the approach and purpose that Good provides. It is through narratives and conversations that we can gain access to the experience of illness. In this regard I agree with Basso's (1990) perspective that narrative and dialogue are the manifold lenses for interpreting social and cultural systems. Health-related stories and dialogue in all its Dithkalay forms capture their cultural meanings of health; of illness and well-being.

In order to examine the health-related decision-making process among the Dithkalay I begin with the model provided by Lock and Sheper-Hughes because it presents an excellent framework with which to divide this project into useful analytic units. Like Lock and Sheper-Hughes, I use the level of the "individual body" to explore what good or poor health means to an individual Dithkalay and how states of health are perceived and understood by the person.

In the analytic level of the "social body" I incorporate the social relationships of both family and community as contributors to individual understandings of health and influential in health-related behaviors. My engagement with the "body politic" level constitutes the arena for examining medical pluralism among the Dithkalay.

Although this model is valuable and important for a critical-interpretive analysis, it needs a theoretical methodology in order to be truly useful as a model for explaining health-related talk and behaviors. This, I think, it critically important. Because issues of health are not static, we must have some method for dealing with and accounting for the processes involved. We cannot and do not have direct access to the illness experience of an individual, and I do not presume otherwise. While we can, in some sense, use health-related behaviors (as the acted on) as evidence for a health-related decision, this has limited explanatory utility. In order to give this model explanatory power I use the discourse analysis of Good. Specifically, it is through a critical analysis of narrative and dialogue that we have a medium for explaining the processes involved in health-care decision-making. The discourse that I use is taken from the ethnographic text I collected during my four-year period of fieldwork in the community.

Some insight into the problem of explaining or making explicit the cognitive process involved in a decision may be deciphered by the diligent reader of David Schum's *Evidential Foundations of Probabilistic Reasoning* (1994). While not a reader-friendly presentation, Schum attempts to explain the requirements of decision-making tasks where the evidence at hand, prior

knowledge (in view of the present evidence) and the weight or value that an individual assigns to the variables can and will alter his/her ultimate decision.

In his explanation of decision-making, Schum suggests that individuals' create a mental map or schematic on to which they interject or eliminate pertinent variables throughout the process. Schum uses the term "structure" to denote his framework of order (schematic) that he contends reflects the thoughts/beliefs of the individual. The interjection and elimination of variables included in the decision-making process he labels as "interpretive." As Schum applies it, the interpretive is a way to describe how conclusions are altered in view of what is meaningful to the individual. Even though Schum's analysis is difficult to follow, he does demonstrate the complexity of human decision-making as a "behavioral task." It is unfortunate that he minimizes the extent that interactions with others may influence the process.

Schum's minimization of how others may influence an individual and his or her decisions returns us to the theoretical and methodological strength of Good's dialogic analysis. Rather than trying to create a mental schematic for the cognitive processes of the Dithkalay, I have selected, transcribed (including the written replication of their speech patterns), and embedded their words within my own.

Along this line, my study of health care decision-making among the Dithkalay is situated in a specific anthropological perspective. It is a holistic approach; there is no single-factor explanation. Because perceptions of wellness or illness are constantly in motion, I believe any examination of health-related decisions and behaviors necessarily involves both the consistency

and fluidity of social relationships, particular historical and political processes, cultural beliefs, and economy.

Thus far, I have suggested that Lock and Sheper-Hughes provide an excellent model for examining the varied arenas of interaction associated with health. In order to provide the model with explanatory power I have added the dialogic approach of Good. Thus, using the model of Lock and Sheper-Hughes combined with the discourse analysis of Good, as expressed through Dithkalay voices, this project can begin to examine the implications of and influences on the individual, family, community and politic bodies when making health-related decisions.

In the chapters that follow I hope to provide answers to the following questions: How does the practice of medical pluralism act on the creation and regulation of power between Dithkalay natives and non-native practitioners? What components, if any, situate the individual within the family and influence subsequent health related behaviors? Do perceptions of illness or wellness create and alter the social/political relationships between the individual and others at the community level? If so, in what way(s)? Are there any consequences?

By co-joining the model of Lock and Sheper-Hughes with Good's discourse analysis we can pursue an understanding of the Dithkalay's use of a variety of medical practitioners and remedies and why that persists. An approach that integrates a critical-interpretive model with a theoretical methodology using discourse analysis also can serve as an example for examining medical pluralism among indigenous peoples. By analyzing the Dithkalay's discourse of health we can pay attention to role of human agency in

the decisions that the Dithkalay make concerning the use of varied practitioners, remedies and facilities.

To my knowledge, studies of either medical pluralism or health-care decision-making processes among Native North Americans do not exist. In the very recent past some studies on medical pluralism outside of North America have appeared. For example, there is Arthur Kleinman's 1979 study on the role of Chinese shamans in medically pluralistic China. Also noteworthy is Libbet Crandon-Malamud's research among the Kachitu where "power, resources and security [are] used to identify with a social class or ethnic group [and] are negotiated through medical dialogue." (1991:23). But what differentiates these studies from an analysis of medical pluralism among American Indians is that the members of these other global groups have been studied from the perspective that Western medicine is an infusion acting on the **entire** society. This differs from the reality that Native American's, such as the Dithkalay, are both highly integrated into and, in some areas, very much encapsulated within a larger Anglo culture.

It would seem that analyses of medical pluralism among Native American populations are limited because until the very recent past even anthropologists interpreted medical practices using an Anglo lens; biomedicine was more scientific. Most likely this was a result of cultural bias as experienced by American anthropologists themselves. Also complicating any success of earlier research into medical pluralism or indigenous health-care decision-making was that biomedical dialogue linked ethnomedicine and indigenous practices to "culture." The inclusion of culture was viewed as detrimental to illness outcome(s). But cultural beliefs cannot be divorced from the day-to-day

experience of wellness or poor health. Nor can cultural beliefs be separated from the decisions designed to maintain or alter a state of physical well-being. Numerous critiques have challenged the all-encompassing and static appearance of culture. But recent research lends insight into how and to what extent is culture shared or contested or how and to what length can its durability or transformative qualities be observed? (c.f. Boon 1994).

These are important questions not only for anthropologists but for all indigenous or culturally distinct peoples. Given the metaphors of "melting-pot" or "stew-pot" in referring to cultural diversity within the United States, I think an understanding for the cultural biases that influence health-care decision-making and the practice of medical pluralism is especially important. Any examination of the illness experience requires a close look at the cultural context in which decisions are made. In this dissertation, I argue that the emphasis should be on how the cultural variables and varied levels of interaction co-construct each other to provide alternative domains for health care practices. In that vein this dissertation is, in part, an attempt to explain how among a relatively culturally homogenous group of people notions of gender, family, community, culture, and personhood interrelate and co-construct each other through health-related decision making processes.

The pathway

At this point, I think it appropriate to provide the reader with an overview of the path I intend to take in the dissertation. In the following chapters I examine the various arenas or levels in which the status of health is embedded in a dialogic process that reflects specific cultural understandings and behaviors. In

Chapters two and three I tackle the issue that individual autonomy among the Dithkalay is not in its strictest sense autonomous. Chapter two discusses the Dithkalay's view of the human life cycle. Cyclical, rather than linear, in nature, the ability to have or maintain good health waxes and wanes with an individual's age. The basic social unit of the extended family is the focus of Chapter three. I link the individual with his/her family identity and discuss the rights and obligations governing individual family members. Chapter three demonstrates that while the actual physiological experience of ill health may be individual, the experience and related decisions are not. They belong in part with the family.

Chapter four explores two case studies to examine the culturally designated social units of the community as defined by gender. Here, I give consideration to traditional Dithkalay understandings of gender relations that both aid and constrain health-related behaviors and decisions. Chapter four also investigates how the perceptions of others can influence decisions made at the individual level.

My conclusions in Chapter five bring together the varied levels of health; individual, social and body politic as they are expressed in the discourse of health. In doing so I present a view of health-care decision-making and the practice of medical pluralism as products of micro and macro-social, cultural and historic processes that are un-made and recreated within the day-to-day experience of daily life.

Chapter Two
Links in the Chain

When people experience illness they monitor their bodies more closely than in states of wellness. Illness, whether acute or chronic brings disruption. The disruption that ill health produces is not limited to alterations in the physical or biological state of the individual. Ill health produces a sense of disorder by simultaneously challenging an individual's knowledge of his/her body.

Faced with the disorder of ill health people seek resolution - physically, psychologically, and socially. Self-medicating with over-the-counter remedies, seeking the advice or expertise of a physician or clinician, or using traditional practices (including Aunt Tilda's secret recipe for Hot Toddies) are but some of practices that may be used by individuals for restoring a sense of order over the physical self. Similarly, the Dithkalay peruse the available remedies at the local Wal-Mart, wait patiently for hours at the local IHS clinic to see the physician on call, and/or request or accept the healing properties of a Native American Church meeting or that of peyote tea.

Making a selection for and then using a particular remedy is but one part involved in the process of recovery. Regardless of what remedy is chosen, its value to the recovery process is relatively limited to its efficacy in alleviating or eliminating the physio-biological distress associated with the illness. Resolution of the illness experience goes beyond restoration of the physical body to a normal or healthy state. The process for restoring a sense of order must also include coming to terms with how the experience has altered the individual psychologically and socially. Health-related talk, whether as dialogue or in narrative form, is a practical activity used by people in coming to terms with the

inner psychological struggle that accompanies the physical disorder of ill health. The creative nature of language becomes the medium for re-creating order with the inner self and also to reconstitute the external social self.

Conscious attempts to view the experience of illness using an integrated perspective does represent a departure from the mind-body dichotomy associated with Cartesian western epistemology. In this perspective the "soul" or mind of an individual belongs to the rubric of religion or philosophy. The physical body, as part of the natural world, is knowable and belongs under the auspices of science (Helman 1994:89, Lock and Sheper-Hughes 1996:48-9, Rhodes 1996:167).

This reuniting of the physical individual body with the psychological self as "understood in [a] phenomenological sense of lived experience" is evident in the recent work by Lock and Sheper-Huges (1996:45), Becker (1997) and Good (1996). In their discussion calling for a critical-interpretative medical anthropology, Lock and Sheper-Hughes suggest "the individual body, as perhaps [the] most self-evident," constitutes but one level of a tripartite constructive analysis of the illness experience (Ibid). Lock and Sheper-Hughes suggest that the construction, interpretation and communication of health and illness are an interaction between the experience, the body as a social and cultural symbol, and the body politic.

Good (1996) also re-unites the body-mind duality. Contributing to "the development of a theory of [the] illness experience" Good illustrates how illness narratives can be used to analyze the experience, medical knowledge and re-making of an individual's lifeworld that is un-made by illness (1996:118). According to Good, illness narratives are constructed as people attempt to

integrate the self or person within culturally prescribed ideas of personhood. The narratives that people construct are a responsive practice that describes what the "sufferer" views as a disruption to his/her normal world. Good bases his argument on studies of chronic pain among Americans. Using discourse analysis, he suggests that health-related narratives are the creative discourse used by people when seeking to link the lived-in experience of poor health with illness etiology to re-shape and re-make a lifeworld dis-ordered by ill health.

Becker (1997) uses chaos theory as her point of departure to illustrate how illness narratives and health-related dialogues constitute a process for reinstating order (Gleick 1988). Like Good, Becker examines how people use the discourse of health to adapt to or justify illness outcomes as a means to re-establish continuity and order to their lives. Both Good and Becker demonstrate the efficacy of discourse analysis as an approach for examining the ways in which people re-create, make sense of, or re-make a world made chaotic, the result of illness.

However, it is Becker's additional variable of a "culturally informed sense of order" that is valuable for an initial understanding of the Dithkalay's health-related talk and their health-related decision-making processes (1997:37). Drawing on the deep structures of orderly disorder within multiple chaotic systems (c.f. Gleick 1988) Becker summarizes how the individuals in her studies draw on Western cultural themes to create continuity and re-create a sense of order. Using the Holy Trinity as but one example, Becker shows that a Western orientation and culturally-informed structure for organization and order are constructed around the number three. This tripartite model permeates the illness narratives and dialogue of the American patients in her study. Becker's analysis

of "orderly disorder" illuminates Good's contention that "examining the dimensions of perception and the perceived world" is a far more rewarding approach to understanding illness and its experience (1996:131).

Thus, what constitutes order and its comparative counterpart - disorder - is culturally constructed. Understandings about or notions of order do permeate social life and provide a structural foundation and means for replicating the worldview of a group of people (Lyon 1990:250). When exposed to a cultural ethos people construct clear ideas and undertake practices to replicate or re-create order as they know and understand it.

Good, himself, uses a tripartite analysis, perhaps in part the result of his own cultural orientation. The illness narratives of Good's patients revolve around: 1) the individual's description of his/her illness, 2) a perceived emerging predicament resulting from differing interpretations of the experience and, 3) resolution of the predicament by the individual (1996:145-65). In both Good's and Becker's studies, the health-related dialogues and narratives as well as the resulting health-related decisions (as resolution of the predicament) reflect a Western-oriented sense of personhood and order based on a tripartite model. I agree that such structural patterning seems to underpin cultural understandings of order and may form a basis for symbolizing concepts of personhood---at least among those with a Euro-American perspective.[1]

But what of the health-related talk among peoples of a non-western, non-linear, non-tripartite structured lifeworld? This, it seems to me, is an important consideration if we are to accept the argument presented by Becker and Good. If we accept their postulate that illness narratives are structured in cultural terms, this means that when we analyze the discourse of health as it is

expressed by others, we need to use as a point of departure ***their*** cultural understandings. Specifically, we need to incorporate their culturally informed perceptions and/or knowledge for order and structure. The Dithkalay's view of the human life cycle is an excellent case in which to examine this point.

Dorothy: "For us Dithkalays it's all number four. Four for being, like being sick. Say you got a problem, sickness, some kind of depression or maybe it's the little one, you go to him [medicine man] and ask his help. He says "ok," you collect four things, ah, he tells you what four..."

Beatrice: "And he works on you for four days, maybe...usually at sun-up, for four days you go and he works on you."

Dorothy: "That's how it goes away, he makes it go, 'little at a time."

Thelma: "Always tobacco...one of the four is always tobacco."

Dorothy: "That's right, he rolls it. It's part of the system, 'cause it comes from way back. He talks to nature 'bout the, your problem. He always starts east, but then talks to the west. Talks north, then south, All four directions he talks to. He has to. Might miss something.

Thelma: "Our elderlies always said you can't get away from it."

Deb: "Can't get away from what?"

Dorothy: "The number..."

Thelma: (interjecting) "...number four, it's from the beginning to end.

Dorothy: "...four. Four gifts, directions, parts. There used to be four bundles. You know that (asking the statement)? Dithkalay live four"

Thelma: (interjecting) "You people [non-Dithkalay] think you have it figured. When I got saved and found my God, the preacher-man tells it's three (there is a positive shaking of all heads) but my Dithkalay part knows it's four. You've got preachers, we've got the elderlies. They know."

Deb: "Three parts? Four Parts? I'm confused. (turning to Dorothy) I know about the four bundles. The four directions I understand. Do you mean the four gifts to the medicine man?"

Dorothy: "It's our medicine. Everyone has some. We all have our own power. Our own medicine, our own personal power. This man, he was not good, used his medicine to hurt others. When he use it, it was in a bad way. That's why some of the old people said, we won't do this anymore."

Deb: "I really apologize, but I'm so lost. Dorothy, what do you mean not use it anymore? Using it, not using it...having it, not having it? That sounds like two to me."

Dorothy: (patting my hand) "You'll learn. Before you lose..."

Thelma: (interrupting)"See! You [non-Dithkalay] think you have to get it. Before you lose it, it's used. But you have to get there first. You're not born with it. You have to respect it."

Beatrice (looking at Thelma [willing her to be silent?]): "See, babies don't have it. No power, no medicine. Growing up, you get it. You learn it. People see you're getting it. They're proud of you, but they don't say. But they know. So then you use it and they respect you. But like my Aunt Iola says, you have to use it in a respectful way. When you get old, well, I'm not there yet, but we're gonna lose it. It goes around. My grandson, Christopher, says Grand-ma, that'll never happen to you. But I know. Look at Andrew. Why he's as pitiful and baby-ish as they come!"

Thelma: "What comes 'round, goes 'round. But I've still got it!"

Dorothy: (ignoring her) "Unless you can get it back, it's over."

Benefit breakfast, March 1996

According to the women involved in this discussion, Dithkalay understandings of the order of things are centered on and around the number four. As an example of what Spradley (1984) identifies as "explicit knowledge;" the women can consciously acknowledge and verbalize that the Dithkalay's sense of an ordered world is based on a quadpartite model. But, if we are going to designate "four" as the culturally significant pattern and the underlying operational principle that reflects a Dithkalay worldview then their health-related

dialogues and narratives should also incorporate a quadpartite model or four-part structure.

A close examination of the women's dialogue does indeed incorporate four sources for reference. First, there is Thelma's reference to herself as an individual - most particularly as she attempts to have others socially validate her perception of herself as having power. Second, there are numerous references to interactions on a family basis. The grandparent-grandchild relationship between Beatrice and Christopher is but one example. The third source - that of the community - can be identified by the women's references to the elders or "medicine men" who had either curative or sorcerous abilities. Finally, there is the fourth, that is relative to "power" itself; where power is an unseen presence or entity that can act on and interfere with the world of the living.

Equated with personal actions and/or the exhibition of control over the physical and social self, medicine "power" is internalized. Ill health represents disruptions in power; the ultimate disruption, of course, being death. But unlike the words "power" or "medicine" that are openly discussed, death or death-related illness are rarely spoken of.

A reasonable understanding of contemporary Dithkalay notions about death, their reaction to it and their reticence to discuss it is impossible without some insight into their eschatology. Among contemporary community members there are competing views concerning afterlife. Some tribal members participate in and are affiliated with Christian religions, especially Mormon and Baptist institutions. This is not surprising given the close relationship between education and missionization initiated during the tribe's reservation period.[2]

However, the majority of Dithkalay people maintain a presumption of "spirits" and it is a person's spirit that is believed to enter the afterworld. In discussing this with some Christian Dithkalays the term "soul" was used. This is, however, somewhat misleading because it alludes to theological conceptions that are not a part of the general references that the majority of Dithkalays use concerning "spirits." Certainly the similarity between "soul" and "spirit" turns on a common notion of immortality. But there is a distinct difference. Spirits are not credited with the functions of thinking, willing, or determining behavior. Best described as a presence, the spirit of the deceased remains in the community.

> "My people don't talk about anything when [others] die, don't even mention their names. Whatever they had, just throw it away. Don't keep nothin'. Given away or burned. Thrown in the river. Later, some was buried. [My father] kept her picture face down on the floor so her eyes can't see. Don't want her spirit watchin' you. I seen that with others. They cover [the picture] with a black kerchief. After she's gone, you sit and eat on the floor - no chairs, nothing. Had to just sit on the floor. I'd go to my brother's. They'd take it all away, nothing to remind you, nothing [for her spirit] to hang around for."
>
> Horace Kleland, May 1996

When talking about their burial practices in the past Dithkalay elders say

> "The old ones, they were afraid of dead bodies and they got rid of it right away. Children were sent from the camp. Someone, a man if it was a man who dies or a woman for a woman would take the body. Usually it was put in rocks [a crevice or outcropping] or inside an old tree. They'd cover 'em with rocks so animals didn't get them. No funeral. Mostly the old ones were afraid of spirits. Old Lady [blank] said the owls always told 'em when they were comin'."
>
> Andrew Pearson, April 1996

Ghosts and memories of the person, his/her involvement with others, and acts committed during the person's lifetime; these are remembered viz-a-viz a person's spirit. Attached to the deceased, the individual's spirit "doesn't want to let go" and remains as a presence that may attempt to infiltrate the world of the living. Spirits can interfere with the medicine power of the living and manifest themselves through illness, inappropriate social behavior or individual catastrophe. The hooting of an owl is viewed by many Dithkalay as a warning message to the living that the spirit of a deceased or loved one may be attempting to rejoin the community. It is "not a good sign [and] all should be wary."

On two differing occasions I participated in conversations concerning the reported hooting of an owl during the previous night. In these instances the majority of the Dithkalay were very cautious that day, particularly in situations that potentially could have a negative outcome. Common and everyday behaviors, such as crossing the street, took on new meaning.

The Dithkalay's tribal complex area has a street running through the center of it. People normally walk across the street without giving any thought to it; there is the assumption that any traffic will wait. Following a report of an owl call, people wait for all the traffic to pass, even if a car is turning the corner onto the street over one block away. After the first reported episode, a tribal member ran into a ditch on the side of a remote road. She was stranded there all night, the rest of her family members thinking she had stayed in town at her niece's. On the other occasion, a tribal member was arrested that night for public intoxication. Among the community members involved there was a great deal of shaking of heads and clucking of tongues the following day. To non-Dithkalay

these events would most likely be interpreted as circumstantial. For the Dithkalay involved, it was confirming evidence for heeding the warnings of owls.

Among the living an individual's spirit acts, in a sense, as a mediator between two other components; "power" and "evil." It is these two elements that concern the Dithkalay in the contemporary community. "Power" or its metaphor "medicine" is thought to be an essence or accumulating force that an individual acquires throughout his or her life time. Because children are born without "medicine power," as life progresses the power in a person increases proportionate to the number of his/her personal and social accomplishments. At the same time there is "evil." Evil acts upon people and its presence can result in anti-social behavior toward other community members or by taking shape or expression in the ill health of the individual.

In a sense then, power and evil comprise a reciprocal relationship where "power" motivates and/or maintains individual growth, both physically and socially, and "evil" invades, either by debilitating the person physically or manifesting itself in negatively sanctioned behavior. Dithkalays can and do articulate this relationship, although not as a specific or concrete relationship, anymore than Becker's (1997) American counterparts or Good's (1996) patients consciously put voice to cultural or moral understandings. Instead the importance that the Dithkalay give to power emerges within the daily context of social interactions and its attendant dialogue.

Several months following the benefit breakfast, I attended an open community meeting. Among the issues under discussion was the credibility of the members of the current Business Committee. One woman, whom I shall call Margaret Haskill, angrily and aggressively charged the various members of the

committee with insensitivity to tribal members' needs, the misappropriation of tribal monies, and of being self-serving by spending tribal funds for personal travel expenses. Margaret's tone of voice - loud and belligerent - was angry and her discourse was peppered with a multitude of four-letter words. With her first outburst the constituency fell immediately silent. Following Margaret's outpouring of criticisms, two Dithkalay got up from their chairs and left the council meeting without saying a word. The uncomfortable silence (which seemed interminable) was broken when another woman spoke quietly

> "You'll have to excuse my sister...she's not well. She means no harm or evil to anyone. She's just not herself and doesn't know what she is saying. You have to excuse her. Her control over...well, please forgive her. She's not well. She has no power over herself ...or us...but we might consider some of her words."
>
> Amy Mulden, February 1996

In trying to reconcile this breach in Dithkalay socially approved behaviors, Margaret's "sister" (who is not a biological relation of Margaret, but is a "sister" as a result of their bifurcate merging kinship system) drew on the cultural discourse that links a biological disfunction or ill health with lack of power or control over one's self; physically, verbally, and socially. In other words, Amy - Margaret's fictive sister - attributed Margaret's behavior to a fading of her "power." For the Dithkalay who attended the meeting, Amy verbalized what they believed; Margaret's verbal outburst was clear evidence of her waning power that was manifesting itself through her inappropriate or "evil-ish" behavior.

The explanation given by Amy for her sister's inappropriate behavior illustrates a critical etiological connection between Dithkalay beliefs about the

human life cycle and the health status of an individual. The Dithkalay envision the human life cycle as circular and comprised of four phases that meld one into the other. Individuals who are in the first phase of life are considered "power-less." Equated with infants and young children (birth to approximately three years old), powerless-ness is symbolized by an inability to both control the physical body and to protect one's self from illness or harm. As children learn physical control and begin learning appropriate social relations, they enter the second phase of the life cycle. I refer to this phase in the Dithkalay life cycle as "obtaining power" and those who are in this phase of life generally range in age from three years to twenty years of age. Individuals in the third phase of life are considered "power-ful." The individuals in this phase are in good health and have mastered the protocol for social behavior. Considered by the Dithkalay to be adults, these persons dominate the socio-political world. The fourth phase of the life cycle is equated with a "waning of power." People who are in this final phase are considered power-less and the Dithkalay refer to these individuals as "elderlies." Movement into this final phase of life is symbolized by a lack of control over the physical body, the result of a chronic or a debilitating illness. At what phase in the passage of life an individual is, is based on the force of his or her internal power. For the Dithkalay, the force of accumulated power is symbolically represented in the physical state of the body. In their framework a person accumulates power through individual accomplishments and the successful negotiation of appropriate behavior and "respectful" interactions. Accumulated power is evidenced by well-ness or good health. Conversely, inappropriate social behavior or ill-health are symbolic of a fading or absence of

power. The exception to this understanding is the inherent powerless-ness of infants and very young children.

POWERLESS CHILDREN

Unlike contemporary Western concepts of the human life course, which emphasize linearity, predictability and continuity (Becker 1997:7), the Dithkalay interpret the human life cycle as cyclical, unknowable, and comprising a set of connecting links. Each link in the chain of a Dithkalay's life represents an achievement and each achievement is the result of self-motivation. For members of the contemporary community, an achievement is visible evidence for accumulating power.

Children as well as adults are expected to learn by watching. Along with this, individuals, regardless of age, are not corrected. This rule of respect extends to and governs even adult conversations. If the listener(s) in a conversation interpret the dialogue of the speaker as uninformed talk ("doesn't know the facts"), no one will correct the speaker or interject conflicting information. There is no perceived need among the Dithkalay to "set the record straight;" given time the speaker will know he/she was incorrect. Once I asked a tribal member, "Why didn't you tell him [the facts]?" The response I received was, "No need to. He'll figure it out. Don't want to be disrespectful." Respectful dialogue, then, has requisite gaps; the words that are not said are equally as important and socially governed as what is said (c.f. Basso 1990).

I too was expected to learn Dithkalay ways by watching and listening. More often than not during my early months among them, comments such as

"you'll learn" or "learn with eyes and ears" accompanied my interactions or dialogues with them. Similar to the way(s) in which they socialize their children, these gentle directives were said to me by women and elders. By paying attention to the advice of another or by observing an example and then mastering the task is how each person learns and obtains or retains his/her power.

Power as a cumulative entity begins at birth. According to the Dithkalay all children are born "power-less." Not having power is directly related to their inability to defend themselves from disease, injury, or other physical ailments. In this regard Dithkalay parents or, most often, grandparents are very conscientious about taking infants and young children for the regular health monitoring and inoculations that are standardized by biomedicine. This generally takes place at the local IHS Clinic.

The Dithkalay's commitment to a positive health status and therefore, the survival of their children, is rooted in the tragedies of their particular history. As I mentioned in Chapter one, the Dithkalays suffered high infant mortality rates prior to World War II. Most especially during the reservation years they were plagued with their share of measles and flu epidemics and ever resurgent bouts of tuberculosis.[3]

> It goes way back in our history. 'Course then we didn't know that it was epidemic. We knew that we had to separate. So...way up north there, uh, oh probably, 150, no, maybe longer, 200 years ago. There's this family; man, his wife...kids. A family of Dithkalay, well we were traders you know. So they been trading with this group in the village. Right after they left, you know, finished all their trading and then they heard that it was small pox. They knew if they

> came back to us, well we might all get it and die. So they decide. They're camped at that big lake there. They got no choice. So the man, he tells his wife and kids, "We gotta do this." His wife, she's crying but understands. She ties all the stuff to their horses, tipi, robes, food, she packs up everything. They get on their horses, kids, a little one too, they get on and lead the horses into the lake. They just keep on going and they disappear into the lake. Forever. But they say, well, if we go back up there and sit, kinda quiet like, they say you can still hear them...talking, the horses, kids playing. Once we had the government, well, it got all different.
>
> Hal Kantor (September, 1997)

Escape from epidemic disease was impossible given the containment policies of the reservation system (Thornton 1987:50-3). Each year the local agency dutifully reported the incidence and varying types of disease and numbers of deceased. Even though the local agent acknowledged the significant incidences of contagious disease, he explained the high mortality rates for all age groups as resulting from the Dithkalay's lack of knowledge concerning hygienic measures, the influence and practices of their medicine men, and the lack of trained medical physicians and services. Ceremonial or celebratory encampments were viewed as an indigenous practice that "should be out-lawed if we are to control the spread of vermin and disease" (A.R.C.I.A. 1890).

High infant mortality rates did not ameliorate with allotment. The southern plains was not conducive to agriculture - as the later "dust bowl" demonstrated - and most Dithkalays had limited economic ability to gain access to nutritious foodstuffs. Many were forced to rely solely on the beneficence of extended family members. As one elder relates it,

> "When they come to see you, feed them. Most important if they got babies, you gotta give them meat. Even little ones. Mama would put it in her mouth and chew it up, real good and juicy. Then she put it in his mouth. Sucking it, he's gettin' nutrition.(chuckles). We like our beef! You can always tell a [names another tribe], he eats the bread first. We eat the meat. If we don't have meat, offer them bread or cookies. Mama always said: If you ain't got anything, offer them coffee, you always got coffee."
>
> Cathie Reevis, March 1997

The global influenza epidemic around 1918 did not leave the Dithkalay unscathed. The historic consensus holds that returning servicemen brought the Asian flu with them on their return to the United States. According to agency records (and supported by Dithkalay oral history) only three Dithkalay tribal members served in the armed forces during World War I. None of them returned with or contracted the devastating influenza. As the elder Kantor's story related, having previously suffered population losses, especially among the aged and the very young, the Dithkalay knew what the ideal reaction should have been; avoid town and contact with outsiders. However, with allotment they were forced into a dependency relationship with town businesses for foodstuffs and supplies. Most likely, increased interactions with the surrounding larger Anglo population exacerbated mortality rates. By 1920, their population had plummeted to a mere 198 persons.

In discussions concerning the statistics related to their population nadir shortly after the turn of the century, most contemporary Dithkalay respond in one of two ways; philosophically or embittered. Some are contemplative and suggest that "as a people [they] were not prepared to adapt or adjust" to the changes that were imposed on them by reservation life and the economic constraints the

result of allotment. Others are more outspoken. The more outspoken Dithkalay are rigorous in their resentment and blame Federal policies both past and present for population losses. For these Dithkalay, high neo-natal and infant mortality rates symbolize White encroachment ("treaty violations"), cultural genocide ("forced to live the Whiteman's way") and the Federal Government's refusal to interact with them on an equitable basis ("sovereignty"). Regardless of whether the individual is more easy-going or adamant, as a collective all Dithkalays agree that it was the reality of high neo-natal and early childhood deaths that explain and justify why infants and young children were referred to as "baby" in their historic past. Specifically, baby is a term of reference and address in lieu of a formal name. There are two reasons for this practice which I will explain.

To fully understand one reason for the use of the kin term requires an examination of neo-natal mortality rates. But any determination of precise crude or neo-natal mortality rates for the Dithkalay prior to the twentieth century is difficult owing to two factors. The first problem encountered is the result of the Dithkalay's traditional cultural understandings at that time. Their fear of the evilish-ness of spirits and ghosts associated with the deceased imposed a prohibition on speaking about or "calling out the name" of the deceased. This cultural constraint resulted in under reporting. Second, any projections would be skewed owing to scanty and disconnected data recorded by area agency officials.

However, population data for the early twentieth century is more complete. Census data, specifically death and birth records for the fifteen year period 1925 to 1940 - a time period well within the memory of living elders -

document deaths for infants and children, five years and under, as comprising fifty-four percent of the total deaths for that time period. Exacerbating infant mortality rates resulting from measles, small pox, influenza or tuberculosis are the incidents of "summer complaint" (a form of heat stroke with attendant diarrhea and dehydration), meningitis and pneumonia. When death came

> "We knew something was up, they wouldn't let us kids around. They tell everybody they got to leave. It's a pretty big camp, you know. Twenty-five, thirty families. Well, (pause) they try to wake up the child, you know. Like they do when first born. They do that to wake it up you know. My cousin and me, they told us to stay away but we see three, four womens going that a'way - go toward the creek. One of 'em, she's got this bundle. So me an' my cousin, we run to the timbers quick.. We run up on the east side, opposite side of the creek. We start watching them, digging, womens, you know. Ground sort of rough, hard you know. Well, they go down, oh, 'bout hip deep. We were watching four, five hours. Watching the women you know perform that little ceremony. It's custom, you know, the one's in charge - back then I guess, it passed down; the experience, what you see, the routine. They cover it up, pick up shrubs, leaves, put on top of it, cover it up. So we go back to camp. My mother, she looks at me funny. She says "Where you been?" I don't say. (he chuckles). She knows. But she don't say nothing to me about it. Nobody said nothing about it. It's that way, you know. No one talks to the mother about it. They got too much respect to talk about it. The housewife [midwife], she don't talk about it either. The elders, they know but they got too much respect for the momma. Might have bad luck in future. Today we just do service but it's the same. We don't talk about it. We go to give honor and respect for family.
>
> Allan Colbert, November 1995

According to Dithkalay elders, names - Indian in the past and Anglicized in the present - belong to families. Members of the present-day community openly discuss that when a person died in previous times "that name was set aside." Not only was the name never repeated in reference to the deceased, but also no other individual would be called by that name until the proper name re-calling ceremony was performed. This proclivity for, in a sense, name protection, meant that in the past infants and young children were not given a formal name until such time as the family felt relatively sure of his/her survival.

The naming ceremony was part of the induction of young children into the first of the four societies of the Dithkalay; the Rabbit Society. The "Rabbit Dance," as the ceremony was called, was but one portion of the process for introducing young children into community life and cultural understandings. Alan Cobert's description:

> "They're be two, three, or four men on this side over here. They stand in a row, they face east. And the kids, uh, they sit over here, facing 'em. In rows. Two rows like this. All right. All they got is butcher knife. And this guy's in charge, they call him "bull" in my language. He's in charge of the ceremony. Ok. Butcher knife over here. In the naming, that's when you get to the man's side or maybe it's on the momma's side, or grandmother, her momma's momma, depending, boy or girl. Names stay in families. When a person dies, they don't call out their name. You don't call it out until you ask this guy here [the bull] for permission. You say "I want to bring back this name." Could be lady's or man's [name]. Those names are important. He [the bull] tells the history of the name. (pause). I'll use my bother's name...Battle Twice. Means he fought one tribe in the morning. Then he fought with second tribe in same day--Battle Twice. This guy, it's his responsibility to tell history [of the name]. Once the

> naming is over, the child could dance right there. They get their hands up here, like bunny rabbit and dance [hopping]. After that there's lots of lulu's. After that is other part of the ceremony.
>
> Alan Colbert, November 1995

While this recalling-naming ceremony is only practiced sporadically at present, a child does not usually go by his/her given name until either a younger sibling is born or until the child attends pre-school or kindergarten.

Even though the neo-natal mortality rate among Native Americans has dropped below the national rate for All-Race populations since the 1970s (Young 1994:38-41) the use of "baby" as a form of address for infants and young children is still used in the contemporary community. As cliche as it sounds, there is no other explanation in my mind other than it represents the persistence of a traditional practice. According to the dialogue of living Dithkalays (both elderly and young), their cultural preference for name avoidance is a practice of the past. But when I began to document the genealogies of Dithkalay families I found that name avoidance is an active practice. As a part of their habitual speech performance name avoidance is practiced with enough vigor that I was compelled to memorize the biological and social relations between individuals and families if I was to communicate and interact on a sensible level. References and pronouns such as "that man" or "this woman, she" as well as fictive kin references, "my Grand-pa" or "Uncle ____" (when referring to relatives that are not consanguineal or affinal kin) are commonly used in everyday conversation. Because names still remain within families, even in the contemporary community there can be as many a four individuals with the same name; one in each generation.

A second reason for the persistence in the use of "baby" as a kin term is linked to their preference for nicknames or, as they refer to them, "everyday names." The Dithkalay's use of everyday names also seems to be a form of cultural persistence. In their traditional past, the Indian name bestowed on a person was generally related to physical characteristics or to a performative act connected to the person. For example the Dithkalay Indian name "Audle-key" translates to "He-has-a-long-lock-of hair" or "Long Hair." Similarly, the Anglicized rendition for "Ah-te-thley" means "She-goes-it-alone" or "Lone Woman." Members of the living community acquire their everyday names in a similar manner. The everyday names given to a person generally refer to his or her physical or behavioral characteristics.

> Well, he got this name cuz of the way he was born. See his mama, well, she bin told:"you gotta have this baby here at the Indian Hospital." Every month, she goes and sees this doctor and he keeps telling her: "I can help you." So my sister, she comes runnin' on that day, yelling: "Its time! Its time! we gotta go." So we go. We load up into her car. [XXX], man, she's yelling: "Hurry, hurry!!" Well, here he comes...me in the back seat with her. She's yelling, [XXX] is running off the road in such a hurry, I grab the first thing I can. My sweater. Thas' all we got, my sweater. No blankets, no rags, no nothin'. (pause in the dialogue). Yea, we got there too late. Doctor was kinda mad at us. But that's how he got his name, had to wrap him in my sweater. Sweater Boy. It stuck.
>
> Iola Porter, December 1996

> "Well, they call her Totsie. Cuz she was small. You know, born too soon...premature. Everyone at the

agency say, "What a tiny tot." Always stayed that a' way. That's how she got that name.

Cathie Reevis, January 1996

Given the system that the Dithkalay use to create everyday names, this necessarily means that a child has to be either developed enough to exhibit a behavior pattern or characteristic that is recognizable by others or a significant event has to have taken place that becomes associated with the child. Generally speaking, the creation of an everyday name for an individual is generated by other community members and not by members of the individual's direct family. Of consequence, until such time, infants and young children remain "baby." On more than one occasion throughout my years with the Dithkalay I was able to witness the unilateral and simultaneous turning of heads by numerous toddlers toward a female figure in response to the utterance " Here, baby." I actively participated in female-oriented activities and numerous children were always present at these activities. Almost without exception, under the age of two and one-half to three years old, they are called "baby."

However, there is more to the persistent use of the term "baby" beyond its obvious referential factor. Extended to their larger framework the term baby as a metaphor has cultural relevance. The retention and significant use of the word in the present community is also a symbolic link to the Dithkalay's understandings of the human life cycle; to be "baby-ish" is to be "power-less." When asked to explain the equation most Dithkalay say it "is because babies are vulnerable. They haven't learned yet. They can't be responsible. Babies got no power." The word "baby" is a metaphor for internalized power. The metaphor binds the physical world of the individual to the Dithkalay's culture-specific worldview. The

metaphor of baby acknowledges Dithkalay representations of age, and as we shall see, of aging.

Vulnerable and power-less, health care decisions regarding the well being of an infant or the very young are the responsibility of primary care-giver(s). Until the toddler or child demonstrates a desire and/or the ability to assume responsibility for him/herself and his/her actions, the decisions made are the responsibility of others. It is through learning how to be responsible for the physical, psychological, and social self that a Dithkalay person accumulates power.

OBTAINING POWER

Accumulating power, viz-a-viz mastering a variety of things including Dithkalay socially approved behaviors, begins at birth. Each accomplishment creates a link in the chain of a Dithkalay's individual life. Every link represents the successful outcome of a self-motivated, specific undertaking regardless of whether that undertaking is the first step for an infant, the first time sitting at the drum or surviving open-heart surgery.

Traditionally, enculturation toward obtaining power (control over the body) began about two years old.

> "In Rabbit Dance or ceremony we got a bunch of songs. It's other part of a naming ceremony involving the little ones. And I'll tell you why. Now when, ah, with naming ceremony there's another ceremony that go with it; uh, bed-wetters. Uh, the child wets the bed all the time. There's two [songs] that are involved in that ceremony. Ok. Now, if you got bed-wetter, ok, you go look for a cotton tail, tie a buckskin on it, make a belt, tie it above the hips. Ok. This man here, [the

> bull], he ties it on, that tail. But its after the naming ceremony. Maybe you got parents over here. If too many kids, you can put up the sides of arbor, parents can sit behind the young one's. When they through with the naming, ...the father's don't have to be involved here [bed-wetters ceremony], cuz, the mama, she's the one, she's the one that knows, that's her job. Whether it's a boy or a girl, she's doing the coaching. When they get to this part, could be two or three kids, maybe four or five. When they get to this part, he's [the bull] got this string, and he ties it right here [around their waist]. Since they were born, their grand-ma or their mama been in charge of teaching them to control, well, its part of our survival. And, uh, manners and respect, that's why they got this. Well, they got this tail. They [mother or grandmother] give him a little gesture so he knows which ones. He talks to them about being respectable, 'bout growing up. The bull, he puts it [the tail] on. Then they go sit down with their mamas and fathers. They got to keep it on for four days and nights. Four days, four nights. They keep it on. And if it works, then they take it somewhere where no traffic, where no animals can get it. Put it somewhere respectable. Don't bury it, you can put leaves over it, cover it with twigs. It works. They don't do it anymore. If it don't , leave it on - in the end it will win out.
>
> Allan Colbert, November 1995

Even though there are a number of versions describing the Rabbit Dance, consistent throughout is that each of the story-tellers emphasizes how the ceremony implanted within the children a desire to move forward toward recognition of self; participation in the ceremony instilled a sense of self-motivation. Other aspects of the ritual are also consistent in all versions. Each rendition of the ritual make reference to the social roles or responsibilities of grandparents and parents (who presents the child for participation), the proper ordering of social relationships (authority of the "bull") and an orientation to the

Dithkalay's quadpartite world (wearing the tail for four days). When I asked the elder Colbert about the significance of wearing the bunny tail for four days, he explained "it's makin' them awares of theirselves. That's why they got to treat it respectable."

Along with the obvious symbolic connection between the Dithkalay worldview and the number of days for wearing the bunny tail, the performance itself is a symbolic replication of their culturally ordered world, although, at first glance, one aspect seems to be missing. Bearing in mind, that the Dithkalay lifecycle embodies four phases; powerless-ness, obtaining power, accumulated power or power-ful, and the waning or loss of power, these four phases have a counterpart in the lived-in world. The orderly lived-in world of the Dithkalay encompasses four levels of experience beginning with the most fundamental, that of the individual. The remaining levels include the family, the community, and finally that of the spiritual or "power." These four levels of experience create spheres for encounters that increasingly expand the Dithkalay's arenas for interaction.

These levels of experience are represented by the performers engaged in the ritual. The power-less child represents him or herself. Parents, in particular, grandmothers, who have obtained power symbolize the family. The "bull", with his accumulated power designates the community level. The gap in the symbolic replication seems to be the final level - that of power, or so it might appear to an outsider.

For most Dithkalay, power is a presence and they view the presence of power in its most literal sense. As an entity that can be accumulated by people, power is always present. In the Rabbit Dance, then, the fourth level (that of

power) is present and the child's participation in the ritual is intended to be his or her first encounter with that sphere of interaction. The encounter is symbolically replicated in the "bed-wetters" portion of the ritual. Here, the child is initiated into the more spiritual arena and is provided his or her first avenue for obtaining personal power by gaining control over the body.

A recognition that the pattern in the performance of the Rabbit Dance is structured in cultural terms is not nearly as important as how it reflects the Dithkalay's properly ordered world and gives form to their distinctive modes of lived experience. As worldview and performed patterns come together they form a dynamic ideology (c.f. Cohen 1976).

In spite of the ritual's integrative significance for the socialization of children, most Dithkalay reluctantly admit that the Rabbit Dance (and its attendant initiation property into the Dithkalay's historic Children's Society) is no longer actively practiced. Nevertheless, the underlying principles are still very active.

Deb: (greeting an elder) "I have not seen your [four-year old] granddaughter with you lately."

Wil Reevis: "I should bring her by to say hello...you should see her now. She's startin' to really learn. We're really gettin' proud of her. Why, just the other day, she gets up and says to her grandma, "Grandma, I need some of my pink medicine." You know, that cold medicine that Doc over at the clinic gave to her. He says that it will help her allergies. I tell her, "come over here, talk to your Grandpa." So she does. She's got runny nose. So I say "Grandma, give her some of that medicine." She's startin' to sing too. She gets a'hold of my cane just like it was those singer's microphones, like she sees on t.v. She starts bouncin' around and her Grandma says to her, "Now, be a lady. Don't be carryin' on like that." She turns to

> her, real serious like. (He chuckles, Grandma accompanies the laughter). "Grandma!" she says real serious like. "That wasn't me. I was just pretending to be so-and-so." Like she seen on t.v. We see she's really getting there. She's gonna' be a strong some day."

In Will's narrative about his granddaughter the implicit use of four to describe an orderly world is relatively easily discerned. Will began his narrative by describing his granddaughter's self awareness for her individual state of health. He then connected his granddaughter to the family or second level; that of he and his wife. He did this by stating that he had instructed his granddaughter to talk with him and by relating that he had directed his wife to dispense the medicine. Will continued on and linked the two more confined levels of household interaction to the larger levels of community and power. He extended the narrative to the community level by including his wife's gentle chiding of the child and that of his granddaughter's assertion that it was not her behavior but an imitation. In doing that he reiterated community level socially appropriate behaviors, especially as the behavior is related to gender-specific expectations. Will concluded his description by referring to the fourth level; that of power, by stating that she will be "strong some day."

Will's story illustrates the influence of culture in the structuring of narrative and discourse. Even though Will is engaged in a story about his granddaughter, his narrative is the medium for affirming an informed and orderly world as well as a medium for confirming appropriate social behaviors and relationships. The narrative in itself is a form of cultural discourse.

Through a closer examination of Will's story, another and related pattern begins to emerge. The first half of Will's narrative contains fragments of a

decision-making process. Will described how his granddaughter was self-aware of her allergy congestion and requested a dose of her "pink medicine." His description of that gave voice to his granddaughter's bodily experience. As the story unfolded, Will and his wife contributed to the decision-making process by their agreement to administer the medication. However, based on the Dithkalay's culturally informed pattern for discourse, Will proceeded beyond the health-related portion of his story. While the health-related part of his narrative actually concluded with the medicinal remedy, he linked the event to other behaviors because they contributed to the proper development of the story. Will's narrative illustrates that discussions of issues related to health are embedded in discussions that have wider cultural significance.

The foregoing narrative also illustrates how in a more general sense self-awareness of one's state of health on the part of young children is viewed as an indicator of "learning." Dithkalay parents and grandparents do not openly correct or discipline children. Instead the children are offered a norm of behavior (often a mere distraction toward something else for the very youngest ones) and are encouraged to engage in what is considered to be appropriate behavior. In general, the suggestions for engaging in appropriate behavior are cast in a chiding form such as "!Now, be a lady." In fact, taking from the dialogue of the Dithkalay themselves, in the very rare instance when a parent/grandparent engages in corporal punishment it is viewed as a manifestation of evil-ishness the adult involved. In no way is it a reflection of the child or his/her potential to be a powerful person. Developing an awareness for one's state of health and of socially approved behaviors are the indicators of personal power. Thus, a

Dithkalay's passage throughout life is measured and marked not by specific physical change or age but by individual accomplishment.

HAVING POWER

Accumulating power in the Dithkalay sense is an on-going individual process. It is acknowledged by the individual and other community members based on the successful negotiations of self-awareness and social relations. Unlike many other groups of people, including other groups of North American Indians and EuroAmericans, life-stage markers go uncelebrated.

Deb: "Lots of groups have ceremonies that mark stages in a person's life. Like turning eighteen, being able to vote...being called an adult..."

Leroy: [chuckle] "It's not like that for us. The Bureau and our Constitution says your grown at eighteen. But that's that."

Deb: "What do you mean?"

Leroy: "Well, for us here, me an' my brothers, we know when someone's grown, when he's a man. It's got nothin' to do with age. You can be forty [chuckle, and a nodding of heads] an' not be grown. Not be a Dithkalay... a man that is."

Deb: "So then when do you consider a Dithkalay boy a Dithkalay man? How do you know?"

[Pause--break in the conversation]

Leroy: "Well, it's kinda like this. It's what he's done or what he's doin'."

Angus: "Say for example, he's helping the family out...taking Uncle to the doctor, gettin' his food, spending time with him."

Melvin: "He getting things done, he's accomplishing obstacles. He sees what needs to be an' he's doin' it. That's how I know."

Angus: "It's 'bout being able to advise, being responsible. Yea, when you do things in a good way for others. Back in our hey-day [nomadic bison hunters], well I

it was when you had a good hunter"

Deb: "What about a female? Are there special ceremonies that.."

Melvin: "Don't know 'bout that, womens you know. No ceremony though."

Leroy: "Guess when she start havin' a family a' takes care of 'em."

Deb: "Don't you celebrate birthdays?"

Leroy: "Sure, buttin' that ain't no true measurement."

Angus: "You got to be accomplishin' things, staying on top."

Leroy: "As long as he's able."

Deb: [directed at Participant 1] "What do you mean?"

Angus: "Well, he might...could get sick. Might not be able to do it."

Deb: "What would happen then?"

Angus: "He might confide in a brother [another male of his generation or "friend"]."

Melvin: "Um-hum [nodding his head affirmatively]. He's weakened."

Michael: "We're obligated to our elderlies. He gets, like Uncle there" [uncle is a man in his mid seventies]. He [Uncle] gets kinda' baby-ish. Can't help his self."

Angus: "It's what being Dithkalay's about. Being there. I'm his brother. I'll support him while he [the brother that was ill] regains his control over what got him down."

Melvin: "Yea, but you can't interfere. He has to do it his self."

Leroy: "Unless he's got somethin' like the sugar [diabetes]."

Deb: "What happens then?"

Leroy: "Well, he's then as pitiful as Uncle [XXX]. He might not overcome. It'll fall to someone else."

Men's Focus Group, April 1997

A variety of significant Dithkalay perceptions and issues emerge within the context of this focus group interaction. One perception that is verbalized is the emphasis that Dithkalay's place on individual autonomy. The importance that the Dithkalay place on individual independence or authority is consistent with the their nomadic past. Distinctly different from sedentary native groups such as the

Hopi who demonstrate a cultural preference for community well-being, the Dithkalay stress individual health outcomes and well-ness.

Second, as the men involved in this discussion relate, numeric age is relatively inconsequential to the Dithkalay. Age and any age-related status that might be accorded to persons in a non-Dithkalay world do not exist. When I asked, "At what age does someone become an elderly," the men responded that being an elderly was based on the status of the person's health and the extent of his or her cultural knowledge. One criteria for being an adult Dithkalay is based on how and to what extent the individual successfully meets social and family responsibilities. There are two other criterion; one is related to good heath, the other to perceptions or accumulation of power. Separate, yet connected, good health and having power are the criterion that distinguish an adult Dithkalay from an elderly. The distinction between good or poor health in the context of adulthood is the result of Dithkalay beliefs that separate episodic illness from chronic illness. In Dithkalay interpretations episodic illness is exactly that: it is an episode, an event from which the individual totally recovers from a "brief brush with it [power/illnesss]." As the men involved in this focus group discussion intimate, with the onset of chronic illness an individual's power fades. The body in a chronic state of poor health symbolizes a waning of power.

Deb: "Last time we talked, we left off at what was going on last summer, right?"
Dana: "Yea, I think so."
Deb: "When Dennis [Dana's son] left."
(long pause)
Dana: "Yea."
(long pause)
Deb: "Was Kimberley [Dana's grandaughter] around then?"
(long pause)

Dana: "Yea, I think so."
Deb: "Did it bother you that Dennis wanted to go up north?"
(long pause)
Dana: "Yea. (pause). Me an' Kim, we was alone."
Deb: "Where was..."
(I interrupt myself. Dana, who is usually a rather vibrant talker was abnormally quiet, as her long pauses indicated)
Deb: "Dana, can I help you?"
(long pause)
Dana: "I was jus thinkin' You bringin' up Dennis an' all"
Deb: "About what?"
Dana: " 'Bout askin' him to pray for me. He's a preacher an all you know. Keeps him movin' round. But things ain't quite right 'bout me, right now. Ain't got no dizzy spells like Muira had. But, well, I's jus not feelin' too pert. Worryin' you know."
Deb: "What's worrying you?"
Dana: "They's turnin' black, I guess. Got that grey color. But I ain't gonna go to the clinic, not yet anyways."
Deb: "Dana, are you diabetic?"
Dana: "Shush now, child. They been tellin' me for a while now, that I'm borderline on that sugar. That's why I'm not 'a going over there. If I talk to them, over at that clinic, thas' as fer as they goes."
(I felt a slight sting from her admonishment: "child." But I recognized that I had made a direct inquiry before she had established that she was willing to discuss a subject that was related to her state of health.)
"Meybe I'll go fetch Donna Lee [Dana's oldest daughter] She's stayin' over at sister's. Has been since that inc'dent within' that car. (pause) Where'n did we leave off on that paper. Been thinkin' bout that. Those questions, you was askin' me 'bout Momma."

Dana Kingsley, February 1996

Dana did not discuss her illness symptoms or her state of being with me for a number of months following this conversation. Her dialogue was quite clear in delivering both a personal and social message. Not only was she not yet

prepared to openly discuss any symptoms of poor health, but I, once again, was exposed to Dithkalay understandings concerning the proper protocol for engaging in health-related talk. Dana's admonishment made my breach poignantly clear; a Dithkalay adult would not infringe on her individual autonomy, only a child, who had not as of yet leamed the rules for proper engagement would do so.

A few months following our interview conversation, Dana was a participant in a women's focus group. Now she was prepared to talk about the incident.

Loretta: (addressing Dana) "I love your dress. That's a good color on you. Wish I could get away with'in it. I'm too pale now a'days. Red makes me look grey."
Riva: "Ain't no grey Indians, 'ceptin old Indians."
Dana: "You kin repeat that, and loud."
Riva: (adopting a defensive tone of voice) "Well now, sister..."
Dana: "I ain't talkin' 'bout no one in partic'ilar. All I know 's that I weren't ready to cross over that line as of yet. But, I gotta tell 'ya, that machine that Donna Lee brought me (the women laugh), well, ya' would a thought I was an elderly the way it done my feet. Sure felt good though, but..."
Beatrice: "I was over there. Ya should'a seen the look on her face! She pulls them feet outta that hot water (the women all laugh at the face that Beatrice makes) well, you know, it was enough to scare it away. I surely did. Was afraid she'd cooked em!! She starts hollerin' at me, go, go, go. Go get Donna Lee."
Riva: "I heard 'bout that. Dorothy over at [names a tribal program office] told me. Sent you some of that Avon."
Beatrice: "Smell!! Yes, indeed. But, hey she puts that on (starts to laugh) When she's done, got the best lookin' feets around. Like the package says, no more wrinkles!! (all the women laugh). She's ready to take on a 49er [a powwow dance with sexual inuendos]."
Dana: "Don't know 'bout that. 'Course them folks over at that Holiness [church], they kinda look like they could!

When Dennis call me, and say, "Momma get over to that 'a Holiness on Sunday, I'm a gonna pray for you. That power, it's gonna reach all that 'a way to you."

Beatrice: "We get there and I never seen such as ruckus as in that White church."

Dana: "Walked away from it. Left that weakness behind. I weren't ready to be no elderly yet. Not iffin' I can help it. Dennis, well he's a preacher man. And he's got that power, said he could talk to it from up there. No sir! Not ready to cross that line yet."

Women's Focus Group, April 1996

Prolonging one's status as a Dithkalay adult and putting off the re-categorization as an elderly rests on having power as it is symbolized in good health and positive health outcomes. Dana's initial way of coping with the discoloration of her feet was to refuse going to the local IHS clinic. By avoiding the clinic, and what she believed would be the biomedical diagnosis, Dana was able to deny the possibility that the physical change was in any way connected to diabetes. Dana's rejection of the perceived diagnosis was also a conscious undertaking to protect her status as an adult. To be diagnosed with a chronic illness, such as diabetes, would alter her status; she would be re-categorized as an elderly. Not willing to accept an elderly status she actively sought other alternatives including an electronic foot massager, a cosmetic anti-wrinkle cream, and finally, a direct confrontation with her personal power, assisted by the power of the local Holiness Church and the power of her son's prayer.

Dithkalay ways for determining adulthood are distinctly different from the Euro-western pattern for accounting of age. In the larger Euro-American culture there are numerous age-related statuses. Some, such as the age to vote are codified by national law. Other age-related statuses may be underwritten by state law. For example, the age at which an individual can marry varies from

state to state. The Dithkalay are aware that their way of determining when a person is elderly differs from the larger Anglo society. The consequences in the different way(s) of accounting can be both positive and negative. When an individual Dithkalay who is in good health reaches age sixty-five, he or she may benefit from the federal funds available to elders. On the other hand, if an individual becomes "elderly" in Dithkalay terms prior to the federally established age, he or she may be disadvantaged.

The dialogue surrounding Dana's encounter with power serves as an example of the fluidity of power. Power, as it is interpreted by the Dithkalay, is not static. While the presence of power is always present, to what extent a person is powerful is not measurable. Some individuals are viewed as having more power than others. Dithkalay oral history contains numerous stories regarding ancestors with exceptional power or "medicine." As suggested by the women's talk at the benefit breakfast, "medicine-power" can be both beneficial and mis-used.

In the past individuals with exceptional accumulated power were band or community leaders; most especially if male. Individuals who sought power did so both actively and passively. Actively seeking power

> "was a vision RE-quest (speaker's emphasis). It was not a vision quest, but, he might get it the same way. Yup, that's right. He'd go off by hisself, and ask for it. For four days and nights he'd be off by hisself, no one follows or bothers him. He has to prove hisself first. He didn't eat or drink, just wait for it to come. On the fourth night, if he's worthy, his vision, uh, it comes to him. Yup, then he's got the knowledge, how to do it, the performance. He's got power to help my people."
>
> Evan Jury, October 1998

Medicine interpreted in terms of power is metaphorical. As entities that can be used in the same way, power and medicine are closely related through perceptual similarity and action (Kirmayer 1992: 333-4). As Alan Colbert's opening narrative revealed, medicine as metaphor persists among living Dithkalay. But "you got to respect it. You don't mess with it." Individuals whose behavior(s) indicate having acquired exceptional or supernatural power were in the past and continue to in the present be referred to as "medicine men" (male) or "healers" (female). The different terms of reference - medicine man versus healer - point to another Dithkalay belief about power. Members of the contemporary community contend that males can and do have more power than females. Consequently, women play a subordinate role in family decision-making, the Native American Church and in the two military societies of the contemporary community.

Having strong medicine was not always beneficial. According to some Dithkalay strong medicine imposed limitations on those having exceptional power.

> "This man here (pointing and tapping the picture of a former Dithkalay chief), he had lots of power. He had strong medicine an that's why he don't have any descendants. They all died out, no one to carry the name one. Yup. He had strong medicine. An he used it to be a leader, to help the Dithkalay people. But you know [pause, tapping the picture] it's kinda like it says in the bible, you can't serve two. Two forces, two powers, they're too strong. Yup, he left no family. [pause] It's kinda dangerous, you see."
>
> Evan Jury, October 1998

"I sat and talked with my grandma, she had ten [babies] you know that didn't have names. They all died. She said she didn't name 'em, she couldn't remember if they were boys or girls. They were all, at birth or maybe little babies, they were gone. She said that my grandfather [pointing to the individual on the genealogy chart], well he was a medicine man. He had that medicine and they say in order for that medicine to work you had to give up your children. There were ten babies that died. I heard it from my mother and I heard it from [names a living elder]. They said that he got tired of the medicine power. That they wanted children. That when grandma got pregnant with my mom, so he talked to that medicine. He said "I'm tired of you. I'm tired of you, ah, taking my children." Grandma said he said, every year. This is how he said it. Every year my woman and my babies, you take my babies and I'm getting tired of you. And grandma said that he didn't want that medicine and he didn't want to pass it down taking the children. He wanted to get rid of it. See at my mom's house in [names the town] there's this porch and they showed me exactly the spot where he threw that medicine in the ground. And it turned black, like black beads an' then it turned like into black worms and it went into the ground. And ever since then, that's when my mother was born. I've heard that they had to give up their medicine if they couldn't control it.

Dorothy Splinder, June 1997

Both Evan's and Dorothy's description speak to the destructive force that medicine power can take - the loss of life. Medicine power differs from personal power because medicine power can be manipulated for the benefit or detriment (via "bad medicine") of the living. At the same time, the force of medicine power can manipulate or alter the life of a person who has extraordinary medicine power.

Personal power, on the other hand, vests itself in the individual. Personal power as symbolized in a healthy body reifies Dithkalay understandings of individual autonomy. The proclivity for individual autonomy is a governing factor in how the Dithkalay construct their discourse of health. As mentioned earlier, when encountering another Dithkalay, the most common greeting is the verbal and non-verbal combination of "what's up?" To open a conversation with a direct inquiry such as: "How are you?" is interpreted as

Melvin: "an invasion of the individual's privacy. If he wants to tell me, I'll listen. But it's not my place to ask."

Beatrice: "You got to have respect. I don't want people talking about me. She's my sister. If she wants my help, I'll know."

Deb: "How do you feel when I ask you questions about health or sickness? When I do the genealogies with you, I know that I may be asking some uncomfortable questions. Is that all right? Or is it an invasion of privacy?

Iola: "Well, it don't bother me. I know you're trying to help us. All us Dithkalay people. But I can only talk about my family. About what I know. I could tell you what I know about my daughters if I had any or about my grand daughter and [great] grandson. But about my boys, well, you'd have to talk to their brothers. They don't tell me anything. They don't want to worry me, I guess. Only once did one of my boys ask me and that was when he first came back from the service. He was so pitiful. They really messed him up over there. He's not much better today. He gets that depression and gets outta' control. He starts lookin' for that bottle. You can't tell him, it'll only get worse. But he don't come around me when he's like that, he knows better. And I don't ask.

The Dithkalay's cultural prescriptive prohibiting direct inquiry is still very strong among adults and elderlies, especially those over the ages of forty-five to fifty. Younger adults, perhaps in deference to an ever increasing interaction with non-Dithkalay people, have adopted the response, "I am well." This response on its own seems relatively insignificant; many people (including those with a Western orientation) may use this reply. The significance becomes apparent in contrast to avoidance responses such as "There are many things going on right now" or "I'm back on the road." In situations where it is common knowledge among community members that the person has been or is ill, direct inquiries into his or her state of health by another adult are conspicuously ignored; the individual usually changes the subject, politely ignoring the other's breach in conduct. Children are usually cautioned, as I was in my initial conversation with Dana. I suggest, however, these rules for governing dialogue has significance beyond that of ensuring individual autonomy. I believe that the prohibition on direct inquiries as well as the use of avoidance responses is directly related to Dithkalay beliefs; to call attention to an individual's state of health is to "invite" an alteration in that state.

Even though inquiries are guarded, as the talk in the men's focus group suggests, the state of an individual's health is constantly being monitored. Ill health, as it is interpreted by the Dithkalay, falls into one of two realms; episodic, such as injury, or chronic. This distinction is based on whether or not the illness is related to the waning of an individual's power. Thus, the import as a variable for altering an individual's status from adult to elder.

> "Some folks don't know, they don't have the knowledge. If it's, well, kinda like something simple, if

> it goes away then they're all right. You got to have the strength to make it go away. Some don't. Among my people there are some that suffer. I feel sorry for them. They don't have the strength. They can't over power it. It can get so bad that folks just stay away. Cuz we respect them. We don't want to interfere, it's their problem. Now I might get a message from him; "come help me he says." Then that's different. See, he gotta ask."
>
> Leroy Reevis, April 1997

Any and all alterations in the state of a person's health are categorized in one of these two ways. The Dithkalay view illness or attacks on the physical self as brought about by such things as colds, headache, or injury as episodic. They interpret illness in this category as something short-lived and a part of life. Episodic illness is not viewed as a **loss** of personal power. Given the individual's interpretation of severity he/she may seek advice from others and a multiplicity of remedies may be used. Remittances of power resulting from episodic illness can be restored. However, self-monitoring for the early signs of chronic illness may begin with the symptoms of an illness event, as in the case of Dana.

WANING POWER

Diabetes, heart disease, and hypertension as chronic illness among the Dithkalay are very recent in their health history That they are afflicted, particularly with diabetes, in epidemic proportions seems directly related to recent changes, some of them having been imposed on them by external alterations in their traditional dietary patterns and lifeway. Not unlike other native groups, such as the Pima in Arizona and more recently the Ojibway-Cree of Canada, incidences of diabetes affects almost twenty-five percent of the younger

adult population. Data taken from the genealogies and health histories that I collected for Dithkalay family members, indicate that the rate escalates to approximately fifty-percent in those over fifty-five to sixty years of age. More importantly, signs of early onset diabetes are beginning to appear in younger people including teens (for general corroborating evidence see Public Health Services- Indian Health Service Annual Report 1994). The severity of the disease varies among the Dithkalay, but there are instances where the illness rendered an individual blind, another, an amputee, and in two cases during my life with the Dithkalay, death from kidney failure.

These increases in incidence are of great concern to both practitioners and administrators in the Indian Health Service. Dithkalay concerns are in equal proportion. Given their reticence to discuss personal well-being and health-related issues, I was quite surprised at their relative openness about the presence of diabetes. However, any discussion of the disease is done in a somewhat removed, objective and non-descriptive manner. The speaker usually states it as "there are a number of my people who...," avoiding personalizing the disease.

During my years among the Dithkalay I did note a few exceptions to this. One exception was that grandparents would occasionally discuss it as a concern for the health of their grandchildren. This is not so surprising given their cultural understanding that children are power-less. However, it was never discussed when any grandchildren were present. The other exception was in the dialogue pertinent to elders. In some discussions when the participants were confined to elders, portions of the dialogue might have included talk about "sugar." According to the elders involved, a dialogue about diabetes/sugar between

themselves was permissible because "It don't matter anymore. We all got it, too late now to push it off." In keeping with the Dithkalay's emphasis on individuality, contemporary community members never openly identify an adult who suffers from the disease. Openly acknowledging the disease in an elder, however, is acceptable in certain contexts and within particular social relationships.

Chronic illness, as an indicator of fading power, finds its way into the community's discourse of health. Because chronic illness is viewed in a direct relationship with waning power, the illness experience alters both the individual's physical and social world. In their discourse of health the Dithkalay employ a number of dialogic strategies, almost as if those strategies were preventative measures against illness.

Beatrice: "I remember when we were children, if they, someone got sick, the old people, they'd make us leave camp. No one says, she's sick. They don't name the sickness. They'd round us up, make us leave, go to someplace else.

Iola: "When my brother got sick, they sent us to my aunt's. We didn't know why, 'cept he had the sickness.

Deb: "Do you know what he was sick with?"

Beatrice: "No, no. They didn't say it. It might come after you."

Iola: "It was their way of protecting us, for our survivorship. We was little, not too much power or strength. But we knew when they was sick, cuz [the individual] who had it would be crying or lazy. Not be right. They might behave funny, you know, different. They didn't talk about it, just send us away.

Beatrice: "Like my aunt Iola says, they didn't call it out. They always said, it's dangerous to do that."

Iola: "Like when sister, over there, got the sugar, we knew somethin' was up. She acted funny and all. Didn't know how to help her, 'ceptin to take her to the clinic."

Beatrice: "You got to be careful around them doctors though. They got bad habits an' all."

Iola: "Do like brother [names a tribal member] does. Perten' you don't hear 'em an' all when they get to blabbin it out."

Women's Focus Group, April 1996

Two rules for properly discussing health are apparent in the dialogue of these women. One rule is related to Dithkalay etiological understandings. To understand why the Dithkalay use this strategy it is important to remember that illness is the visible evidence of the unseen and intangible reciprocal entities of "power" and "evilish-ness." As entities, they exist and have a power of their own. If called upon, they may appear. Beatrice verbalizes this belief when she states that "to call out its name is dangerous because then you might get it." As an avoidance tactic this is similar to the rules that prohibit direct inquiry as to the health status of an individual. Both avoiding the name of an illness and prohibiting direct inquiry into health status' serve to thwart the perceived invasive quality of evilish-ness.

The second discourse strategy that the Dithkalay use is related to the first. Any discourse of health must inevitably identify disease. To further insure the safety of the participants who are involved in a health-related conversation, the Dithkalay practice, what I call, "semantic alterations." Not truly metaphorical in nature, the words that they use for specific illnesses are more closely aligned with the construction of the everyday names that they give to themselves. Just as everyday names are created around the characteristics or behaviors of an individual, the terms that the Dithkalay use to identify specific illnesses are drawn from characteristics of the disease. Most Dithkalay refer to diabetes as "sugar." They avoid the clinical term of heart disease and replace that with "constriction." When referring to hypertension, "elavation" is the proper Dithkalay term.

It is the juxtaposition of chronic disease and senescence that completes the circle of life for the Dithkalay. Chronic illness, as a representation of powerless-ness in the individual, demands a re-constituting of the socio-political world by the individual who is now re-categorized as a power-less elder. The visible markers of chronic illness - having a restricted diet, using a walker following a stroke, needing a driver because of blindness, being confined to a wheelchair as an amputee - demarcate the limitations of the individual and of his or her personal power or ownership of self. These limitations are viewed and interpreted by other members of the community. In turn, then, the dialogue of other community members becomes part of the re-constituitive process in re-establishing an identity, albeit as an elderly.

Cherie:	"There's Uncle Mike! Uncle Mike! Come sit with us if you like."
Mike:	(addressing me) "It is good to see you granddaughter" (turning to my companion) "Niece, is my nephew with you?"
Cherie:	"Yea. He's out there, he's with 'em on the drum. They sound good, don't they? Is Allison gonna come along? Haven't seen her in a bit. Oh, not since she been back from out west. Guess she'll be along later."
Deb:	"Mike, would you like something to drink? I have some bottled water and diet pop here in the cooler?"
Mike:	"Water 'I be fine."

This snippet of the conversation that Cherie, Mike, and I were engaged in was the chatting sort of talk that takes place between Dithkalay peoples during social events. The social event that we were attending was the annual performance by one of the Dithkalay's military societies. As is common at these sorts of events,

people plan to stay the day and late into the night. They bring along with them lawn chairs, coolers loaded with beverages and food (enough to share), their personal regalia, and anything else that they think they might need. Cherie had an economy bag of individually wrapped candies that she was eating during the course of our conversation. Mike's attention seemed to be on the drum and drummers in the center of the arena. However, each time Cherie opened another piece of candy, Mike's attention was diverted to her action. He watched attentively as she opened each piece and ate it; his interest in her candy was obvious. Cherie finally acknowledged that.

Deb: "Mike, are you going to sit at the drum tonight? War dances are on the schedule."
Cherie: (turning toward Mike) "I see you got your drum stick"
(she opens a piece of candy)
Mike: "I'll go in later, yea tonight. Gotta wait 'til it a bit cooler. This heat's too much for me right now."
Cherie: (turning to Mike) "You know I'ld give you some, but you're a sugar-baby! (She laughs) Don't be looking at me all sad like, like that little one over there."

The Dithkalay's acknowledge the transformation of the physical body from healthy to impaired through metaphor. Cherie's reference to Mike as a "sugar baby" is one example. She links Mike's diabetes with being power-less in the manner that a child is. Just as a baby is power-less and lacks control over his or her physical body, the elder who lacks control of his or her physical self (as a result of chronic illness or senescence) is "baby-ish." Baby, as metaphor, acknowledges Dithkalay cultural representations of age and of aging. To be "baby-ish" is not simply about the discourse of health and aging, it is in itself a metaphor for powerless-ness.

Chronic illness such as diabetes, heart disease, and hypertension are symbolic of a waning of power. The weakening of power allows for "evilishness" to intrude, as in the case of Margaret, or to inhibit or constrain a person's ability to meet his or her obligations, as suggested by the men in the focus group. Losing power can alter one's status; a re-categorization that Dana actively sought to avoid, and having "lost" his power, Mike's identity was redefined by the community.

The example of Margaret illustrates the idea that appropriate social relations are not only about a cultural ideal, but also an embodied metaphor for power. That is, proper social relationships represent respect for the autonomy of others, the proper order of social relations, and adhering to rules for cultural discourse; these represent internalized personal power.

Dana's experience illuminates not only how one's sense of self is disrupted by the physical experience of illness but how the experience necessitates restoring order both psychologically and socially. She strives for self control and resists what she believes will be altered perceptions of her by others; she makes use of a multiplicity of remedies and resists re-categorization as an elder. Two recurrent themes give structure and create order in the world of Dithkalay peoples; a quadpartite worldview and the concept of internalized power. These themes create categories of thought and experience. As the women discussed during the preparations for the benefit breakfast, the Dithkalay world is structured around the number four. Whether in examining their levels for interaction: the self, the family, the community, and personal power or in analyzing the pattern and form for their cultural discourse and ritual performance that reiterate these categories, there is a persistent replication of a

quadpartite model. Thus, the Dithkalay's quadpartite worldview is not only reified in the day-to-day lived experience but it informs embodied knowledge.

At the same time, anxiety about gaining and retaining personal power is keen enough that it persistently appears in their cultural discourse also. The cultural discourse of the Dithkalay not only establishes critical links between health and power in the formulating of personhood, it also informs the discourse of health. Through the discourse of health, the Dithkalay not only focus on the meaning and significance of the experience for their lives, they also interpret their actions and those of others through the lens of a culturally constructed self.

Chapter Three

Ties that Bind

"There's this young man. He's walking through the prairie. His moccasins are getting worn; the weeds are whipping his leggins'. He has no water or food...so he sees what he thinks is a mirage. You know - it's not really there. But there it was, a tipi in the distance. He keeps walkin' toward it , finally reachin' it. It's sewn shut tight with laces. So he sharpens his stone knife and then cuts the laces so he can get in the tipi." (The elder paused briefly, looking out the side window of the car. Turning back and facing forward, he used his finger to point repeatedly to the right side of the car dash.) *"He goes inside and there's something on the side* [of the tipi] *under a fur...an animal fur. On the other side is everything he needs to survive; all laid out - water, dried meat, plums, herbs. The man is so exhausted that he drinks the water and eats, then falls to sleep. He never looked under the furs over there."*

"The next morning he feels something taping his leg. He opens his eyes and it's a beautiful young woman. He notices that the shape under the fur is gone but he doesn't say anything. She offers him food and water and he does his part by hunting for more. They live that'a way together for a long time. After awhile he starts thinking about how he wants to stay with the woman...you know, kinda like marriage. So he asks her and she says no. So they go on. But it's bothering him. So he waits awhile and then asks her again. This time she says, "ok" but only if he will agree to two things. First, there will be no family right away and number two, he must promise never to get mad at her or whip her because then he would see her as evil. He agrees and makes his promises to both things. Life goes on."

"But where they are living there, there's lots of wild horses and he catches some of them. But there's this one horse...he wants it bad...but try as hard as he wants, he can't round it up. He tries everything but the horse is so wild, it bucks and tears around. Finally, one day, he say to the woman, "you help me. You go there and head him in my direction." The woman, she goes where he points, and they try to catch the horse. But they can't. He gets away. The man, he's frusterated [sic]. He's been trying so hard for so long that he's mad. He gets mad and starts whipping the woman and hollerin' . He yells at her. He yells "You devil woman, get over there. We're gonna try this again. Do it again, you're being evil." The woman picks herself up and starts to leave to where he pointed to. He realize right away what he done. He remembers his promises and apologizes immediately. Lots of times. But the woman, she don't say anything. She don't look at him. He feels bad. He don't know what's gonna happen now. He got no heart left for chasing the horse."

"The next morning he wakes up; the sun is shining...the fire is out. He pats the other side of the fur to wake the woman. But nothing. There's no

response. The woman she don't move. He gets up and lifts the back of the fur and there it is. It's a skeleton. He knew. He knew what he had done. He knew what had happened. He stepped outside the tipi and there was that horse. There was that horse that he had tried so hard to round up. It was just standing there, as tame as can be. It been so wild [sic], but now as gentle as he hoped to make it. He went back into the tipi and put everything; the water, the herbs, the food, back where it was when he just came there. He went back outside the tipi and laced it up like he had found it. He knew what he had done with his temper and it was too late. He turned and walked back out into the prairie."

Allan Colbert, June 1997

I listened intently as the elder relayed his story; fully aware of the importance of oral narrative as a means for communicating history, morals or social behavior (c.f. Vansina 1985). I wondered what social moral I might have unknowingly transgressed. On the other hand his reference to the "devil" or "evil" and the underlying implications regarding life and death led me to wonder if his story was precipitated in part by the day's planned activities. We were on our way to document the location and condition of the various burial areas or cemeteries belonging to Dithkalay families.

My involvement in this project stemmed from my daily interactions with the members of the Dithkalay Culture Program and the Tribal Administrator.[1] Over time, the Dithkalay and I had developed a reciprocal relationship; they knew of my research and in turn, I assisted them with theirs (see Dyck & Waldram, 1993 for a discussion of the practices and issues surrounding advocacy anthropology). As an outsider - and funded - I often had the ability to gain access to resources that facilitated our interaction(s). For this project, I had done everything I could think of in order to ensure I had the necessary means available; a vehicle, gas money, lunch money (enough for all involved), topographical maps, and photo equipment.

The impetus for documenting the Dithkalay family cemeteries was the direct result of discussions with and among tribal elders. The tribe had received notification that some items of material culture and human remains were recovered in an area affiliated with their indigenous territory. Consequently, Dithkalay elders were consulted for their input and a verification of the location. However, identifying or esttablishing conclusive evidence for archaeological finds as being affiliated with the Dithkalay is difficult at best. As a nomadic people they did not maintain cemeteries. Nor did they normally return to particular sites for internment of the dead. Consequently, under Federal laws, such as the Native American Graves and Repatriation Act, they are, like many other groups of native peoples, disadvantaged with respect to these issues. Nonetheless, this most recent notification led to a gathering of elders and to a discussion of both past and current practices regarding the disposal of deceased community members. Like most dialogue in the community, embedded in the discussion were the connections between the presence/absence of power, personhood, community, family and family responsibilities.

Returning then to the elder Colbert's opening story, a couple of points can be made about his account. First, Dithkalay cultural notions of what constitutes appropriate family behavior come to the surface. Here, respect for one's self and for other family members is a guiding principle directing the interactions and dialogue between family members. While the elder's story speaks to the idea of respect between spouses, the principle of respect is not limited to that relationship. The rules governing behavior, and therefore dialogue, extend to all family members in a multiplicity of ways, which I explore in this chapter.

Secondly, as the senior member of our party he gave a hint of the behavior expected for our small, investigative group when intruding on the physical space of family-designated lands, especially family owned and maintained burial sites. Furthermore, he alluded to the intertwining of how the rules directing intra-family interactions also establish parameters for guiding the behaviors and dialogues for inter-family interactions.

> "I tell my grandson, turn that junk off [television talk show]. Now, what I think, it's their business what they do. They don't have to tell - who's on the TV. What they're doing, what kinda' trouble they get in, telling all that. Like they should keep their privacy. I don't do those things, I'm not bragging about it, but I don't want to hear 'bout it. (pause) It's just like I come from the courthouse, I tell 'em I don't drink, I don't smoke, (pause) I may do a little running around (the men chuckle). Just like my wife, she's sitting in the car right now. She don't ask me where I been, what I'm doing. But these kids now, I'm in the courthouse with my grandson - well, it's like draggin' it out in the open. Just like on TV, it should be kept private to the family.
>
> Willie Jarrett, Men's Focus Group, April,1996

Willie's reaction to both the public discourse of the Courthouse and of that exhibited in television talk-shows is a response to what he viewed as an affront to traditional Dithkalay family behavior. He interpreted the open public dialogue relating to (in this case - negative) behavior as threatening the autonomy of the individual and his/her family. For Willie listening to or participating in personal or family-oriented talk also denied the autonomy and the self-governing principles of their traditional bands or the contemporary extended family . Thus, in stating that he "doesn't want to hear about what others have done," Willie alluded to his

resentment that somehow he had become a complicit party in negatively-sanctioned behavior; specifically, the invasion of privacy accorded others - whether that be an individual or a family.

Willie's attention to the relationship between privacy and family autonomy re-states Dithkalay thoughts about respect and respectful relationships. Based on a hunting-gathering economy, all members of the nomadic band relied on each other for survival. Establishing a foundation for respect was a strategy used to promote group cohesion and reliance.

Studies of historic social structure among some other nomadic Plains peoples identify either three or four levels of expanding organization (Eggan 1955, Hoebel 1960, Oliver 1962, Tefft 1965). The fundamental unit was an entity comprised of several nuclear-based family groups. Then, by expanding to include both affinal and inter-generational kin, the larger group more closely resembled what is "typically" thought of as a band. Because local resources would rapidly deplete, Dithkalay bands spread out over their indigenous territory. Those bands that were in relative geographic proximity to each other often comprised a division. The bands that comprised the divisions were often drawn together by a common political or military goal; especially after contact with Euro-American outsiders. At various times of the year, the bands/divisions united at the tribal level for purposes of spiritual and social rejuvenation, only to then separate once again for economic reasons.

But determining what a peoples' understandings of their social structure is, means the levels that structure the organization must be viewed from their perceived historic context and through their interpretation of their lives.

> "See, the set-up was this a'way. Way back, they [outsiders] called us bands. Families, you know. Each had their spot. Being here first we had big territory (pointing to the great Plains area on a map), from down here to way up north here. Each one [group] had their favorite place. Maybe they like plum or chokecherry. They stake it out, uh, this spot, everybody knows it kinda belongs to them. Well, if'n you want to go into that place, then you gotta ask permission from this guy here. He's the head of the big family, it's his job. He always eats last, sleeps last, he's got to take care of his people first. They [other groups] stay in touch with each other, they ask. They might say "See, we're outta food." He says "ok." Then maybe they stay next to each other, help each other out but they don't interfere. Kinda like today, we help each out but we don't ask, don't interfere. Brother [not a relative] comes by the house the other day. I seen him walking up the [road]. We talk, the wife, she feeds those kids of his. He's stranded out there by my place. I give him gas money, cuz I see he's got a problem. I don't ask him "Why no gas money? Why those kids with you, not their grandma?" Not my place [my emphasis] to ask. If he wants to tell me, ok. But I don't ask, not my place [my emphasis]..."
>
> Melvin Jury, August 1998

In the beginning statements of his narrative, Melvin made clear that the extended family was in the past and continues at present to be the basic social unit. He linked the past to the present by drawing on Dithkalay rules that govern intra-family interactions. While reliance on and assistance from other tribal members is an acceptable interaction between parties, social rules govern the way(s) that this interaction takes place. Melvin stated one of those rules when he said that "it was not his place to ask" why another tribal member needed assistance. Specifically, dialogue that might include soliciting explanations or

justifications for assistance is governed by rules that prohibit intrusive inquiry regarding non-family members.

> "...Gosh, I would embarrass myself. I don't want folks talking about me. Take that group we got in office now [referring to the business committee]; they're kinda rough. But that's different. Jumping the fence, I mean. It's, well, when that kind of stuff [an issue dividing the community] comes up, some families side with each other. Some folks might change their mind. But you can't change your family, they're always your kin. In the end they'll all go with what the family decides."
>
> Melvin Jury, August 1998

In this portion of his narrative Melvin also alluded to a potential consequence of over-stepping culturally accepted boundaries. If the individual offering assistance questions the need for assistance, then any possible increase in his or her status as a gift-giver is negated. Indeed, to inquire is to lose status. In establishing where the parameters for acceptable discussion begin and end, Melvin is addressing two different levels of Dithkalay social organization. One level is the family, the other is a socio-political group or "division." As Melvin related it, the family or band is permanent and membership is not fluid. Even with marriage, individual identification with one's family of origin persists. For example, Dithkalay women, regardless of the number of spouses, retain their family or maiden name. More importantly, in community situations requiring a consensus, allegiance is with the birth family and family members will support the consensus of that group.

Then, as well as now, family members form a unified and distinct entity. Instead, it is the socio-political "divisions" - comprised of a number of families

having a similar perspective toward a specific issue - that are fluid, not static. In describing how some "folks may jump the fence" regarding issues that can divide the community politically, Melvin also intimated that this sort of talk is not governed by the Dithkalay's family-oriented privacy rules. Members of divisional groups, comprised of a number of families with a similar hoped-for outcome on an issue, are often persuaded to join together based on the productive abilities or dynamic nature of a spokesperson or leader.

Following the Dithkalay's confinement to their designated reservation lands, their socially organized residency patterns were duplicated on a far smaller scale. Bands of extended families who previously traversed the Great Plains area now moved about the reservation area, coming together for the annual distribution of annuities or for particular ceremonial events. Divisional affiliations during this period revolved around Dithkalay interactions with the Federal government. According to Dithkalay oral history, three political affiliations existed at this time that were, most likely, symbolized by the tribe's sacred medicine bundles - even though four bundles existed at that time.

> "It happened way back then. The group, well, it got too big so they decide. They got to break it up [one of the sacred bundles]. Too many peoples, well, the group's too big. They care about each other, they know about the good of the bundle so they agree. See they're still tight now a'days It was a big family, too many to survive together so they split up. They got to split it up too [the bundle] for survival.
>
> Horace Kleland, June 1997

Horace's explanation, voluntarily offered to me while sitting together at a Dithkalay powwow, opens the door for resolving the discrepancy between three

socio-political divisions and the existence of four medicine bundles. From Horace's explanation we gain an understanding for the bonding relationship between two groups, each group having been the recipient of one-half of the former bundle. Because the bundles are viewed by the Dithkalay as being embued with both social and health-related curative powers, in dividing the bundle the overly large band recognized an obligation to provide for those that were leaving the immediate vicinity. Consequently, dividing the bundle did not in any way separate or relieve the formerly united families of their relationships or obligations of the members to each other in times calling for a collective decision among division members.

Between 1885 and 1900, the Dithkalay had replicated their residency and divisional affiliation patterns by dividing the geographic landscape of the reserve. During this period, the use of place names to refer to a divisional group or family's geographic location or to the topographical features of their occupied area, became the lexical means for linking individuals with their family and socio-political/divisional group.[2] Just as bands that "staked out their place" in close proximity to each other most likely comprised the divisional affiliations in the past, the three political divisions of the contemporary community are each associated with a different geographic location. Thus, the Dithkalay's present-day understandings of the social geography of their community is not, from their perspective, a new one. It is a perpetuation of their pre-historic past. Using place-naming identifiers for families or the socio-political groups is part of the every-day language spoken among the Dithkalay. However, place-naming identifiers that associate individuals with a socio-political affiliation or division are mostly heard in the contemporary dialogue relating to community-based politics.

However, "place" as metaphor does consistently resound in the discourse of the Dithkalay. Metaphors of place comprise one way in which members of the community communicate their cultural framework where multiple levels of interaction are linked to Dithkalay values, social and interpersonal dialogue, and socio-political divisions. When Melvin stated that it is not his "place" to inquire as to how or why another community members was stranded, he spoke to Dithkalay values regarding individual autonomy and of the privacy rules governing non-family member dialogue. As Melvin's story unraveled he proceeded to explain how speaking out of "place" now referred to the divisional or geographic place-name identifiers. Thus, the metaphor of place links social space or the distancing between relationships with physical space.

The Dithkalay's use of place names for identifying the divisional or residency areas of family or kin-based groups is not the only way in which they replicated their social relationships across the geographic landscape. Because the local agent permitted each of the Dithkalay to select his/her individual 160 acres as the designated allotment, members of the contemporary community are bound together and collectively own varying percentages of numerous allotments. This is the result of polygynous marriage patterns.

> "We came into it this way cuz, well, before those church folks and government showed up on a regular basis, well, them old men, well they might have three, four wives. Plenty of womens. Guess I been got short, I've only had two (he chuckles). [Pause] See, well, she [grandmother] had her tipi, her place, over here. On the east side. He's [grandfather] got his place here, in the middle. (He chuckles loudly) He's got to be the go-between. Cuz she's [second wife, other grandmother of the speaker] living here in her place on the west side."
>
> Allan Colbert, December 1995

My examination of the assigned allotments validates Allan's assertions for the replication of social relationships across space. Using agency *Family Census Cards* and by plotting the assigned allotments on topographical maps, then cross-referencing this data with Allan's genealogy, his two grandmothers did indeed select allotments based on their relationship to his grandfather; the "first" wife selecting the allotment to the east of his grandfather's land and the "second" wife opting for a parcel to the west.

Understanding the Dithkalay's family relationships means decoding the agency census cards using a Euro-American perspective and then re-coding the individual within his or her Dithkalay kin relations. Attempting to instill Western ideologies agency officials re-categorized Dithkalay relationships to fit their perspective, most especially the government's attitude regarding monogamous marriage. Within this framework, the older of the two females was generally designated as the "wife," and the younger female was relegated the role of "head-of" a separate household. Despite government attempts to eradicate the relationships, even today the Dithkalay verbalize the family connections. When people get together informally, this previous attitude and action by the government is often a source for conversational levity.

> "Don't know what they thought they were accomplishing. Just because they [agency officials] didn't name him as her papa - did they think people didn't know he was? (the group laughs) We always been a small group, everybody knows who's being gentle with who. (more laughter) Then, oh, ten, fifteen years later they want us, well, go legalize marriage. Then they start squawking, divorce rate!! (peals of laughter). Got nothin' to do with divorce rate. Grampa, he says to him [agency official], I don't want

> to divorce her [present wife], I just want to get married to her [add a wife].
>
> Dithkalay Annual, June 1996

Additional family relationships and connections are also apparent in the "assignment" of allotments.

> "She [grandmother] always said that she knew that he [grandmother's brother] was *zohn's* pick [favorite grandchild]. He would get it [her land]. Guess, well, maybe she [great-grandmother] felt that she had to take care for the rest of 'em. When they come around [agency officials] her momma says,"I'll take this for him." Put him over there near her [great-grandmother's] place. That a'way he'd have two spots together. Really makes [names another tribal member] mad, no gas or oil on that land. He's always trying to get some of ours, the office [BIA] won't let him. I say, let by-gones be by-gones, but he ain't that a'way.
>
> Loretta Stringer, June, 1997

Loretta's story reiterates the special "pick" relationship between a grandparent and a grandchild and the recognition of that by her great-grandmother, as it was told to her by her grandmother. In doing so, she made clear that the allocation of her male relative's land was the product of traditional behavior. By calling on the past as it is connected to the present, Loretta hoped to extricate herself from a potentially negative interaction with her contemporary male family member by re-calling the traditional behaviors of her allotted grandmother toward family relationships. While her explanation for the assignment of lands does in some way(s) reflect her discomfort for the present-day situation, Loretta hoped to

absolve herself by calling on the psychological conclusion of their ancestor. In doing so she engaged in what I call "avoidance talk."

I learned about avoidance talk by living with Dithkalay families. Families, as collective, cooperative units contain an internal structure dictating appropriate cross-gender dialogue. Within the nuclear or extended family, female verbal assertions are, in some situations, somewhat constrained. This is particularly true if the woman's declaration may potentially conflict with the discourse of a male family member. There are two factors underpinning these guidelines; one is historic, the other is related to the Dithkalay's view of the lifecycle and its attendant concept of power.

Living in bands comprised of consanguineal and affinal kin the Dithkalay practiced avoidance relationships. The strongest prohibition occurred between the affinal kin of the opposite sex, most especially between the father-in-law and his daughter-in-law and a son-in-law with his mother-in-law. Individuals in these relationships were not permitted to speak to each other, be in the same place together and, traditionally, they were to avoid eye-contact with each other. [3]

Thelma: "Well, it's kinda the same way today. Back when I was sick, I'm staying with my daughter. There I am, strolling around the house, not thinking about it. Considering bringing out my pot and chasing those bad things away [smudging the premises]. Here, comes his truck [son-in-law], pulling up the drive. Boy, I dive in the bedroom as fast as I can, my robe a' flapping around my ankles. (laughter). I was stuck in there all day. He flops down in front of that T.V. [she utters vehemently a four letter word] I couldn't even get a decent cup of coffee."

Corrine: "We would never be in the same space..."

Thelma: "When my daughter gets home, I'm yellin' at her, "How could you do that to me? You could've at least

warned me. She looks at me like, don't be so old-fashioned. Well, I'm not old enough to be old-fashioned. Not old enough. Just go ask those girls over there in the office [one of the tribal assistance programs]. They're always tellin' me I not near old enough for elderly help."

Women's Focus Group, April 1996

While present-day dialogue and interactions in in-law relationships exhibit some flexibility compared to the past, other restrictions that hinder cross-gender talk within families remain relatively entrenched.

Thelma: "We learn by watching others. We didn't get any real instructions. I just know it's not right for me to go to my uncle, jump on his lap. Just like we know as kids it's not right to interfere where the adults are talking over there. We learn without any instruction.

Iola: I guess I learned by watching my mother and her actions with her brothers. By eight, nine years old you can't touch 'em. My aunts are different. If I don't see her for six months, maybe I give her a kiss..."

Thelma: (interrupting) "Not with my brothers or uncle. Anything, well, even touching yourself below the waist in front of them is a taboo."

Iola: (picking up where she left off) "but with my brothers it's different, unless we're out somewheres eating. I fix his meal, put it on the table, then leave. I don't sit with him. You didn't stay in same room as my brothers."

Corrine: "Even now, saying we're sitting around, maybe talking about our mother. One of my brothers comes in - we shut up. Specially if we think it's something he shouldn't hear. They're like that too. If they're talking, they stop. If they don't say something, we know. We'll get up and go out."

Women's Focus Group, April 1996

The stories and explanations that the women shared illustrate both behavioral constraints and the moral force of a culturally understood ordering of

relationships. Thus, among the Dithkalay, even at present there are "prohibitive" relationships, the strictest being that between brothers and sisters; closely followed by the relationship between a niece and her uncle(s).

The deference that women demonstrate and the authority accorded to male members is not new in the Dithkalay's social history. Among a number of nomadic Plains societies, males were in the past and continue at present to have a greater degree of authority (Collier 1988, Klein 1983). This persists in the contemporary Dithkalay community, most particularly for the oldest living male of an extended family line. Among Dithkalay men, the ascribed status accorded an individual through birth order is constantly validated in both dialogue and decision-making opportunities. Deeply embedded in their perception of how their world is ordered, the notion of age-related status is incorporated into both community-based and external arenas.

> "Well, he [his younger, biological brother] was over there working at the warehouse when I got out of the service. I go get a job and the boss says to me, "Hey Melvin, your brother, your brother over there is your boss." I say to him [the boss], how can that be? Whew-w-w-!!! I'm older than him. That's not acceptable. It's not 'sposed to be that way-he's got to listen to me. I'm not taken no orders from him. I didn't last there a week."
>
> Melvin Jury, Men's Focus Group, April 1996

While an eldest son or eldest male family member orientation is a central principle in Euro-American society, when applied to the Dithkalay this is preceded by one caveat: providing the individual does not display a physical disability or impairment that can be interpreted as a loss of power. If the eldest

male member exhibits a waning of personal power, then the authority role for decision-making processes becomes the responsibility of the brother next in line even though the latter may be the youngest in age of all the siblings. Within families having numerous male siblings the authoritative position may be accorded to the second or third eldest brother. Because authority status is validated via good health, if the eldest brother demonstrates or experiences numerous bouts of ill-health where "his medicine [keeps] leaving him" so also does the authority accorded him.

Body talk

Dithkalay efforts to continuously maintain their ordered relationships are reinforced in their talk about the human body and health. Cultural ideas about self/body and the relationship to cultural discourse begins early and continues throughout life.

Amy: "I would never talk about my person, my body, anything like that in front of my brother. I'd never say, "Hey, my bra strap broke the other day." Lordy, he'd fall out, if'in I didn't first. Just never would. Now, my husband, he's [names another tribe], they're not like that. Why if he does ask me something personal, well, I just cut him off." (the women laugh loudly)

Iola: "The [names another tribe] are like that too and we live around them. But they've never picked it up [adopted the practice]. No respect."

Corrine: "Maybe it's got something to do with the tribe."

Iola: " That's what I would say. They got no respect for each other."

Thelma: "Mama would say, "Hey don't wear that shirt, your brother's here." We were always reminded not to dress improper in front of our uncles and brothers.

Don't be affectionate with them, keep your distance"

Iola: "Like me, when my husband was still living. He's lying on the bed. I went in the closet. I wanted to change clothes, go work in the garden. I thought well, I just put on some pants, jeans, you know. I went in the closet, put them jeans on. I come out of the closet, and he look at me, "Hey," he says to me. "put a dress on. You got grown boys in this house you know. You're a lady, don't wear them pants." It's to show, it, he didn't want my boys seeing me in pants. I might shame 'em. We don't show no part of our body. That wasn't so long ago, late fifties maybe. 'Course, now I wear slacks, I'm a modern woman (the women laugh), that's my granddaughter's doings.

Beatrice: (speaking off record, and re-constructed from my memory and fieldnotes)Back then we weren't allowed near them men when it was our time [monthly female cycle]. Maybe I was thirteen or fourteen when it happened. Mama didn't say nothin' about it to me only that I couldn't go near that bundle. Grandpa, he had it hangin' on that wall there. Everytime I needed to go from the back of the house to the front, you know, kitchen to front room, I had to walk all the way around the way outside. That's all Mama said, "don't cross its path." Only later did I learn that it [female menstrual blood] could take away [power] from it.

Women's Focus Group 2, April 1996

Two significant aspects concerning body-related talk are represented in the discourse between these women. First, Amy, who is much younger than the other women, breached the requisite sequence of culturally informed order for the proper discussion of both body and health; she moved her speech from the individual level of "never talking about her person" to a community level that compared the behavior of her non-Dithkalay husband with appropriate community understood behavior. In a sense she circumvented the family level. So while her story that links a speech denial to the denial of intimate marital

relations elicited laughter from the women, the older women re-established the proper order for discussion by restoring the reference to family (Iola's husband's admonishments) to community (the bundle) and concepts of power.

The second aspect that we glean insight into is one of the Dithkalay's historic understandings concerning the division of the sexes. Because they link somatic expressions to concepts of power, with menstruation, the boundaries between a Dithkalay woman's physical body and her social body become blurred. For the Dithkalay, this means that female menstrual blood is viewed both as a weakening of the woman's power and as contaminating. The blood associated with the female monthly cycle can or does interfere with the power of the living, most especially that of men - at least from the women's perspective. Even though women in the contemporary community no longer need to avoid contact with the medicine bundles or "medicine" men, prior to menopause the women do interact with others in conformity with these prescriptives; the most constraining being community activities that require cross-gender interactions.

> "My Mom was very shy, discreet I guess you might say. She never did tell me about it, sister saw I needed help. She showed me what to do. But Mama knew, maybe sister told her, she never said. All she, Mom, said was "you stay outta' that circle when it's your time. Don't be going near no men. Aunt, she says, that way back they didn't make us go off like those other [names a tribe]. But we didn't go near those men. Didn't cook for them, we chop wood, haul water, don't be touching their [male] stuff. Even now, I go powwowing all, every weekend. I don't sing, sit behind that drum. I stay outside. Maybe I wear my shawl, but that's all. I don't want to be giving any disrespect or causing trouble. Like I just told [names her daughter], you stand out at our annual, you'll be making things go wrong all year."

Dorothy Splinder, June 1998

Dorothy's explanation for the governing of a female's social body further illustrates the symbolics of female blood in relationship to personal power. As a small population with high neo-natal mortality rates, the onset of the female cycle symbolizes a "missed opportunity" for reproduction.[4] Even though the emphasis on reproduction has lessened somewhat in the community, Dorothy's admonishments to her daughter illustrate that the Dithkalay's traditional rules governing the body still persist.

The division of the sexes is an active variable associated with determining culturally appropriate rules when dealing with illness in a family member. Relatively strict gender boundaries dictate the allocation of varied responsibilities within the family units. As the illness experience unfolds two significant fields for interaction emerge: the circle of people who are designated as the health-care givers and the sphere of those individuals involved in the health care decision-making process. These levels are not synonymous, though they do overlap. Dithkalay parameters defining who is and who is not a family member usually excludes the spouse of the individual who is experiencing ill health.

> "When the mother of my children got sick, I didn't want her to have that surgery. I even told her so. But she don't listen to me, she listens to her brothers and sisters. They decide ok, so she goes ahead. She was gone six months later."

Melvin Jury, August 1998

One-on-one care-giving responsibilities are relegated to same-sex relatives. Mothers, aunts and/or sisters are cared for by their female relatives and the same holds true for males excepting for the additional reliance of

Dithkalay men on their "brotherly-friends." Consequently, the administering of remedies, spending time with the victim, guidance (both practical and spiritual) and assisting with personal hygiene are strongly regulated by gender.

> "When our dad was sick, he didn't want to be in any hospital. We said, ok, we'll bring you home. My sisters cook for him. They tell me when it's ready, then I take it to him and, and he and I, we visit while he's eating. if I had to be somewheres then brother looked after him. We do it to show our respect."
>
> Thurman Wendell, February 1997

The divisions governing and guiding same-sex care giving extend to other interactions, even those beyond the community level.

> "When I was in training we had a practicum part where we were assigned the care of a patient. You know, taking their vitals, bathing them, walking with 'em, changing beds, all that kind of stuff. Well, I got my assignment and I walk in and it's, well, he's Dithkalay! I went to my supervisor and said, I can't do this. That's my [fictive] brother in there. We just don't do that. Fortunately she understood that I couldn't be caring for him, that it's part of our culture, you know. She gave me another patient."
>
> Dorothy Splinder, June 1998

Dithkalay males, by virtue of biology, do not experience the monthly loss of power that women do (symbolized by the a female's monthly cycle). Thus, males are viewed as having more power and tend to dominate the sphere of decision-making. However, if the person who is ill is female the boundaries governing dialogue are more flexible. Dithkalay men recognize that as the care-givers for other women, female family members may have information

pertinent to the process of making a decision. Potentially having influential information allows for an increase in cross-gender dialogue in the decision-making process. When the illness results in death, the decision-related dialogue becomes even more elastic, taking on a posture of ambiguity. With death, Dithkalay ideologies for consensual agreement are interjected into the decision-making process.

> "When Mom was sick, sisters took care of her, but when she passed away we all make the decision. We get the whole family together, all us [including siblings from mother's first marriage]. We start by finding out if she left any word with one of us. More or less we listen to oldest brother and we would try to follow the advice that she might have left with someone. We come to an agreement."
>
> Thurman Wendell, July 1998

Thurman's description of the process involved identified a shift in responsibility from gender-specific behavior associated with health care to a shared family responsibility for decision-making. In this manner, Thurman spoke to the durability of the family as a consolidated unit and he reiterated Dithkalay notions concerning consensual agreement. This is particularly true in the health-related or final disposition decision-making process about parents.

> "Like with my Momma, after she passed away, there was this decision that had to be made. The doctor wanted to do an autopsy. I say "no." We come from a big family - I have nine brothers and sisters. Well, she was so scared, they been running all these tests on her in the end - I say, "no, don't ask me." My oldest brother, he was still living at the time, he makes the decisions, I said, "no don't ask me." See

> he's the oldest and we got to come to an agreement. So I say, "don't ask." It's very hard sometimes"
>
> Erma Weber, Women's Focus Group, March 1997

In describing the decision making process internal to her family, Erma's discourse exemplifies "avoidance talk." Bearing in mind that adopting a disagreeable or a confrontational attitude has potentially serious consequences with respect to "power," sisters often engage in talk designed to deliberately avoid confrontation. In telling her brother, "Don't ask me," Erma both expressed her differing opinion but avoids having to openly state that. At the same time she retained her individual autonomy while maintaining the solidarity of the extended family as a unified entity. In deferring to her brother's authority Erma validated Dithkalay understandings for the proper ordering of relationships within the family.

Yet, the role of family in postmortem decisions differs from circumstance to circumstance. From the interviews and sessions I conducted, the final decision is a delicate intertwining of a number of variables.

> "My brother, way back, well, he died very young. He was on a ship, he was in the service, and the ship was hit by a nuclear sub. I can't remember if it was German or not. Well, since that mishap, he was taken off the ship by helicopter and taken to San Diego. Well, he died three - four years ago. They did all kind of research and studies on him. His immune system was shot. They diagnosed it as lupus. At this point my bother's cells were still useful. Cuz we as a family thought it was important, we all gave cells. Lupus is a big problem for Native Americans now. I have three siblings, who are full-blood siblings with him and have it [lupus]. Me and my other brother, we have a different father, we don't have it. Three others have been diagnosed with it. It's very rare, three

> sisters living with it. 'Cuz we decided to give permission his cells are still up there, still living. When I realize how they might suffer, I sat with my brother for three days and nights. I don't know if he wanted us to do that, he never said anything to us before, yes or no. We kinda crossed over the line there. But there's other tribal members with it, maybe it'll help them someday. The rest of the family agreed, I wouldn't have said "yes" on my own. We - all the brothers and sisters get together and we agree..."
>
> Dorothy Splinder,
> Women's Focus Group, March 1997

Dorothy's explanation of the decision-making process identifies two variables that the family considered. First, like Thurman's explanation, the process included considering if the deceased had expressed any requests prior to death. Thurman related it as "finding out if the person left any word with a family member." Dorothy acknowledged that she did not know if her deceased brother would have agreed with the family's decision to preserve his cells.

The second variable considered was whether or not there might be any benefit in preserving the cells, either to the living members of the family or to other Dithkalay community members.

> "...Now, when it came to my Mom, I said "No." They said they saw strange things in her brain activity and they wanted to do an autopsy. My feeling was no, just leave her alone. They said well, it might help your family some day. But I couldn't do that. They already put her through so many tests and they didn't know. We have some strong ideas about our body, not just who we look like or how we were raised, there's our spirituality. Indian spirituality. First, they said it was lupus, then they said no. Now, well, if we did it, it was like desecrating her body. They said they wanted to study her. We agreed, no"

Dorothy Splinder
Women's Focus Group, March 1997

In completing her narrative, Dorothy interjects a third variable; the challenge that the decision may or may not have for the perceived personhood of her deceased mother. Because the Dithkalay do not subscribe to a mind - body dichotomy, for Dorothy, to support permitting an autopsy of her mother's brain was not possible. The proposed autopsy went beyond a violation of the physical body, performing the autopsy would also be a violation of her mother's spirit. Thus, Dorothy's story, when taken in entirety as a re-stating of the facts, also incorporated a fourth level; that relating to the presence or absence of power.

In order to regain a sense of personhood an individual needs a successful health outcome. Yet, recovery is dependent on an etiology and successful treatment. In spite of their "many tests," biomedical practitioners failed to make a diagnosis that would have led to treatments, thereby, both restoring her mother's physical health as well as restoring her personal power. Dorothy's statements illustrated how she believes biomedical health-care givers, through their indecision, denied her mother the necessary knowledge to recover; she blames the practitioners for her mother's ultimate loss in power - death.

A critical analysis of the decision-making process as a behavioral task reveals an organized pattern that replicates the Dithkalay's structure for cultural discourse. In Dorothy's description of the process the four spheres of the Dithkalay's worldview are incorporated. When her family gathered together to make the decisions, they first considered the individual: Had he or she

expressed any desires to a family member? Then, in considering whether or not to preserve her brother's cells, the decision-making process included the family level and whether the retention of his cells might benefit another family member in the future. This portion of the process then pivoted to the community level. As Dorothy stated it, "Lupus is an Indian problem" and the family members gave thought about how their decision might benefit other community members in the future. The fourth level, that of power, was incorporated into the process by refusing to permit the autopsy because it was a violation of personhood. As a discourse of health the process of decision-making is a re-statement of Dithkalay cultural discourse.

Recognizing a state of poor health challenges the perception of self and personhood. When individuals seek out the assistance of others to restore good health, retaining the proper ordering of family or social relationships is a guiding principle for the Dithkalay. Accordingly, women seek the advice of other women and men may seek out the counsel of other males.

Deb: "If you are not feeling well and would like to talk with someone about it, who might you talk to?

Riva: "If I have a problem, I may seek out Aunt (nodding her head in the direction of another participant). She's my aunt. If it weren't too serious, I might talk to my sisters."

Rachel: "Wouldn't want to worry them."

Corrine: "Aunt is the closest thing to Momma, she's my mother too. I would never talk to my uncles or brothers."

Deb: "Yet, you seek the advice of men on other things. Are there specific things that you might not talk about, even if you were healthy?"

Margaret: "Childbearing. Female stuff. Anything like that. (pause) You might talk to other men." (laughter)

Deb: "You might talk about that to other men but not your uncles or brothers?"

(all the female participants laugh loudly)

Corrine: "Sure, especially you might talk to your brother-in-law. That's like I got six sisters, they're not all married. But if they were, then I got six husbands. I can say anything I want to them. (More loud laughter).You can talk to them about anything."

Margaret: "'Course you don't like 'em all the same. That's a..."

Corrine: "Like my older sister, she was married to a Whiteman. He was good to all of us, my Momma, my Daddy, all my brothers. But I wouldn't talk to him that way, he wouldn't understand. Might think I'm bein' fresh or flirty. No, never talked to him that a'way.

Women's Focus Group, April 1996

In articulating the dialogic constraints that surround the talk with specific males, the women in this group suggest that female talk with brothers-in-law is exempt of those restrictions. However, after further inquiry, the postulate of open, cross-gender dialogue turned out to be more "ideal" than real.[5] Women do not engage in personal health-related talk with their brothers-in-law. Instead they are referring to a joking relationship that permits the telling of a dirty joke in the presence of a brother-in-law or allows for women to make remarks regarding the person of a brother-in-law, such as "what's that smell you got on?". In reality, women do remain within gender boundaries when requesting health-care advice or assistance.

Dithkalay men follow a similar pathway when seeking out health-care advice.

Deb: "If you were not feeling well and would like someone to talk to, who might you talk to about that?

Thurman: I might let them, my brothers, know. If I was sick, not serious I wouldn't bother them. If serious I might let them know. If no experience, I would probably go to uncle. Like my brothers, my friends - I call them brothers, I might go and tell them what's wrong, wait

> for them to discuss it with me. I'd give 'em a choice; they can either talk to me or not. (he chuckles) I'm not as young as I used 'ta be. Yea, I'd probably go to uncle after thinking about it. He's strong, has a lot of knowledge."
>
> Thurman Wendell, July, 1998

Thurman, like many of the Dithkalay whom I interviewed responded to my direct question but then proceeded to direct his explanation in a manner consistent with Dithkalay understandings for the proper ordering of power/health-related talk. As Thurman's narrative unfolded, he began by speaking about himself as an individual, most especially about his perception of the fictive illness experience - is it serious or not? If he interpreted the disruption in his imaginative scenario as serious, then he might seek out his brothers. Here he used the kin-term "brothers" as a semantic pivot to maneuver his story to community-level interactions, where "brothers" include close male friends. From Thurman's perspective though, the "plot" is not complete until he referred to his uncle's strength and knowledge; both being codifying aspects relating to Dithkalay notions of power. He accomplished this by using "strength" as a metaphor connecting physical power with personal power. Thus, Thurman's dialogue once again demonstrates the tendency to incorporate and exemplify the ideal, approved-of values and understandings of order in Dithkalay society.

A further illustration of Dithkalay idealized relationships is Thurman's reference to the "optional" dialogue that may take place between both biological and social brothers or between females/sisters when engaging in health-related talk. Among the Dithkalay, eliciting advice from or broaching upon a discussion with others regarding health one's state of health does not require that the

listener(s) comply with the individual's desire to discuss a health-related problem or issue. Some hesitancy factors include the belief that "if I get to close to him, it might come after me" or "I've got grandbabies to look out for." These perspectives are consistent with Dithkalay etiological understandings. The first justification for avoiding health talk relates to the belief among many Dithkalay that "to say it [the illness], is to invite getting it." The second reason for disengaging oneself returns to the notion that children are viewed as power-less. Thus, to divert the attention of the care-giver and to redirect it toward another may dilute the individual's ability to protect the child.

> "My wife and I, we got to watch out for the young ones. In our culture, that's our job, they're too little to do it for themselves. The parent's are out tryin' to work. So we watch out for them - through ups and downs [good health and illness]. If'in they don't feel well I may give some peyote tea to my grandkids every now and then. When they got high fevers or something like that. It'll put them to sleep, they'll be all better when they wake up. Don't want it too strong for them. Put two or three of those buds in there. I got some there at the house now. Put it in the icebox and leave it there. Works real good with that stuff that [names his wife] gets over at the Wal-Mart. She puts that [VapoRub] around his mouth. While he's sleeping he breathes that in. You got to give 'em the advantage"
>
> Will Reevis, September 1997

For Will, providing health care assistance to his grandchildren is the responsibility of his generation and, therefore, his efforts are prioritized in that direction. The fact that he is responsible for the health care of his grandchildren also means license to use a multiplicity of remedies at that same time if he views that as the more efficacious route. On a practical level, the pain-relieving and

restful effects from mild doses of peyote tea allow the child to sleep peacefully and for the body to heal. Combined with the de-congestive properties of an over-the-counter remedy such as VapoRub, peyote tea helps to relieve the symptoms. On a more reflective or introspective level, Will views using a number of remedies at the same time as "staking recovery in their favor." Plainly put, tandem remedies are analogous to double assurance for restoring good health. Thus, one might argue that from Will's viewpoint, the simultaneous administering of different remedies is the more "practical" approach.

When asked to assist with a health related issue, those who agree to are not generally caught unaware. Most Dithkalay who are solicited for assistance do have prior knowledge of the situation. Despite the emphasis on gender-specific privacy, brothers and sons are aware when sisters or mothers are experiencing disruptions in good health and vice-versa. However, resulting from the Dithkalay's proclivity for individual autonomy, in most cases the decision to engage in either dialogue or assistance takes a circuitous route.

> "When mom was sick, we had peyote meetings all the time. Her brother ran some for her. This old man from [names a town near-by] ran the other ones. Sister comes to me, she says she's talked with Momma or she says "she's not getting better" or "it's getting bad again." I know cuz I can see it. So I would ask her [his mom] - do you want me to help? If she say "yes" then I would ask her "who do you want to run it?" If she says, "go get the old man," I go see him and talk to him about helping her. If she's sick, not feeling good and says "go get brother" I would talk to uncle. Say what I wanted, what she wanted, he might say "go ahead." If he don't have some [peyote] I go to [names his living brother]. It helped. They doctored her in the meeting, she'd feel better. It eased some of the pain. Don't know what she was sick with.

Thurman Wendell, February 1997

Thurman's discussion illustrates two points concerning care-seeking and care-giving behaviors. Because the Dithkalay emphasize individual autonomy, even though an individual may be aware that another person is not well, s/he will not initiate a dialogue of that matter; to do so is disrespectful. One of the rules, then, is that the person who is not feeling well must first request assistance. The other rule reflects the elevated status of males over females. In arranging for health-care assistance, such as a Native American Church meeting, only a male is permitted to approach the man who potentially may provide the service. This rule of conduct reinforces the proper ordering for Dithkalay social relationships.

This practice of providing and caring for each other begins early in a Dithkalay's life. So too do the lessons regarding the means and appropriate way(s) of engaging in assistance. Given their hunting-gathering past and the economic situation of the present, cooperative behavior that recognizes the autonomy of the individual, is both traditional and contemporary. During the fifties and sixties when

> "we were young and small, we didn't get no money. Maybe we would get fifty cents for the weekend and go to the show. We could get pop, candy bar, see the movie, be with our friends. When we get older we might go pick cotton. Then we had more than we needed, so I give it to Mama. I tell her go get some groceries. If you need food, go get some. Buy shoes for little sister. Taking care of us, that's her job. It helps her do her job."

Thurman Wendell, February 1997

The behaviors and dialogue associated with assisting others is both resilient to the outside influence of the larger Anglo socio-economy and persistent in governing daily family life. Even at present Dithkalay children learn

at an early age that concentrating on the individual benefits for oneself may have consequences for the entire family unit.

> "Trisha's living here in town with me now. She's not out at my Mom's and Dad's place with the other little ones. She got herself a part-time job. She's really helpin' out. She goes out and gives some [money] to my Mom and some to my Dad [Trisha's grandparents], she keeps a little bit for herself, that's ok. She gives the rest to me. Helps with the groceries and power bill. She knows her grandpa is stuck on that cheese, I can't believe how much they want for it. I know she's keepin' gas money, she's got that old truck of uncle's, and she takes 'em [the grandparents] over to the clinic if they got a 'ppointment.
>
> Doreen Appleby

Providing daily necessities and health care to those in the "power-less" years, (particularly young children and elderly grandparents) is the responsibility of all family members. In my analysis of the discourse surrounding the health-related assistance process, a dyadic interaction model is strongly shaped by family dynamics and expectations that reify the larger social and cultural Dithkalay consciousness.

Riva:	"Brother, I need to talk with you. (she waits for his acknowledgment which he does by looking up from his paperwork and by looking at her). Dad, he needs our help."
Angus:	"What's going on?"
Riva:	"He's got this appointment tomorrow you know, up in the city with that specialist. I'm taking the day off [of work], I'll take him up there, I'll go with him."
Angus:	"And brother Rudy?"

Riva: "We're usin' his truck to get there. Eddie Lynn [another sister] will wait by the phone for my call after we see him [the specialist]."

Angus: "Taking L.T. with you?"

Riva: "No, he's gonna watch the kids over at Sister's [names another sister]. She'll have supper waiting on all of us afterward."

Angus: "It's gonna be all day?"

Riva: "Well, his appointment is at eleven [a.m.] so we'll be leavin' about eight-thirty or nine [a.m.]."

Angus: "Lunch?"

Riva: "Chrissy [a different sister] is packin' us a lunch. Charlie [a different brother] gave us money for drinks and extras."

Angus: "Gas money?"

Riva: "Not yet."

Angus: (takes out his wallet and opens it) "I don't have much, but I'll give you all what I got. I'll get someone to give me a ride home and pick me up in the morning." (he looks at me, the researcher, I nod my head affirmatively).

In soliciting and negotiating her brother's participation, Riva related the responsibilities that have, prior to her conversation with her brother, been assumed by other family members. In doing so she affirmed their siblings' support for their father's decision to seek the advice of a biomedical practitioner. At the same time, Angus addressed a number of the considerations necessary for an undertaking such as this, in part to determine what his role in this endeavor might be. He did this by posing open-ended questions that narrowed the field for yet un-assumed responsibilities. In turn, Riva also employed a similar speech tactic; she maintained open-ended responses thereby avoiding thrusting unwanted expectations or responsibilities on her brother. She allowed him to come to his own conclusions regarding his participation, whether that be financial or otherwise. In the Dithkalay dialogic process, open-ended dialogue

serves to preserve the autonomy of the individual while providing opportunities for cooperative decision-making and health assisting behavior.

The dialogue between Riva and her brother also serves as an example for one area where the encroachment on same-sex rules within the family is permitted. In cases having to do with the very elderly or the very young additional avenues for health care generally require cross-gender co-operation. For Riva and her brother, obtaining the advice of a biomedical specialist for their father necessitates crossing the boundaries; she will take their father to meet the specialist because she has some biomedical knowledge.

In a similar vein, grandfathers often accompany granddaughters to biomedical facilities.

> "Well, taking care of the grandkids, that's our responsibility. I may take 'em to [names a town nearby]. They don't question us, even if I think it's serious so I take, they don't ask us, the doctors understand the parents are working and this granddaughter here is my responsibility. We worry more about our little ones, I'll take them to the clinic over there faster than anyone else. I think about it though. Once took the boy to the clinic. The Doc, he wants to do surgery on his knee. We talk about it in the family and we decide, ok. Then he did the surgery on the wrong knee.

However, not all health-related events, whether as a decision-making process or within the experience of ill health, conclude with positive or supportive talk or interactive results. Perceived illness in adults - those persons who are categorized in their "powerful" years - can have substantially different outcomes for talking about health and/or in availability of assistance. This is most obvious in situations where the adult individual is viewed by other community members

as being in the grips of a confrontation with his/her personal power. For the Dithkalay, both depression and/or intermittent alcohol abuse are public manifestations of remittent power. Specifically, health, good or poor, is the embodiment for the presence or absence of power.

> "Oh, I don't know. I just get so messed up with it all. I tried all sort of things, even those pills they gave me at the clinic. Four men, four babies. Well, uh, well, Daddy, he says I ought get taken care of [tubal ligation]. He loves those babies but he can't take on no more what with Carrie's kids too. I don't know, I don't know what I'd do without my [fictive or biological] sisters. And my niece, she's the one that looks after me the most when those times...'course the guys, they don't come around. Oh, hell, I'm just as glad, they'res the ones what causes it all. Oncest they held a meetin' for me That hellp't a while. But it came back on me. Got all weak again. Only-est one 'round here [the community] that ever say anything to me was Great-grandpa Horace [respect term: he is not a relative]. All he, well, he looks at me and says, "you take care now, girl - little granddaughter." Mostly folks just stay outta the way. I just don't have the strength to overcome it, I guess."
>
> Monika Reiner, May 1996

In recounting her experiences, Monika reviewed her recent past. With introspection she re-formulated for herself what it means to be a self-assured Dithkalay woman, all the while recognizing that her bouts with depression kept her from accomplishing that. For Monika, personhood is intimately tied to overcoming depression and in resolving her perceived failure as a mate. In attempting to re-constitute herself, she drew on the Dithkalay's informed pattern for a discourse of health that incorporates their four levels of reference.

She began by identifying her individual attempts to resolve her depression, including her use of prescribed anti-depressant medication. Her narrative then moved to the sphere of the family and she revealed how her reliance on her father may be placing a hardship on him. Unable to overcome her depression, she relies on same-sex "relatives" for assistance, as well as some fictive sisters, but mostly on her biological sisters and her niece to see her through these times. But in referring to her sisters, who may be fictive kin, Monika created the turning point for moving her narrative to the community sphere. Now, she referred to the Native American Church meeting that was held on her behalf, even though she felt the restorative power was limited in longevity. All the while Monika recognized that she and others view her as power-less. When an older male member of the community (who is not related to her) called her "granddaughter," she was faced with a re-categorization of her person by the community. Her depression had rendered her power-less; she was as powerless as a (grand)child. In attempting to re-constitute herself, she was forced to acknowledge the perceptions that other community members held about her.

Alcohol abuse, as an "illness disruption," is an additional arena of illness in which the Dithkalay depend on social relationships to re-constitute an ordered world. However, labeling over-indulgence as an "illness" is somewhat misleading because it is an illness category proposed by recent paradigm shifts in biomedicine (Clayman 1989, May 1986). Over-consumption is not interpreted in a similar manner - that of an illness - by the Dithkalay. Thus, the resolution of intermittent alcohol abuse or alcohol dependence in adults, as an example of power-loss, is far more problematic in the Dithkalay community than a biomedical framework entails. The first difficulty encountered is the result of

different etiologies. The other difficulty is related to cultural perceptions about the experience itself.

As the experience plays out, same-sex relatives (usually "sisters"/nieces or "brothers"/nephews) assist and care for the individual. Among the Dithkalay gendered health-related assistance is an inclusive package of behavior. It may, and often does include, buying additional alcohol for the individual, cooking and cleaning for him or her and the other relatives present, caring for his/her person and then assisting the individual with cleaning or vacating the premises following the disruptive event.

It is in the process of assisting the individual that the conflict between understandings internal to the community and an external biomedical approach arises. The care-giving behaviors of the individual's Dithkalay relatives are contrary to a biomedical perspective that views these actions as "enabling" (Rhoades, et all.1987, Sugarman, et all 1992). A further complication in the resolution of the experience is the biomedical approach that encourages confronting the individual. Labeled "intervention," the dialogue is intended to instill a sense of situational consciousness in the individual who is over-indulging (Nofz 1988, Peterson, et all 1994, Thurman n.d.). But among the Dithkalay confronting the individual is both contrary to their cultural prescription for privacy and it also potentially subjects those who interfere to a loss of power.

Underlying Dithkalay behaviors are degrees of implicit cultural knowledge. Purchasing additional alcohol for the individual rests on the premise that over-consumption is a manifestation of the challenge to individual power. Once the individual overcomes the intruding forces, he/she will denounce any further consumption---this does take place. Cooking, cleaning and caring for the victim

is viewed as a necessary support network. Bolstering and, in some sense, aiding the individual draws on social relationships in the Dithkalay's past. This is particularly true if the individual is male.

"Friends/brothers" are less vulnerable to the forces of intruding evilish-ness than closely related biological kin. The motivation to assist is steeped in their traditional social relationships where the obligations and responsibilities of paired "friends" toward each other were the same as if they were consanguineal kin, including remaining by each other's side in a battle. Viewed through the lens of the Dithkalay, to abandon the individual at this time is analogous to deserting one's friend who is engaged in a battle, albeit this battle is with his/her remittent power. Dithkalay readily articulate the super-imposition of the past onto the present in comments such as "Well, s/he's doing battle with her/his problem."

The resolution of the unseen battle between the presence of "evil" and the individual's power becomes known either through the subsequent behavior of the person or in the dialogue between the individual and his/her supporters. Resuming care for one's physical appearance, passing on the next round of alcohol or merely stating,"time to clean up this mess" signify termination of the illness disruption. Accordingly, the restoration of a re-ordered self is symbolized by reinstating order to one's residence. By assisting the individual with this final stage the other participants acknowledge that their responsibility as the bulwark against an unwanted presence is finished; they also will return to the order of everyday life. For the individual, re-establishing order after the event means that his or her efforts are directed toward convincing other family and community members that the experience was merely episodic.

In analyzing the discourse and narratives I found two health-related areas where breach in the Dithkalay's relatively regulated rules governing dialogue and decision-making occur. One area is related to chronic illness, the other appears in the interactions between grandparents and grandchildren. Both revolve around illness events juxtaposed with Dithkalay cultural ideologies of power-lessness. In the following narrative, Leroy began by establishing what being powerful and exerting control and management over one's state of health means to the Dithkalay.

> "He had pneumonia, oh 'bout ten, twelve years back. I seen it was getting pretty serious so when he talks to me about it, I say I'll take you to the clinic. Well, the doctor started getting too deep [inquiring into his father's previous health history], See he had this collapsed lung when he was a young man spent seven years in the hospital for it...maybe it was t.b.. So the doctor wants to take x-rays, run tests, put him in the hospital. Dad says, "Hey, I been in the hospital before, I don't need nothin' like that." Doc tells him, "he got to or he's gonna die." He [Dad] puts on his stuff and leaves. Today he'll tell you, "See that Doc said I wouldn't live six months and here I am ten years later." He was stronger back then. Little bit by little, I been picking it up [responsibilities] for him"
>
> Leroy Reevis, June 1997

In reconstructing his father's encounter with the clinic physician, Leroy made immediately clear that his father's pneumonic episode was exactly that: an episode. Interpreted using the Dithkalay's concept of individual power, his father's self monitoring and recovery categorized the illness event as episodic. More importantly, a positive health outcome is embodied power. Recovery

signifies an individual's power and strength and is a means for maintaining or increasing status.

Throughout my years with the Dithkalay I listened to many a dialogue, especially in public settings, where an individual recited his/her recovery as a means for publicly affirming or validating a continuation for the presence of personal power. Included in these situational re-countings are phrases or expressions such as "I was faced with surgery and came back from it" or "they talked about [this medicine or procedure] but I never gave in to it."

On the other hand, chronic illness, as a disruption from which there is no absolute recovery, re-categorizes an adult Dithkalay both personally and in the re-defining of family oriented responsibilities. Because chronic illness re-categorizes an individual (from adult to elderly) the willingness by another family member to assume responsibility for an individual's care often precedes the willingness of the person to accept the assistance.

> "...He was havin' these dizzy spells. So they run tests on him to find out why. They run this test on him and he got the sugar problem. He's got it, been eight or ten years ago. Now he takes his pills. He was always craving pop and that bakery. I guess when you got it, you crave it - that sugar, it wants to get inside of you. He'd go get, he loved those long johns [bakery confection], he'd go get six or seven of them at a time. Sit at the table and eat 'em all. I'd say to him, "you gotta quit that, look at uncle [father's brother with known diabetes]." He don't listen. He says, "come on," so we go, I drive. Sometimes all the way from [names a town about 30 miles away] to here. He stock up on those things and eat 'em all. I think he shut down that bakery (Leroy laughs). I drive - just to the bakery. See, he don't want to give up. After a while - I don't know - he got that high sugar content in your blood. Turn it worse. That's when he got cut off, got to quit it. Feels bad, you know, sick..."

This segment of Leroy's narrative provides insight into his father's current health situation. It also clarifies Leroy's concluding comments in the first portion of his story. He related how his father was "stronger back then" and how he, Leroy, has over time assumed the care-giving responsibilities for his father. In recounting how he had previously advised his father against consuming high sugar content foodstuffs and how his father refused "to give up," Leroy also implied that by denying the symptoms, his father resisted a potential change in his status.

In continuing his story Leroy explained how his father finally came to accept the re-classification of his individual and Dithkalay identity viz-a-viz personhood and power.

> "...My niece, you know, when I'm over here, she takes care of him. He kinda raised us both. She's kinda like a blood doctor - she's a member of the family - she takes him his medicine. She doesn't live with him, just checks on him. I think it started helping when she started telling him [to watch his diet] - 'cuz he looks at me "Sonny" he don't have to listen to me, you know. But if a granddaughter or grandson tells you, you got to listen. They're the ones' that's spoiled first - there's a real communication there. He spoils 'em [the grandkids] and when she starts gettin' older and advising him - he's gonna listen to her. He'll take her advice under serious consideration."

Leroy's narrative does not describe a unique situation. The social and personal bond between grandparents and grandchildren is extraordinary. Bound together under a cultural ethos of power-lessness, the reciprocal relationship that develops between grandparents and grandchildren includes the sharing of knowledge.

> "I give praise to her. She's smart, goin' to school and all. She learns, she talks about, well (pause) she got knowledge that I don't have. She and I sit, we talk about our culture. I tell her about the way it was and how it is. That's my job - tell her about our Dithkalay ways. Then I talk to her about today, is she doing ok. She likes sports, we talk sports - being in good shape. We go watch the school play those guys from [names a town], we watch t.v."

From the opposing end of the generational spectrum,

> "I listen to Grandpa Allan. He's the one that tells me how it's done. I like it when he talks about the old days and how it used to be. Makes me feel proud to be [Dithkalay]. I got friends at school, yah, they're Indians but they don't know who they are...they's mixed blood , uh, mixed tribe lines. Don't know where they belong. We talk about that, how some of the mixing is confusing things. When he gets tired of talking, I remind him to take his medicine."

Emanating from two differing generations, these related narratives give credence to the reciprocal relationship between grandparents and grandchildren that pivots on sharing of knowledge and monitoring of each other's health. Regardless of whether the dialogue of shared knowledge is about their traditional cultural or constructed out of contemporary life aspects, the relationship, in conjunction with concepts of knowledge, operates as an appropriate field for health-related discourse that crosses both generational and gender boundaries. Symbolic of this close bond is the Dithkalay kin term, "*zohn*" that means grandparent or grandchild.

Most of the narratives and dialogue I examined reflect a continuous tension between the perceived illness experience of an individual and family boundaries, and how the individuals involved invariably rely on their Dithkalay

notions of self and empowerment, gender and birth-ordered relationships, and family identification. When an individual is confronting an illness experience or alteration in life resulting from an illness disruption, families may both assist and avoid the person.

In life altering disruptions, whether they be physio-biological illness, such as heart disease, stroke or diabetes, or resulting from psychological distress as it is manifested in depression or substance abuse, or the ultimate health disruption - death - the role of the Dithkalay family is an integral segment in the illness experience. When Dithkalay either seek-out or contemplate providing health-related assistance, their tendency is to adhere to and operate within the culturally approved rules that define the parameters of family and kinship obligations. In this manner, the family operates as the nexus for connecting the individual level of an illness experience to that of the larger spheres of interaction; the social body on a community level and the body politic.

To most non-Dithkalay, this emphasis on family - especially to the extent of excluding a spouse from the decision-making process - seems unfathomable. Yet, within the community, all persons are engaged in health-related processes. Specifically, while an individual may be excluded from the decision-making discussions about his/her spouse, as a member of a birth family s/he may be an important link and active partner in the health-related behaviors and decisions of blood kin, either by providing health care assistance or by participating in decision-making conversations in an appropriate way. The open-endedness of health-related dialogue and the use of avoidance talk (especially by women) serve as means for articulating the Dithkalay's emphases on individual autonomy and consensual agreement. Metaphors of place, as creative expressions,

capture and reinforce the Dithkalay's cultural boundaries that govern who is permitted to speak with whom about health.

Similarly, Dithkalay narratives that describe the task of making health-related decisions also put into words their cultural perceptions for order. As a cognitive process, the decisions made by a family take into consideration and incorporate the four aspects of the Dithkalay's worldview. Family-based dialogue serves to link an individual's somatic representations to his or her social status at the community level and to Dithkalay beliefs about personal power. The comparatively consistent references to relatives functions as a semantic pivot to connect the blood relatives of the family to fictive kin members in the community. Metaphors of strength and weakness put voice to their cultural framework of embodied power. Through the discourse of health the family becomes the potential mediator for the illness experience, health-related decisions, and the process of recovery.

The Dithkalay's emphasis on the role of family in a discourse of health is distinctly different from the constructs of the larger Anglo culture, most especially in the arena of biomedicine and in interactions with biomedical practitioners. The contrasts are particularly noticeable when examining the dialogue and narratives of Euro-Americans who subscribe to a biomedical paradigm in contrast to those of the Dithkalay. In my discussions with biomedical health-care providers in the area where the Dithkalay live leads me to conclude that any inexplicitability or lack of understanding of the Dithkalay framework is grounded in two decidedly western perspectives. One has to do with a Euro-American emphasis on individualism and the other relates to concepts or notions regarding the responsibilities that are generally accorded to the next-of-kin.

The historic processes that gave rise to biomedicine as a science based on rationality also produced ideologies and cultural understandings about illness and recovery. Practitioners rely on a multiplicity of data in determining the "cause" or basis for the experienced illness beginning with the health history of the individual and, if deemed necessary, a battery of tests used in establishing cause and then measuring outcome. Physicians then discuss the data with the individual who is experiencing ill health and provide the necessary prescriptives for re-establishing a normal state. In essence, this shifts the responsibility from the practitioner and the medical domain to the individual exclusively. More importantly then, patients who do not follow the specific orders of the physician are categorized as "non-compliant" - suggesting deviant behavior - or "non-competent" - unable to resume individual responsibility for recovery (Holm 1993, Trustle 1988). Thus, in emphasizing individualism, in a biomedical paradigm recovery symbolizes the person's cognitive skills or rationality of mind based on scientific understandings of cause and effect.

Emanating from an emphasis on individualism are two consequences for the process of recovery. On the part of patients, individual responsibility means people become responsible for disruptions that are essentially beyond their control (Becker 1997:99). In a recent study of stroke victims conducted by Becker and Kaufman, the transferring of responsibility for recovery from the "professional to [the] moral domain of the patient" makes physical recovery an area of uncertainty (1995:165-87). On the part of physicians, biomedical practitioners expect that a patient will accept and engage in the recommended treatment because the remedy is based on the premises and logic of biomedicine (Kirmayer 1992: 326).

For the Dithkalay, the emphasis on individualization at the expense of excluding family or blood kin has far greater consequences. In a community that embraces a cultural ethos of co-operative behavior and assistance, the exclusion of blood kin eliminates an available network for seeking health-related advice, receiving health-care assistance, and making health-related decisions; all of which lead to a positive health outcome.

The other distinction between the culturally guided framework of the larger Euro-American society and that of the Dithkalay is the responsibility accorded to the next of kin. The Anglo world gives precedence to first, spousal and then to direct affinal kin (i.e. parents, oldest son, brother or sister) in health-related situations. This too is decidedly contradictory to the Dithkalay's understandings of health. The Dithkalay's discourse of health places importance on consanguineal kin relations. While the pre-eminence accorded affinal kin in the larger culture has its history rooted in the emergence and political economy of nuclear families - most especially in the United States - it contradicts Dithkalay understandings for socio-culturally ordered relationships. A discourse of health at the family level reiterates Dithkalay cultural discourse and the mediated health-related decision-making processes of family members re-affirm the family as the primary unit of social organization. The consanguineal family is where allegiances lie and it is within this framework both females and males operate. As a mediator in the illness experience, an individual's interactions in the family form the foundation for re-constituting one's self within the larger social arena of the community following an illness episode.

Chapter Four

Connecting Fences and Boundaries

A biomedical perspective that emphasizes illness as an individualized experience of biological disfunction misses crucial elements of the illness experience in the social and cultural context of the patient. This is particularly salient when the illness disruption results in behavioral change or alteration(s) in the physical body that can be readily observed by others. In sickness, the individual must not only confront his or her perception of a dis-ordered self, s/he must also grapple with others' potentially altered perceptions of him or her. Thus, it is in the mundane world of everyday dialogic interactions that an individual strives to re-constitute him/herself both individually and as a member of a culturally-ordered world.

Health-related talk as an avenue for re-structuring the socio-political self is the thesis of Libbet Crandon-Malamud's (1993) recent study of Kachitu peoples in Bolivia. Her examination of the health-related narratives and dialogue of the medically pluralistic Kachitu serves as an excellent example of how people use the discourse of medicine to negotiate identities and to shift social affiliations using illness diagnoses. According to Crandon-Malamud, the diagnosis process reveals an explicit connection between an assigned causality for the illness and use of the various medical sectors based on the diagnosis.

Crandon-Malamud's (1993) conclusions are somewhat parallel to the study of competing medical systems in Manus culture by Iola Romanucci-Ross (1969). Based on her analysis of the sector-selecting decision-making process among Melanesian patients, Romanucci-Ross contends a patient's use of the

various medical sectors is formulated using a hierarchy of resort where both the efficacy of the treatment and illness causality are factors taken under consideration when selecting one sector over another. In Romanucci-Ross' work an assessment for the persistence of indigenous Manus health-related practices is given primacy. In Manus culture the selection of a particular medical system emphasizes the social components of the illness (sorcery versus European-born disease) and de-emphasizes the perceived curative ability of the system.

However, there exists a significant discrepancy between the analytic approach and conclusions of Romanucci-Ross and those of Crandon-Malamud that are important to the project at hand. To the point, the approach of Romanucci-Ross stems from the circa - 1960 perspective of acculturation theory. The Manus population, having been Christianized and introduced to biomedicine, served as an example for investigating indigenous adaptation to larger cultural ideologies, most especially the science of biomedicine. In Romannuci-Ross' study, the "yardstick" for measuring Melanesian resistance to acculturation or hegemonic processes rested on Manus acceptance or rejection of biomedical etiologies and treatments.[1] Thus, while Romanucci-Ross provides excellent data for a decision-making outcome, this approach affords very little insight into the decision-making process.

On the other hand, Crandon-Malamud's study of Katichu discourse does provide some insight into the underlying motivations embedded in health-related decision-making processes. In Crandon-Malamud's assessment, the moral economy of medical discourse transforms Katichu social relationships and cultural identities. Thus, in the social, political, and economic worlds of the Katichu, medical discourse based on homogeneous beliefs form the primary

avenue in which people can gain access to the real and necessary resources of land, jobs, goods and social or political power. Crandon-Malamud's assessment is that the "matrix of simultaneous or differential reliance on multiple traditions" alters the real and experienced world of Katichu People. (1993:204).

Bryon Good attributes these "worlds of experience" with the works of phenomenologist Alfred Schutz and Schutz' categorical analysis of a "common-sense reality" (quoted in Good 1990:122). In summarizing his use of Schutz, Good contends that giving shape to the common-sense reality of an illness experience begins with the conscious acknowledgment of the dyadic nature of the physical body; as an inhabited object the body is both an object of and for action and, especially with illness, it is an object acted upon. Good goes on to say that it is in recognizing that the experienced world is occupied by and shared with others who have a similar cultural ethos that the body becomes a source for negotiating the social and/or political self (Ibid: 116-28).

In a similar vein, Lock and Sheper-Hughes assert that cultures provide codes for the "regulation of the body to meet the needs of the social and political order" (1996: 63). Lock and Sheper-Hughes draw on Foucault and view the larger analytic level - the "body politic" - as capable of exerting control or power over individual bodies in defining and shaping a socio-culturally understood appropriate state for the physical body. It is in the actual lived-in experience of "bodily praxis" that Lock and Sheper-Hughes suggest that the negotiation of a social and/or political body is validated or redefined following illness (1996: 65).

The critiques of Good, and Lock and Sheper-Hughes contain two common aspects that are important when attempting to explain the discourse on health surrounding illness or how the outcome of an illness is viewed by a group of

people. The first point that Good, and Locke and Sheper-Hughes share is the perspective that all people have some inherent understanding for an individualized self. In a phenomenological sense, the embodied self is separate from the other bodies that occupy the individual's world. As a separate entity, the individual is capable of recognizing an internalized self with self-generated thought and action.

However, individuals do not live in vacuums. Each individual is also a member of a socio-cultural collective, however those parameters may be defined. That individuals are also members of a collective is the second aspect that Good has in common with Locke and Sheper-Hughes. Both Good, and Locke and Sheper-Hughes give consideration to the individual as a product of his or her social and/or cultural world. Consequently, following an episode of ill health the individual must operate within the parameters of a culturally-held framework when attempting to re-integrate as a member.

The foregoing perspectives deserve serious consideration when examining the process entailed in health-related decision-making. Specifically, if the discourse of health can successfully (either consciously or unconsciously) pressure individuals into conformity, then how might deviance (c.f. Parsons 1964), resistance (c.f. Scott 1985) or self-determination be explained? As a number of examples in chapter three illustrated, many Dithkalay adults resist the re-categorization from being power-ful to rendered power-less, the result of a less than positive episodic or conclusive chronic illness outcome.

It is in combining the example provided by Crandon-Malamud with the perspective of Locke and Sheper-Hughes in conjunction with the approach and methodology of Good that the present undertaking is best served.

Crandon-Malamud provides data to support the perspective that in determining a diagnosis the Katichu people engage in acts of "human agency." Katichu patients become empowered with the ability to alter social identities and political classifications by manipulating the medical discourse surrounding health. Lock and Sheper-Hughes propose that the parameters defining good versus ill health are established by a culture and/or a society. Specifically, just as a group of people have created the boundaries or definitions for a healthy body, so also has the membership defined the characteristics for poor or ill-health. Therefore, when an individual seeks to affirm him-or-herself as a viable member of the group following an illness episode, the process for doing so must operate within the confines as established by the membership.

In his examination of chronic illness or pain, Good suggests a means for understanding this process. He also contends that re-affirming one's self within the parameters established by the social group is a process which all individuals undertake in the re-constituting of the self following an illness episode. As Good explains, the narrative(s) produced around the illness experience reflect the cultural framework for mediating the re-making of a real and/or social world that has been un-made through the illness experience.

In the Dithkalay's world of the family, the resource person(s) who may be available and the constraints that limit - sometimes prohibit - the participation of others in health-related assistance reflect a traditional understanding for gender relations. As the talk between brothers and sisters has revealed, there exists a delicate balance that allows for individual autonomy within the larger confines and consensual goals of the family. The community level of interaction, which further expands the Dithkalay's social and political worlds, also revolves around

similar gender-specific boundaries. By extension, when a Dithkalay experiences an episode of ill health, whether acute or chronic, the autogenous process for re-integrating into the social and political worlds includes paying attention to how the illness experience and its outcome are viewed by other members in the community. Here also exists a sensitive balance that allows for assertions of personal power within the larger cultural framework of the Dithkalay community.

How the Dithkalay mediate re-affirming or re-constituting the individual self within his/her real world is the subject of this chapter. In order to explain how this process evolves I give attention to a number of variables. In each of the examples I provide, I begin by examining community-constructed perceptions of what constitutes a healthy body and the Dithkalay's cultural views about management of the body in times of distress. In order to provide a more inclusive picture of the process involved, I then move to the Dithkalay's etiological understandings and the attendant linkages of their quadpartite worldview. Here, I examine the influence that the Dithkalay's culturally-held beliefs have on the dialogic process of validating or re-establishing the self following either an episodic or chronic illness experience. I conclude the chapter with a brief discussion for the cultural construction of health.

> Andrew: "I just knowed you'ld be along. Rosie ain't even up yet, she worked the late shift las' night. [She] made sure my breakfast was laid out; got it me-self. She rests easy knowin' you'ld help. She don't complain. But I know. Trips, well, uh, three days a week; it's hard on her, ya know. But she don't say nothin'. (Pause). She say, "I don't mind" cuz she loves me!!! (He chuckles, flashing a toothless grin accompanied by a "knowing" wink from his sight-less eyes). Got to be quiet, ya' know; don't do no good to get the whole crowd a talkin'. You been with us Dithkalay, well, you

> know how it is, been here long enough to know the workin's. I know I got to go. Maybe, well maybe, with all the stuff them guys [biomedical practitioners] is doing...hey! I might come back some day. Chase the ghost outta' all of 'em!! Well, I'm ready, unlessen' you're gonna tell me my shirt's on bass-ackwards."

Andrew's introduction to our interaction took place at 7:30 in the morning on the kind of cold, windy and dank winter day that only the southern plains experiences. The previous evening Rosie (Andrew's significant other and mother to his fourteen year-old daughter) had called me and asked if I would be willing to drive him the one-hour trip to the local Indian Hospital. In his early seventies and blind (directly related to cataracts and complicated by diabetes) Andrew required dialysis three times weekly.

Andrew was one of the very first individuals I had encountered in the Dithkalay community. At the time another person was with me and stated that "he did not know how helpful Andrew might be as he [was] a peripheral member of the community." The person who accompanied me was correct. At that time Andrew was a member who interacted on the fringes of community life. But it was only through the process of my research that I learned how he had become relegated to that status.

A few weeks prior to Rosie's phone call I had seen Andrew walking along-side the street curb making his way home from the tribal complex. He was using the curb as a guide to navigate the four-block walk to his house. At the time I was driving and I asked if he would like me to drive him home. He adamantly refused my assistance. I had accepted his refusal, viewing it as one of the Dithkalays' practices designed to maintain the separateness of cross-gender interactions.

When Rosie called that evening I was by now well acquainted with Andrew's health and socio-political status. He and I had spent many hours together in constructing his family's genealogy. He was also a regular attendee of the noon meal provided for Dithkalay elders at the tribal complex, so we conversed on a regular basis. Based on Rosie's request in conjunction with my relationship with both Andrew and her, I set aside my hesitancy and agreed to serve as "transport" for Andrew's trip to the hospital.

My concerns about potentially violating community-understood behaviors were put to rest by the family I was staying with at the time. The male head-of-household was a member of Andrew's extended family; Andrew was his "grandpa" because he was Andrew's brother's son's son. When I tentatively announced my intentions to assist, the family's response was, "This is a good thing. Andrew, well, he's pretty pitiful. He needs all the he'p he can get."

Returning to the early morning interaction between Andrew and I,

Andrew: "Now don't be a' helpin' me. I probably know my way to that curb better 'en you." (he is referring to where my car is parked)
Deb: "So what will you do while you are resting there?"
Andrew: "Don't do much a' anything. They got that T.V. up on the wall, sometime I listen to it. If Rosie, Danielle [his daughter], or Cap [his nephew] brings me, then we jus' talk while we're a' waiting. It's not too good. But you 'en me, we kin talk, it's fine with me. Maybe you got some more fam'bly questions you want 'ta ask?"
Deb: "That sounds like a good idea. You know me, I'm full of questions." (He chuckles in response to my statement). "I also have some tapes from last year's annual if you would like to listen to them. They're right there in the back seat."
Andrew: "You think that machine of your'n will work?" [He is referring to my tape recorder/player].

Deb: "Sure. It's got fresh batteries and I've got my extension cord. I'll bring it in with us and you just let me know if you want me to set it up."

Andrew: "Sure would be nice. I miss it, but can't he'p it. I don't go no more. Well, maybe, if'in Rosie's a' going, I'll go and listen to those songs your talking about. But I ain't gonna go and embarrass myself. I don't dance no more. The songs, well, I know 'em. They're good to me and, well, uh, I'm proud that they're belonging to our people. But I ain't gonna mess up by trying to be what I'm not. I ain't able...don't want to show disrespect. That 'id be bad for the rest of 'em [his extended family members]. Folks would think I'm trying to be what I'm not...not able, you know. Us, well, us Dithkaly do things by watchin'. Can't do that no more."

Deb: "So you don't dance because people..."

Andrew: " I got no one to blame but me-self. They [other members of the community] say I got no one but me to look to. Yea, I hear what they say...even my own fam'bly. They say, it's my fault, cuz I was part of the crowd. Part of the crowd 'ya know that went under back in the sixties and seventies. 'Ya know, them was pretty dreary times; people divided an' all."
(long pause)

Andrew: "Some o' them folks can get rough, ya know, uh, well specially those from [names a geographic location]. They're down there near them [names another tribe]. Some even marries 'em. Makes 'em mean-spirited. That ain't our way, well, uh, it ain't Dithkalay."
(long pause)

Andrew: "Yea, specially those 'ens. [he shakes his head]. Just cuz the sugar 's gone to my eyes they think I don't hear so good. [he chuckles] But I know. I know what they're a' sayin'. And, well...well, it just ain't no good to be bringing up the past liken that. Not good for the young people, we got to move ahead."
(long pause)

Andrew: "The old man, he usta tell me "don't be talkin' bad about your peoples, there's enough of 'em out there [doing so] that we don't need to be a' he'pin them."

Deb: "What old man?"

Andrew: "Grandpa [names his grandfather]. 'Course, well, he,

well, he's, he was that a'way. He had a lot o' power, he did. People always listen to him; he'd advise, you know. He'd tell me don't never talk bad about nobody. Didn't do no good, he said. Just causes folks to have hurt feelin's an' it makes the talker look bad."

Deb: "So what are people saying? What is it that is disturbing you?"

Andrew: "Ever body got their own version I 'spose. I guess I weren't right, none of us were right. But we thought we were doin' the good thing back then, you know. (he turns toward the window of the car). Yea, we thought we was bein' good, but they [the government] said "no". Took us all away, 'ceptin for Horace. And look at us now; gone [deceased] or pitiful [chronic illness]."

Andrew's narrative, up to this point, has followed the Dithkalay's established pattern for health-related dialogue that moves from talk about the self to concepts of power. He began his dialogue by speaking about himself. In stating that "he got his own breakfast" and that he "can make his own way to the curb" he sought to establish his autonomy. He then moved to the level of the family by discussing Rosie's, Danielle's, or Cap's assistance with his health care. Andrew then directed his dialogue toward the community level. In doing so he located himself as a member of the community who is governed by its beliefs that connect the status of an individual's health with his or her interactions within the Dithkalay community. From Andrew's perspective, his limited participation in present-day ceremonial life, being the object of community-based gossip, and his past actions as a local-level politician are in some manner linked together.[2] He concluded the requisite four-part cycle by calling on the directives of his power-ful grandfather.

In some sense, it seemed that during the latter part of his narrative Andrew attempted to salvage some semblance of having personal power. He did this by recalling his grandfather's advice concerning the ramifications of negative gossip. He approached this by reiterating Dithkalay beliefs; to speak negatively or "disrespectful" about others is an indicator for the remittance of power. According to Andrew, negative gossip is an activity that he does not engage in. Instead he used that fact as a means to defend himself against the perceptions that he believes other Dithkalay have about him.

But it is in the manner in which Andrew intertwined his rendition of the discourse at the community level and his perceptions of himself that two significant points emerge. First, in explaining what he is not, Andrew is at the same time making statements about what he believes he ought to be as a reflection of and as a member of the community (c.f. Boon 1994). Through Andrew's dialogue we gain some knowledge of how and by what criterion the Dithkalay define a healthy body. Andrew summed it up using a single term: "capable." Because Dithkalays learn by watching and because ceremonial participation relies on the proper co-ordination between visual and auditory cues, one criterion for a healthy body includes the sense of sight. Based on my observations, when a Dithkalay loses his or her sight the individual is re-categorized by others in the community as "baby-ish" or "power-less." At the same time, the stricken individual seeks to re-constitute him or herself within the confines of "power-less" or "dependent."

Becoming dependent on others has a very real side to it. Two other Dithkalay had to deal with a loss of sight during the four years that I lived among the people; Andrew was the third community member. In none of the cases did

the individual engage in rehabilitative activities such as the use of guide-sticks, seeing eye dogs, or learning Braille - activities that, from a biomedical perspective, might be the expected response. Instead, the individual's and the community's response was to address each situation by relying on the traditional and expected obligations of family members to provide assistance. More importantly, even though non-family members of the Dithkalay community maintained a position of non-interference and non-assistance, there was talk - albeit in hushed tones.

As I learned, the health-related gossip that accompanied non-interference on the part of other community members became a particularly potent mechanism for empowering the individual involved. Gossip was significant because it established the parameters that created the possibility for the re-affirming of the individual. In the situation of Andrew, he knew what he was not because the larger community (through gossip) had reclarified his status based on his health-related weaknesses.

The second important point revealed in Andrew's dialogue is his reference to an illness causality not previously discussed; an etiology stemming from socially inappropriate behavior. Andrew broached the subject by referring to his actions and the activities of other business committee members in the past. In Andrew's words, "all of the members involved were deceased or pitiful." So I asked of him,

Deb: "Andrew, are you saying that you have to cope with your diabetes today because you did something wrong in your past?"
Andrew: "What?"
Deb: "Well, you're talking about the past. Are you talking about what went on in the sixties and seventies and

the whole situation with the tribal business committee and the housing authority? How is that is part of what people are talking about today?"

Andrew: "Sure. Look at, well (pause) we wasn't doin' **wrong**. [He emphasized the word and seemed to be resisting an accusation that he felt I had implied]. Folks around here, well...they just didn't, well, they just don't understand 'til it's them. No support. We just had no support. Folks all lookin' to help themselves. So we was to blame. Look at 'em now with that Bingo biz'ness. Ready to point the finger at the other."

Andrew's reminiscence refers to the decade of the sixties that was witness to several crises of authority among the Dithkalay; one cultural and one political. The cultural crisis of authority revolved around the recreation and re-establishment of one of their military societies. According to community members a group of middle-aged men believed that recreating the society would help to integrate and symbolically represent the Dithkalay as a functionally distinct tribal unit. Even though these men relied on Dithkalay elders for their recollections, input on costuming, and recordings of the appropriate songs, certain innovations in organization and the construction of symbols resulted in a fissioning of the military society by the mid-sixties.[3] In the present-day community there are two military societies, each claiming historic authenticity.

One group claims authority based on "tradition;" where tradition as it is expressed by the Dithkalay embodies the inheritance of the symbolic staffs by an appropriate male (a member of the former staff-keeper's family, though not necessarily of direct descent), the importance being that the leader (a.k.a. the "whip") has the acquired knowledge of the history and actual performance by having mastered the associated oral history, and that the individuals who hold the position of staff-keeper or the "whip" have been approved by the elders. The

other group claims authority through "legitimacy." Legitimacy being: a) a state registered and recognized charter that includes, b) criteria for membership (only married males can be members of the society) and in which, c) the staff-keepers and the whip are elected positions.

Shortly after the society's re-establishment the younger, middle-aged men failed to observe a particular aspect of the ceremony causing the staff-keepers to withhold their participation as well as the use of the staffs. This precipitated the creation of a new set of staffs and a dispute over authenticity. Consequently, it was differences in the origins of authority, organization of the society, and the validity of symbolic representations that factionalized the Dithkalay.

Within a short period of time, the cultural crisis became a political crisis as some of these middle-aged men also became members of the Dithkalay Business Committee. Traditionally the Dithkalay selected older men as their leaders, most especially older men who had demonstrated an ability to successfully negotiate local-level politics with nearby tribes, had achieved results with government officials (especially area agency representatives), and had facilitated assistance to community members in need. However, the composition of this particular business committee did not reflect the Dithkalay's traditional bias. The older members comprised a minority (two of the five).

The dispute within the Dithkalay Business Committee also revolved around the question of authority. In keeping with a traditional attitude the minority older members believed that tribal political decisions belonged in the hands of their constituency, the Dithkalay General Council. The middle-aged majority believed the authority for tribal-level decisions rested in the hands of the five-member business committee. As the dissention over who had voice and

power in their tribal political structure increased, the two military societies emerged as political factions. Similar to their cultural crisis, this issue was also over authority---political authority. Those members of the military society (and their families) who claimed authority based on cultural tradition argued that absolute authority rested with the Dithkalay general council; that is a community consensus validated by a majority vote of adult Dithkalay. The other group, those individual males (and their families) who asserted authority via legitimacy aligned themselves with the business committee majority. In 1972, by a stand-up vote in a general council meeting, the authority to transact business and otherwise speak for and on behalf of the tribe in all matters was given to the Dithkalay Business Committee

Armed with the authority to act outside of the general council some members of the business committee successfully negotiated the infusion of Public Housing Authority (PHA) funds for their constituents.

> "Back then, most of us didn't have nothin' so to speak. Most of the time we lived outta our wagon 'til I got married anyway. He was blind you know, our Dad. He'd given it [his allotment] up to have that eye operation. Before we moved to town back in , oh , 75 that place that me and my man had was always falling down around us. We did'nt have no inside facilities, like folks got now. Twice that ol' out building [outhouse] got struck [by lightening]. Burnt it down. You know, I was still a'haulin' water back then, outta that well we had out there. Heck, we did'nt even have one of those push pumps inside. We was livin' in the Dark Ages, I guess. (she laughs)"
>
> Iola Porter, November 1995

Thus, with apparent good intentions in mind, the members of the Dithkalay Business Committee sought to meet what might be considered basic needs for their constituents. But as the conflicts between the elder minority members and the middle–aged majority escalated, so also did the divisiveness between the two socio-political factions. There were charges of preferential treatment; thirty-seven of the fifty homes contracted for under Public Housing Authority funds were designated for the members of one faction. The two older committee members accused the other members of conducting secret meetings. Ultimately, it was bureaucratic red-tape that resolved the internal conflict. Failure to file the proper disbursement and accounting forms with federal agencies led to the federal government's investigation and successful prosecution of the three middle-aged business committee members for the mismanagement of tribal funds.

According to the Dithkalay, the two older committee members used the prosecution and incarceration of the three former members as an argument to motivate community members to return to their traditional practice of consensual agreement. The older committee members argued

> "We never done that before, lettin' one man decide for us, we decide together. That's the Whiteman way, letting one or two folks to speak for us. Yup, For us, well, it takes input from all the families. Always did."
>
> Horace Kleland, August 1996

The call by the older committee members for a return to their traditional way(s) of deciding tribal issues was successful. By a majority vote of community members, the Dithkalay Constitution was amended. By amendment, the

authority of the business committee became subordinate to the Dithkalay tribal general council as the supreme governing body.

This synopsis is a compilation taken from the interviews that I conducted. Without exception, each individual I interviewed discussed the social and political crisis at some point during the interview. The scars of this tribal trauma remain in the community even today, but the healing process has long since begun. Even though there are two military societies, the members assist one another and most Dithkalay attend both annual ceremonies. The socio-political factions in the present community tend to revolve around the three geographically identified groups.

Andrew: "Seems like we Dithkalay always havin' groups."
Deb: "Which group do you belong to?"
Andrew: "I couldn't say. Ain't the same two groups today as back then. Now it's those other folks, the ones down [names a geographic place] that's always a' stirrin' things up. For me, I jus' stay away. When I was in the political circle, was always askin' people to get together, ain't no good to be a' arguin'. Now, well, I got no place in there. Not in my condition."
Deb: "You have diabetes, right?"
Andrew: "Ya, an' that sugar it's gone to my eyeballs I guess."
Deb: "Did you have trouble with your eyes before that?"
Andrew: "Sure 'nuf. I wore glasses up to 'bout a year ago. Lost 'em when my car got on fire. Thick things, but we well, the tribe, we ain't got no money to get more. 'Sides, wouldn't do me no good now anyways."
Deb: "Were you driving before you lost your glasses?"
Andrew: "Got my first one's back in the service, forty-four or forty-five I guess. Never had no problems with 'em 'cept when I was workin' those dynamite fields out west. The boss man, outta there made me wear special ones. Made lots of money doing that. But I give it up when they can't always find what they'd set before. Got scared I guess, that stuff could go up sky high. Quit drivin' back, oh, 'bout eight year

ago. Right after I had wreck out there. Danielle, she tol' me she heard that owl a' hootin. Guess I got scared that something was a' pointin' its finger at me. Havin' that wreck, an' all."

Deb: "So who's been driving you around?"

Andrew: "Mostly I get around me-self. If in' I need a ride somewheres usually Rosie or the boys [his nephews] takes me. Don't want to be no big drain on them."

Deb: "So how long have you had sugar problems?"

Andrew: "Well, for real now, oh, 'bout twelve, maybe fifteen years. I got that sugar poison in my system. It ain't so bad though, ain't lost no parts of me yet. Look at my Sister. Sister, she I feel sorry for. It started with her big toe, tumed black, ya' know. Pretty soon those docs took it off right up to her knee. Now they've taken the other side [amputated], her whole foot. Sisters couldn't help her no more. It sorta made her a little off in the head. She don't talk no more. They had 'ta put her over there in [names a town and nursing home]."

Deb: "Have you ever thought about that, maybe losing a limb?"

Andrew: "No. Don't do no good to worry 'bout what ain't happin'in."

Deb: "If the docs did say that to you, who might you talk to about it?"

Andrew: "Well, I guess it 'a depend on whether I took that guy [the doctor] serious like."

(long pause)

Andrew: "I guess it's kinda like this. See, he been telling me 'bout my eyes for a while now. Says he can help 'em some. I got this stuff on 'em...uh, what they call it? You know, that film..."

Deb: "Cataracts?"

Andrew "Ya! that's it.

(long pause)

Andrew: "If that old lady were still alive, I'ld have Rosie talk with her 'bout fixin' it up. She could do that you know. Seen her lots a times, fix folks up. She get that long blade o grass, she'd work on 'em for four times. Then she mixes that stuff up, leaves it on their eyeballs for four days. Don't even think we kin find them roots anymore. Now a'days, them guys want to take a knife to ya. Ain't riskin' that, no need to, if'in you ask me."

Deb: "But if the doctors could help you see better, wouldn't that be a good thing?"

(long pause)

Andrew: "Well, that's dependin'. See I ain't so sure it'id work on me. Why take that, well, it's chanc-ey. Long as I got the boys [his nephews] to he'p me, don't need to. get around alright. (pause) Don't be a discussin' this with Rosie though. She's thinkin' I ought to do it."

Deb: "Have you discussed it with your nephews?"

Andrew: "Nope. I gotta decide that for I go talking to them [seeking advice]. Don't wanna be worryin' them for nothin. Got to give the matter serious consideration. Could be complications."

Deb: "You mean complications following the surgery? I hear that it usually is pretty successful. Takes time to recover though and they can only do one eye at a time. So I guess it's really two operations"

Andrew: "Well, see, there ya' go. It's twice 'round and that 'id be two chances."

Deb: "Two chances?"

Andrew: "Of stuff goin' around."

(long pause)

"That's why I ain't gonna worry those boys or none."

(long pause)

"See I ain't what I usta be. Jus' go ask any Dithkalay, they'll tell 'ya. We all got our own kinda power. But, well (pause) mine's gottin' kinda di-luted, thinned out I guess. Those boys, well, they'd be obligatory to be remindin' me 'bout that. That's why I quit [driving] after that wreck. I knowed it was time. "

Andrew Pearson, April 1996

My interview with Andrew had taken place almost a year prior to the phone call from Rosie requesting my "transport" assistance. Prior to this excerpt, Andrew's and my discussion had focused on Dithkalay political structure and his role as a former Dithkalay business committee member. As is usually the case when the dialogue proceeds to include health, Andrew immediately utilized the appropriate four-part structure for discussing the topic. I was accustomed to this by now. More importantly, what Andrew said in the course of

our conversation revealed more about himself and the strategies he engaged in for the specific purpose of saving face (c.f. Goffman 1959) than it did about his actual state of health. Andrew accomplished this by locating himself within the social structure of the Dithkalay. In responding to most of my direct questions Andrew described the social relationships that he believed were pertinent. Andrew's answers revealed the important connections he makes between himself, his family, and other Dithkalay. While the overt topic was his health, the real topic was Andrew's status in the community.

There seemed to be two over-arching factors that influenced Andrew as he discussed his blindness. One was how to negotiate the definition of a healthy body as it is defined by the community and the other was how to retain what status or personal power he felt he still had. Andrew's diabetes (as a chronic illness) and now his loss of sight were observable and symbolic to the community-at-large of a waning of his power. Most Dithkalay were well aware of his thrice-weekly trips to the hospital for dialysis, although it was not publicly discussed. Nor were his observable navigations around the tribal complex using the curb or other features to make his way ever a matter for public discussion. In assigning an etiological basis for Andrew's continued ill health the community had concluded that it was the direct result of his political indiscretions twenty years earlier. However, in establishing causality the community had not relied on Andrew's singular health status. At the community level, establishing an etiology was accomplished by constructing comparative relationships. One variable was the socio-political relationship of the three middle-aged men involved. The other factor was the health status of the men in relationship to each other. One of the men was now deceased, the other had suffered a massive stroke two years

earlier that confined him to a wheel chair. In the community's perception, the health-related state of all three men involved demonstrated an absence of power and the common factor between them was their economic indiscretion many years prior. Andrew's social status had consequently dropped in spite of his efforts to present himself as self-sufficient and able to care for himself with the assistance of family members.

At some point throughout the process Andrew had internalized the community's interpretation. Now it influenced his decision to "ignore" or deny any potential benefit that he might accrue by having cataract surgery. He had accepted that he had to undergo dialysis; biomedical practitioners had convinced him of that. Removing the "sugar poison" from his system was not something his family could do. But undergoing cataract surgery with an unknown outcome was not an undertaking Andrew was willing to do. If it was unsuccessful he potentially could lose additional status, the result of a less-than-positive outcome.

Most significant in Andrew's dialogue was his obvious reticence to undergo the proposed cataract surgery. In his own words it was "chancey" and "twice stuff could go around." The "stuff" that worried Andrew was the presence of evil power. In his final remarks on the subject Andrew made clear that the presence of power, as he interprets it, is not located in one place, but roams about actively seeking persons who are vulnerable. Living with diabetes and his vision further hampered by cataracts, Andrew was not willing to risk any further loss in status at the community level nor was he willing to risk any confrontations with his personal power on an individual basis. It seemed to me at the time that he simply had not encountered the situation that would provide him with the motivation to undertake surgery. He had Rosie and Danielle who took care of

him, his nephews who looked after him, and he had found the way(s) to navigate his dignity within the etiological opinion of the Dithkalay community.

Having sight, as a symbol of a healthy body, does not seem so far-fetched given the Dithkalay's traditional lifeway pattern as bison-hunters and gatherers. The inability to see as a bison-hunting male provider, or the inability to produce a pair of moccasins as the female counterpart, most likely relegated the sight-impaired individual to a dependent position. Certainly it can be argued that the absence of sight is considered an impairment among most groups of people. According to the American Medical Association (AMA), approximately 214 persons per 100,000 in the larger Anglo culture are legally blind (Clayman 1989:180). However, the difference between a biomedical perspective and that of the Dithkalay is that the AMA assigns causality as stemming from "injury, disease, or degeneration of the eye or optic nerve" (Ibid). For biomedicine and its practitioners there is no evidence for a sociologically-based vision impairment. For the Dithkalay, the absence of sight can have a sociological basis; it can be related to the inappropriate interactions of an individual at a community-level.

I served as "transport" for Andrew a number of times over the next few months. On one return trip from the Indian Hospital, Andrew renewed the discussion of cataract surgery.

Andrew: "Gotta ask 'ya somethin'."
Deb: "Sure."
Andrew: "Rosie, well, she's really pushin' at me, you know on this marriage thing. Says it ain't right for Danielle. She [Rosie] don't like what her Daddy sayin' to her neither. She says we otta get married. We's just like that, takin' care of each other in all. I jus' don't know. Seems like it might change things, you know."
Deb: "How do you feel about it?"

Andrew: "I'm a guessin' it id be better for Danielle. She get a share an' all when the times come."

(pause)

Andrew: "I jus' don' feel right about it an all. Seems like it ain't fair to Rosie. She'd be stuck with me an' all, with my con, well, situation an all. She says she don't care, but I'm thinkin' she might in the end."

(pause)

Andrew: "Get married, well, things is supposed to happen. Changes you know."

Deb: "What kind of changes? You and Rosie have been living together for sixteen years. Seems to me you have made all the adjustments you needed to already."

Andrew: "Well, that ain't it. It' id be my job now, you know, to take care of her. Right now, well, she takes care of me an' Danielle. Somehow, it don't seem right to be a'straddlin her with me, legal like, you know."

(long pause)

Andrew: "Do you think I could do that surgery? What you think about it? Does it always work?"

Deb: "All I know is that my mother-in-law had it done a few years back and it worked really good for her. I guess it took a while, you know. She couldn't bend over, that would put pressure on her eyes and she had to wear those special glasses for awhile."

Andrew: "How long's it take?"

Deb: "That I don't know. Why? Are you thinking about having it done?"

Andrew: "Don't know yet. Jus' thinkin' 'bout it."

October, 1996

Andrew did "think about it" and, over the next six months underwent two successful cataract surgeries. In early May I received a wedding invitation; Andrew and Rosie were getting married. For Andrew, Rosie's insistence on marriage had not only provided the impetus to overcome his reticence for the surgery, it also created a means for Andrew to re-negotiate an increased status in the Dithkalay community. The import of Andrew's success at mediating an

increase in status was verbalized by other people in the community. Specifically, in making plans to organize another men's focus group, I was informed

> "We need to hold the next focus group for mens on a Tuesday. That way Andrew can be with us. He's one of our elderlies, you know. His input will be valuable He's got considerable knowledge, specially on the old ways."
>
> Angus Carroll, June 1997

Having a social-behavioral etiology for a prolonged or inexplicable illness among the Dithkalay can, at times, have consequences that extend beyond the individual who is experiencing ill health. Here, the case of "Aunt" Rachel Richardson serves as an excellent example.

Aunt Rachel had suffered over a length of time, approximately one year, with non-descript (i.e. lacking a "positive diagnosis") illness symptoms. At times, it was her stomach that gave her trouble, generally described as nausea during meals or subsequent indigestion. On other occasions she complained of facial neuralgia, difficulty walking, and of "pains in [her] back startin' between the shoulder blades and just shootin' everywhere," that kept her awake at night. At one point she was diagnosed by the local IHS clinic physician as having hypertension.

The first time Aunt Rachel discussed her symptoms with me she said she thought that "her sugar was gettin' the best of" her. Aunt Rachel was diabetic having been diagnosed with Diabetes Mellitus about five years earlier. Based on my interactions with her I knew that she monitored her glucose level carefully and was conscientious about taking "them sugar pills." I asked Aunt Rachel about her intake of fluids; had that increased, or was she experiencing any dizzy

spells? She told me "No," that she "just don't feel right, just not" herself. It was late August and the day-time temperatures were over 100 degrees. Having lived with Aunt Rachel, I also knew how warm the inside of her house was. Even with a fan running constantly, the indoor temperature rarely fell below eighty-five degrees and that was usually around five o'clock in the morning. Perhaps she had heat exhaustion? Nevertheless, I knew Aunt Rachel's fictive "sister" Robin, who usually drove her to the clinic, had left earlier in the week to visit relatives in the Southwest. I offered to drive her to the clinic the next morning.

Rachel: "Long way out to the country here, thanks. I hope it don't take too long, I didn't eat no breakfast. Run me by the smoke shop first. If 'in I gotta sit, I'll get nervous. Smokin' calms me down."
Deb: "As soon as we're through at the clinic, I'll take you to get something to eat."

Our trip to the clinic occupied the greater portion of the day. Aunt Rachel's appointment was for ten o'clock that morning; we had arrived at nine-thirty. When we arrived most of the chairs were already occupied by other people, but I finally located two adjoining available seats. I settled Aunt Rachel in one and went to check her in. By now I had learned the appropriate social rule for not instigating health-related talk in public. I waited for Aunt Rachel to open the conversation. She did not. We waited in silence for over one hour before the clinic practitioner called Aunt Rachel's name and sent her off to the laboratory for blood tests. I wondered what circumstances or information may have been documented in her health history that precipitated the need for blood tests prior to her seeing the nurse practitioner or physician. I said nothing to her or the laboratory assistant. Again we waited. By now it was after twelve noon

and I was beginning to worry about Aunt Rachel not having eaten. Finally, around one o'clock she saw the physician. Aunt Rachel emerged from the physician's office fifteen minutes later. She had a dispensary note in her hand.

> "He says there ain't much wrong. Got to quit the beans and slaw. Least a'ways it's not my sugar. That's a relief. Says to cut down on meat, use chicken. He don't know (she laughs) how us Dithkalay gotta have our beef. Chicken. Umph! Chicken's only good for soup, lessen' it's fried. Then they'll holler 'bout that."

I looked at her dispensary note. It was for a 250 count bottle of Maalox tablets.

The second time Aunt Rachel discussed her symptoms with me was a few months later. It was early fall and Aunt Rachel and I were documenting her family's genealogy. We had eaten together at the noon meal served to the elders at the tribal complex and I noticed that she taken her two Maalox tablets. What amazed me was the manner in which she did so. With a "slight of hand" that a magician would admire, Aunt Rachel had taken her prescribed pills so that unless one was explicitly taking notice (as I was) her consumption of the medication was virtually non-observable.

I knew better than to ask in public so I waited until we returned to the Dithkalay Culture Program office (to further pursue the documentation of her genealogy) before approaching the subject.

Question: "Are the pills helping?"
Rachel: "I'm gonna quit after this batch. Don't know if it's them 'er not. My stomach don't bother me anymore, if that's yur' question. Christa [her daughter] says, "Momma, you jus' worry too much." Tha's all tha's wrong. Maybe she's right. It ain't my stomach. It's

like I was tellin' you this mornin'. This pain, I got over here (she puts her hand over her right eye and checkbone), that's the trouble. Keeps me 'wake. Jus' stabbing and a wrinklin' up this side of my face. Can you see it? I can if 'in I looks really close. I asked Robin if 'in she could.

(pause)

Sister [Robin] brought me some cream, I been puttin' that on, but don't help. Maybe I should go see that Doc over at the [IHS] clinic. Haven't asked Sister yet, haven't decided. Now, that old lady there (pointing to the symbol indicating a member of her genealogy), she had bad pains. Not jus' in the face, all over. 'Course it wern't her fault none. She been in that sanitorium, they got her hooked on some stuff. Boy you could hear her holler at times cuz it ..."

The week following Aunt Rachel's description of a new set of symptoms, she and Robin appeared in the doorway of the Dithkalay Culture Program office. At the time Angus, Leroy (both middle-aged Dithkalay), and I were involved in completing the documentation of the Dithkalay's original allotments using topographical maps. As the two women stood in the doorway, Robin signaled with her finger that she and Aunt Rachel wanted to speak with me. I excused myself and as I approached Aunt Rachel and Robin, Aunt Rachel said, "I gotta go smoke." I knew this was my signal to follow them outside; whatever they wanted to discuss neither Aunt Rachel or Robin were willing to risk having it overheard.

Robin: "Gotta ask you a question."
Rachel: "What in the hell is nur-all-gee-iac?" (I could tell by the tone of Rachel's voice she was clearly upset)
Deb: "I'm not sure. What are, who said that to you?"
Robin: (looking at Rachel to be quiet) "Well, I took her over to the clinic just now and he [the doctor] says she's got a facial nur- allgia. Is that serious?"
Rachel: (interrupting) "He's askin' me 'bout headaches and

such. I told 'em I ain't got headaches, I got this pain that keeps hurtin' over here. I told you 'bout it.

Deb: (looking at Rachel) "Did he maybe say you had a facial neuralgia? Did you ask him what he meant?"

Rachel: (starting to calm down) "Yea, that sounds like it. You sayin' it the same way. But he didn't say what, what's it mean? 'An why's he's askin' me those other things? He's one a them Indian folks [Middle-eastern]. Didn't hardly understand nothin' he's sayin'. I asked to have a nurse in there, he says to me it ain't necessary. He's jus' plain ig'nerant !! Why not, I ask him, they're [the nurses], those women are jus' standin' around out there, not doin' nothin."

Deb: "Aunt Rachel, it's ok. What he means is that you have a pain in your face. Neuralgia means pain, facial just says where the pain is. The..."

Rachel: (interrupting) Well, hell I know that! That don't say nothin' I don't already know. (she throws her cigarette on the ground) It's keepin' me awake. I wanna know what he's gonna do 'bout it?

Deb: "Well, that's why he was asking you about having any headaches. Sometimes the neuralgia you are having can come from migraine headaches."

Robin: "See, it's gonna be ok. It's jus' migraines."

Rachel: "Only-est one givin' me migraines is Christa [her daughter]. She jus' makes me feel poorly.

(long pause)

Migraines, uh. Well, I can live with that."

The conversation between Aunt Rachel, Robin, and I illustrates one of the difficulties encountered in the medical dialogue between the local IHS health-care practitioners and Dithkalay patients. At times the medical dialogue exemplifies dyadic mis-communication. On one hand, given the Dithkalay's hesitations to reveal more health background or symptoms than they believe to be absolutely necessary for a diagnosis, physicians are sometimes required to repeat the questions. On the part of physicians, the repeated questioning - without further explanation - stonewalls productive dialogue with the patient. In

Aunt Rachel's encounter, the situation was most likely exacerbated by cultural differences. When the physician denied Aunt Rachel's request to have a nurse present, he also invalidated her cultural understanding of appropriate cross-gender interactions. In turn, by not having the necessary female presence, Aunt Rachel's discomfort increased to the extent that she did not ask the physician for a clarification of his diagnosis.

Mid-winter Aunt Rachel developed a new set of symptoms. I had talked with her earlier in the week and she asked me to come and spend the weekend with her and make her some of "that I-talian lasagna." I noticed that she seemed to have lost some weight and lacked her usual ribald humor. I agreed to come that weekend.

I arrived in the early evening on Friday after leaving the tribal complex. Aunt Rachel had beef, onions and potatoes cooking in her slow roaster for our evening meal. I agreed to make the fry bread. After dinner we sat and talked and she said she was "worried about Christa and the money thing." I had heard the rumors concerning Christa and the military society's money through other women. It seemed that Christa had assumed the job of collecting the monies necessary to properly carry out the Dithkalay annual military ceremony the previous summer. The funds under discussion were the proceeds from raffling-off prizes, donations, and from the sale of refreshments. Generally the proceeds were used to pay the bills associated with the ceremony; the master of ceremonies, electricity, preparation of the dance grounds, to mention a few. That Christa had assumed responsibility for collecting the funds was not the difficulty. Indeed, this was fairly common. As it was relayed to me, the problem was that

"Christa has broken protocol. It's ok for [the] women to collect it all, ya' know, but we's 'sposed to hand it over to that man [the whip] soon as that ceremony's over. It belongs to the mens, we're jus' there to help 'em do it right."

Beatrice Toomish, February 1997

As Aunt Rachel and I talked, she confided that she knew "peoples [were] startin' to talk." Meaning, Christa's failure to follow the proper procedure was the basis for some recent community gossip. I asked Aunt Rachel if she had discussed this with Christa. She said she had, but that Christa was "thinkin' she can do a better job. She's an accountant [bookkeeper] you know." She went on to tell me how Christa's management of the funds was causing stress among the women. This I also knew about; a few of the women having previously approached me about Christa's behavior, seeking my opinion on the situation.

The Dithkalay women involved were the female relatives of the men who were members of the one military society. In listening to the women's dialogue, it seemed to me the dividing lines were not following the usual patterns, that is, divisions based on family or geographic locations. Instead, the conflict seemed to be an inter-generational issue. The younger women tended to "side" with Christa and offered her their support for managing the military society's funds. The older women stated her "behavior's unbecoming; it's not right."

Nonetheless, Aunt Rachel was seemingly distraught over the conflict among the women, being related to the person who was a subject of gossip (albeit on the perimeter), and unable to "ride herd on these young folks anymore." For Aunt Rachel, the Dithkalay's lifeway was "takin' a turn for the worse." She announced that Christa was coming over to the house tomorrow so

that she, Aunt Rachel, "could get some sense into [Christa's] head 'bout returnin' that money."

Christa did come by Aunt Rachel's the next morning. But Aunt Rachel never did talk with her about the military society's money while I was present. When Christa arrived she had a friend with her; her friend was a member of a different extended family in the Dithkalay community. I excused myself by saying I was going to visit Uncle Hal (fictive "brother" of Aunt Rachel, both of them being of the same generational group). As I drove to Hal's, I remember thinking to myself that if I were Christa and Dithkalay I might have engaged in a similar tactic; bringing a non-family member into the home. I too might rely on the traditional boundaries governing family regulated talk in order to avoid a confrontation.

When I returned a few hours later, I found Aunt Rachel in bed. She refused to get up, stating she had "these horr'ble back pains that were killing her." I heated some of the previous evening's lasagna for supper, but Aunt Rachel refused to eat; her nausea had returned and she "didn't have no appetite for food, specially nothin spicey."

Around two o'clock in the morning, I smelled something burning. I got up, concerned that Aunt Rachel had fallen asleep with a cigarette burning, even though I could hear her talking. As I wandered into the "front" room I saw Aunt Rachel. She had filled an old cast iron kettle with dirt from the front yard and was wandering around the house carrying it. Inside the kettle were burning coals. Aunt Rachel was burning a mixture of sage and cedar, saying "go away, you bad things. I gots to feel better." As soon as she saw I was up, Aunt Rachel asked if I had any "tapes" in my car. (It was relatively common knowledge that I

carried taped recordings of Dithkalay songs in my vehicle; some were taped at the Dithkalay annual military ceremonies, others came from two local radio broadcasts that included Dithkalay gospel songs and traditional music). I said that I had some and immediately went to get the tapes and my tape player. We played the tapes and Aunt Rachel "smoked" the premises (smoking is the Dithkalay's term for the more common one of "smudging"). About one hour later she stated that she was exhausted and ready to sleep.

I awoke around seven-thirty on Sunday morning; all was quiet. Aunt Rachel seemed to be sleeping. I made coffee and waited for Aunt Rachel to appear. By nine o'clock, I was concerned so I went to look in on her. Aunt Rachel was awake and, according to her, had been for some time, but "jus' didn't have the energy to get outta bed." Her back was "a botherin' her" and she wanted to be left "outta things, at this point." I made the decision to telephone Robin, who, in turn called Beatrice. Two hours later, Robin and Beatrice appeared at Aunt Rachel's house, announcing they would "look after her." In making the decision of whom to call I realized that I had in many ways become Dithkalay; I knew who Aunt Rachel's primary care-givers were. However, when Robin and Beatrice appeared I also had to address that I was the resident anthropologist with a particular status. I had specific, often conflicting responsibilities, some to the research program and some as an adopted member of the Dithkalay community. I turned the care of Aunt Rachel over to Robin and Beatrice willingly.

I had very little direct contact with Aunt Rachel over the next month. I felt it was my place to stay on the periphery and wait until I was approached by the appropriate family members. Yet the dialogue among the women (via gossip)

continued to focus on Aunt Rachel's health situation. The over-arching questions seemed to be "Why was this happening to her? Why was she not recovering?" Most of the women who talked to me about Aunt Rachel's health situation felt that IHS biomedical practitioners "lacked knowledge" Their condemnation was directly related to the absence of a specific diagnosis. Without a conclusive diagnosis, Aunt Rachel was, in their opinion, being denied the information she needed to rectify a waning of her power and to gain control over her physical self. It was the lack of specificity in diagnosis that provided the fuel for the dialogue among the women.

Erma: "See, that's the way it is. We leave it to the family, they's the ones what has to decide."

Beatrice: (in a challenging tone of voice) "So, you gonna be the one to talk to brother?"

Erma: "Well, some one of us got to bring it up, least a' ways."

Deb: "Aunt Rachel isn't any better? I thought I saw her here the other day. She seems to be getting around now."

Beatrice: "Yea, but she can't get no breath 'causa them pains in her back. I took her the other day over to the Wal-Mart. Over there, we, she had to rest up on me twice. I was hoping she'd buy somethin to fit [clothing]."

Dorothy: "Did they [clinic practitioners] take a chest x-ray?"

Beatrice: "It ain't her lungs. She feels bad, jus' look at her. Why she hasn't got no energy. She don't eat. She's gettin' weak it seems like. Walks like that old lady."

Erma: (in a hushed tone, barely above a whisper) "Maybe it's the change that done it [menopause]?
(long pause)
It almost killed my momma."

Dorothy: "Well, I don't hear her making no more jokes about men and all." (the women all laugh)

Beatrice: (laughing) "Not since that forty-niner over there at (names a dance ground). She bouncin up and down, that fringe of her's [on the dancing shawl] just slappin' up and down." (they all start laughing)

Dorothy: "She saddled up to that old man [names a tribal member]"
Beatrice: (still laughing) "Darn near scared that old man to death. He's backin', he's backin' away, jus' as fast as he can. Look on his face, well, you would 'a thought she'd hooted..."
Dorothy: (interrupting) "Way his eyes blew up, he looked like the owl."
(the women are laughing hysterically. Then silence)
Beatrice: "That old lady, ya know. Well, she been gone how long now? Twenty-five, thirty year?
Erma: "Longer 'en that. I remember her though. She come by an' stay with us after the old man died."
Beatrice: "Dropsy. That's what they said took her."
Dorothy: (turning toward me) "You don't 'spose it's her heart do you?"

Women's Focus Group, March 1997

Up this point the dialogue of the participants in this women's focus reveals two important aspects. First, there is the articulation of a number of significant Dithkalay beliefs about what constitutes a healthy body. The consensus of the women is that bodily mobility is an important indicator of a healthy body. Being mobile is similar to Andrew's perception of being "able" that I discussed earlier in this chapter. Specific to Rachel, other visible signs of impairment included Rachel's need to "rest," how "she cannot catch her breath," and the alteration in her body from weight loss. As stated by Beatrice, Rachel was getting "weak." Beatrice's reference to Aunt Rachel's weakness is both real and metaphorical. The lack of strength to motivate without disruption is a symptom of physical weakness. For the Dithkalay, visible weakness resulting from biologic disfunction is symbolic of the weakening of an individual's personal power.

The second important aspect embedded in the women's dialogue is the way in which the women's discourse debates the diagnosis for Aunt Rachel. In the course of the women's discussion a number of causes were put forth: lung

ailments (Chronic Obstructive Lung Disease could be suggested), menopause (as related to a noticeable decrease in sexual drive), and "dropsy." Dropsy is an out-of-date term for generalized edema or the collection of fluids in body tissue (Clayman 1989). Edema is especially related to congestive heart failure. Dorothy, who has some medical training picked-up on that as an additional potential cause for Rachel's state of health.

Erma: "Wouldn't them guys [physicians at the clinic]over there know that? They told brother when it found Grandpa Horace. They give him them pills. He couldn't breathe neither 'til after he start takin' them.

Question: "Do you know, have the clinic physicians talked to her about her heart? (turning to Dorothy) You know, the indigestion she complains of off-and-on might be angina."

Dorothy: "Aunt. Aunt. Aunt Beatrice! What did they say about her stomach pains? Did the guy check her heart?"

Beatrice: "He said it weren't her heart. Depression, he said."

Erma: "That's what happened to Momma after the change hit her. Don't seem like that to me."

Robin: (speaking for the first time). It's prob'ly depression now. Depressin' me. Seems to me, every time Christa comes 'round Rachel she's, well, she's getting sadder. 'Ta other night, well, she jus' let Christa go on and on 'bout that new program we got. She didn't say nothin 'bout not feelin' good."

Beatrice: "Depression don't make you sick."

Erma: "Those doctors over there, they just patch us up. If it can't be fixed with a bandaid or asp'rin they've not got the time. Don't want to be bothered with us Indians. Send us to a specialist, get us outta their hair. Most times those specialists, they don't know neither. Look what they did..."

Robin: (interrupting) "They've had plenty a' time. Specialist is the one saying it's depression." (pause)

Dorothy: "How long has it been?" (pause)

Erma: "Long time, seems like." (pause)

Beatrice: "Been since last summer."

Women's Focus Group, March 1997

This portion of the women's dialogue signifies a shift in the directional flow of the conversation. Specifically, the direction of the conversation shifted from a discussion of Rachel's varied symptoms to a critique of the biomedical practitioners who have been consulted at various points in Rachel's illness experience, and with their final remarks on the subject, an implied consensus had been reached by the women. The consensus was it was time to look elsewhere for both an etiology and a remedy. The diagnostic abilities of biomedical practitioners had failed to produce a conclusive diagnosis, or so the women involved in this discussion believed. More importantly, the women drew on their own previous experiences with illness among other tribal members and they used those experiences to dismiss a biomedical diagnosis of depression for Rachel. In dismissing the validity for a diagnosis of depression, the women also established that all other biomedical diagnoses ought to be discounted. As Beatrice stated it, "the medical practitioners have had plenty of time" to establish the source for Rachel's biologic disfunction.

The third time Rachel discussed her health status with me was the week following the women's focus group. She had attended the noon meal at the tribal complex and stopped by the Dithkalay Culture Program office afterward. I was alone at the time and she opened the conversation with a discussion of what had been served for the meal. She said nothing about indigestion, back pains, nor did she appear to be out-of-breath. The problem, she said, was "this poundin' in [her] ears." Aunt Rachel described her difficulty as being unable to lay on her side at night because she could hear her heart "a' racin, like them ponies used to pound." I asked her how everything else was going. She replied that she had "given up on them doctors. [She] made a big pot of beans and side meat for

dinner the night before." I inquired as to whether she had discussed her heart-pounding with anyone; she had not. We went on to talk about other matters. Saying she had business with one of the other Dithkalay programs, Aunt Rachel soon departed. I was left with the feeling that she had wanted to ask me something, but that in the course of our conversation she had changed her mind.

The next afternoon, Beatrice and Uncle Hal approached me.

Beatrice: "I've talked with brother here."
Hal: "We're gonna' have a meeting for sister [Rachel]. We're gonna put up that tepee and have her in. We could use some help."
Deb: "When are you putting the tepee up? Friday?"
Hal: "Week from, is best. We need some time to get all set up for it. Are you gonna be here?"
Deb: "Not this Friday. Next Friday? I can be, not a problem."
Beatrice: "Well, me 'an Robin, Riva, Dorothy. We're gonna cook the breakfast meal. I'm gonna ask Corrine and Ema."
Deb: (looking at Hal) "Are you leading the meeting?"
Hal: "No. I've talked to Uncle [names a tribal member]. He's our roadman. He'll conduct it. I'm gonna assist."
Deb: "Witnesses?"
Hal: "I've talked to the boys [nephews] an' they're set. Sister here, says, it's important. Got to get it underway now. She comes to me a few days ago. I take it to Uncle, he says ok."
Deb: "Where are you going to hold it?"
Hal: "Out at my place, I'll sponsor"
Deb: "Ok. (turning to Beatrice) I'll bring my big fry pan?"
Beatrice: "Sure would help."

I now understood what the quiet and implied consensus of the women who had participated in the recent focus group (where Rachel's ill health was a subject for discussion) entailed. The view of the Dithkalay women involved was

that the appropriate remedy was to hold a Native American Church meeting. Following the appropriate pattern for such an undertaking, one of the women involved in the focus group had approached a Dithkalay male who had the proper credentials to negotiate the undertaking.

However, as the situation of Aunt Rachel's illness experience played-out, it was not a simple matter of completely discounting biomedical diagnostics and curatives and moving on to another sphere of possible remedies. During the ten days in which the arrangements for a Native American Church meeting for her were underway, Aunt Rachel once again visited the local IHS clinic. According to Robin, Aunt Rachel was being "belligerent and mean-spirited cuz of the pounding in her ears." Robin had taken Aunt Rachel to the IHS clinic and the physician on call had diagnosed her problem as hypertension. Aunt Rachel was put on beta-blockers to reduce her blood pressure and told to monitor her blood pressure that had registered at the IHS clinic as 175 systolic over 130 diastolic. The physician told her to return to the clinic for a follow-up appointment in two weeks.

> "Now how's we 'sposed to do that? I can't be drivin' her to the Wal-Mart twice't a day to check her pressure, 'ya know. She's my aunt, I know, but I got Devin [Robin's grandson] to think about too! She [Aunt Rachel] says she ain't gonna get a ride to Dorothy's office twice't a day to do it. (pause) I guess I could ask those girls over in CHS [Community Health Services]. (pause) What's 'a matter with you?"

I responded to Robin's consternation by explaining that I had a portable "machine" (a battery-operated sphygmomanometer) that Aunt Rachel could

borrow. I told Robin that it would measure Aunt Rachel's blood pressure and was a machine that she could operate herself. I agreed to bring it to Aunt Rachel and to show her how to use it. In the meantime, preparations for the Native American Church meeting to alleviate, and hopefully to resolve, Aunt Rachel's illness experience were underway.

The Native American Church as a source for spiritual guidance or as an indigenous medical remedy is not new to the Dithkalay. According to Dithkalay elders,

> "It come to us from way back. It was given to us by our Dithkalay relatives when they come from down south. Well, when the government put us all together [confined to the same reservation], they show us how to use it. How to pray with it. We take it up. It's our way, it's our Indian prayer.
>
> Alan Colbert, November 1996

The socially integrative and/or medicinal uses of peyote among many Native populations has been examined by others (see for example Hill & Beals 1966, Le Barre 1975). Among the Dithkalay the motivating factors for having or participating in a Church meeting may be a birthday celebration, to give thanks, for spiritual renewal, and as a remedy for illness.

> "Mostly we use it to honor someone or for sickness. It's not for using regular like, say like going to a White church. It's got to be respectful. It's our Indian religion. You got to respect the power inside that tepee."
>
> Alan Colbert, November 1996

The term for the male who conducts the meeting is "Roadman" or "Peyote Chief." Within the community I knew of two chiefs, each one having inherited the songs, paraphernalia, and procedure from a male family member who occupied the position. Consequently, specific aspects of the meetings do vary, depending on whose "road" is being followed.

The days preceding the meeting are devoted to the proper preparations. The women involved (usually female relatives of the sponsor or of the individual experiencing poor health) accumulate the necessary foodstuffs for the required closing breakfast and the following day's noon meal. Men, under the guidance of the sponsor and Roadman erect the tepee and prepare the interior.

> "In the past, we sat on the ground, in winter time might be really cold by morning. You wasn't 'sposed to leave from start to finish 'ceptin' for emergency. First time I went, I guess maybe late teen-ager, no - maybe, early twenties. Curiosity, you know. Grampa says to me, you just watch and listen. Start out as witness you know. I don't say nothing, don't want to interfere with them songs. Later, I get involved, now I pass it on to [names a current Roadman]. gets harder when you get older, my age (he chuckles), get kinda stiff. You know what I mean? Now a'days it's better. They put straw in there, push it up kinda along the sides. Helps keep the wind out. Lay out a bed [of straw], cover it up with blankets for folks to sit on."
>
> Alan Colbert, November 1996

Traditionally women were not active participants in the meetings, the exception being if a female was ill and the meeting was being sponsored on her behalf; then she would attend. One of the distinguishing features between the two roads in the present community relates to the extent that women are allowed

to participate inside the tepee. One roadman permits a woman to both "witness" (observe the meeting) and to "participate" (consume peyote and sing) provided she has proper knowledge of the songs and procedure. The other roadman maintains stricter guidelines where a woman may only witness, unless she is the intended recipient for the meeting's curative powers. Some Dithkalay women who desire the more spiritual aspects of the Native American Church do participate in Church meetings among neighboring tribes where the gender restrictions are more lenient.

The meetings usually begin between eight and nine o'clock in the evening. The women assisting spend the meeting hours (until approximately sun-rise) preparing the closing breakfast and begin preparing the noon meal.

> Long time ago, we didn't have a water break at midnight. The chief he would put out the fire and talk to that power. He'd say, come and help this person here or he might just talk to it about helpin' the people. That one man though, he would kinda do it wrong maybe, then somethin' would go wrong with it. So the old ones, they say, we got to stop this, so now we take a break. Two actually. We got a break at midnight, then at four. That woman, she's in charge of the water. She brings it to the tepee and passes it in. That's her responsibility.
>
> Hal Kantor, March 1998

The water woman is usually a female relative of the sponsor. Shortly after sun-up the meeting will draw to a close and breakfast is served. Among the Dithkalay, the breakfast meal is consistent in both roads and is comprised of water, corn meal mush, fruit and dried beef.

The Dithkalay have a rather pragmatic attitude toward the efficacy of peyote as a curative; its curative powers are not effective for episodic disease, such as a broken bone, or for terminal illness like cancer. Brewed as a tea, peyote has alleviating qualities for pain, whether the discomfort is temporary, as in the case of a toothache, or chronic, such as arthritis. However, in the context of a Native American Church meeting, the curative power of peyote should be relatively immediate.

> "I seen it happen in there. Some time ago, it worked for [names a now deceased tribal member]. He had that problem, you know, he can't stop it from movin'. No control over his body, he jus' (pause) what they call that? [calls over another tribal member]. What's that, that [names the victim of the disease] had, you know where, he just kep' dancin' around? Couldn't stop his-self. He's gone now, but I seen it. The old man [roadman] he takes him in there and he prays for him. He drums, sings them songs, passes that smoke over him with that fan. (pause) That dancin' well, it stop it right there. He didn't have that no more. I can't call it up right now [think of the disease], oh, yea, sombody's dancin'. What'a they call that? It left him, jus' like that, never did have it again. (pause) Yea that's it! Vitus dance [St. Vitus' Dance; a.k.a. Sydenham's Chorea].
>
> Alan Colbert, November 1996

The individuals involved, both male and female, were convinced Aunt Rachel would with relative immediacy be restored to good health.

The evening of the Church meeting arrived. The necessary preparations were completed and the designated persons were present; the chief or roadman, his designated drum-chief and his fire-chief. Eleven males were present to enter

the tepee. Five of the men were Aunt Rachel's relatives; one brother and four nephews. The remaining males were members of other Dithkalay families. The Church meeting was a community undertaking; five of the major Dithkalay extended families were represented by the individuals involved. At eight forty-five, the roadman announced that all preparations had been completed; it was time to commence.

Earlier in the evening Aunt Rachel had discussed her inability to go inside the tepee to Beatrice. Beatrice in turn had conveyed this to Uncle Hal, sponsor of the meeting, who then relayed this to the roadman. It was agreed that Aunt Rachel was best served by her not going into the tepee, but the curative powers would reach her in Uncle Hal's house.

The women present included myself, Dorothy, Beatrice, Robin, Erma, Riva, Doreen, Patty (Hal's wife), and Christa. Christa was unexpected, although she had, according to protocol been informed. The women talked quietly; taking turns at preparing food, gently gossiping and keeping an eye on Aunt Rachel for any reactive signs. Beatrice, the designated water woman, kept a constant vigil with the clock.

Erma: (talking to Christa) "It's good you come. Your momma needs all the support she can get."

Dorothy: "Want to start peeling these potatoes for me? We'll jus' set 'em in some cold water. Deb, can you start cuttin' up that meat, it's gonna take all night, 'ya know in that roaster."

Erma: "How you feelin'? [asking Aunt Rachel]"

Rachel: "Oh, I don't know. Seems like this is a' takin' alot of energy. You girls are good to me. That's the way it oughtta be. Now days, you pull up in someone's drive they wanna know, what 'ya doin' here. This is like when we were kids. You know, folks helpin' each

other out. (pause) Seems like it's mighty quiet out there. Can you hear that drum? Don't seem like I can.

Shortly after the four o'clock water break, most of the women moved outside to sit on the front porch. The cool breeze of the early morning air was a respite from the heat inside the house.

Beatrice: "Have you been with your Momma lately?"
Christa: "Yea. I was out to her place as soon as I heard and then again yesterday."
(long pause)
Beatrice: "So, how's it going down at the center [Christa's place of employment]?"
Christa: "Ok, I guess."
Beatrice: "We's all here to help her. Her not feelin' right an' all."
Christa: "Thank you Aunt. It hasn't been much easy lately. I jus' stay so busy, I don't have all that much time."
Beatrice: "These men here, well, and 'specially Brother [Christa's Uncle Hal and sponsor of the meeting], and Brother [names the roadman] they's doin' a good thing for your Momma."
Christa: "I know."
(long pause)
Beatrice: "Don't you think it's time to be helpin' it along?"
(long pause)
Beatrice: "Be thinkin' 'bout it."
(long pause)
Erma: "When did it first come on your Momma?"
(long pause)
Erma: "Right after our annual last year."
Christa: "I hear, I stay away, I heard it from Sister."
(long pause)
Dorothy: (very quietly) "What did you hear?"
Christa: (starting to cry) "It's me. She says, Oh, she can jus' be **so** mean."
(long pause)
Christa: "It's me, ain't it? (she asks the question in an accusing tone of voice). Did Uncle say that?"
Beatrice: "You got to give it up, Christa. It ain't right you holdin' on to that money that 'a way. Look what it's doin' to your Momma."

(pause)

Dorothy: "Well, it's kinda like what they say about not walkin' behind no bundle-holder. Kinda like ya' can't walk behind those mens what got power inside. We's got to follow the rules. Aunt, here, she's right, I'm thinkin'."

Christa: "I don't believe it."

Erma: "You got to. You gonna be responsible? You gonna wait 'til it [personal power] leaves her completely?"

Beatrice: "You got to give it up. We's all callin' it up best we know how. Listen to that tepee. We doin' all **we** can"

(break in the conversation. Christa is sniffling, the only sound is the creaking of the rocking chair that Dorothy is sitting in)

Christa: "Ok. I'll give it [the military society's funds] to Uncle as soon as they come out. Right after breakfast."

N.A. Church Meeting at Hal Kantor's, March 1998

Even though Beatrice, Erma, and Dorothy had spoken in very hushed tones, the moral force of their directives to Christa was felt by all the women present. Following the conversation, one-by-one the women returned to the kitchen, with the exception of Christa. Aunt Rachel, who had been intermittently dozing throughout the evening in a chair, roused and announced,

> "that beef is sure startin' to smell good. Hadn't smel't that good since old man [names a tribal member] come by to visit way last summer. Dorothy, did you put carrots and tomaters in there? I like carrots and tomaters in mine. (pause) Sure does. (she laughs) Hell, I might get me up enough energy to go hunt me down a man."

Beatrice looked around the kitchen at the women knowingly. The culturally understood order for social relationships had been re-established, the healing power of the Native American Church was validated, and Aunt Rachel's health had been restored.

The significance of the examples

Two identifiable processes are illustrated in examining these two cases as closely as I have here; one is social, the other is medical. The connections between the two processes both influence and contribute to the other. Thus, the Dithkalay's discourse of health is as much a commentary on social relationships as it is about the state of an individual's health.

What types of healing the Dithkalay turn to when a disruption in health occurs depends on a variety of factors; resource availability, family relationships and obligations, community-dictated concepts for a healthy body, and cultural beliefs about the human life cycle and personal power. Because the moral authority established by the Dithkalay community encompasses the group's beliefs, the process of illness resolution emphasizes a framework reflecting those values. In turn, Dithkalay cultural beliefs about the accumulation and/or loss of power - as it is symbolized in control over the body - reinforces the authority of the "body politic" (c.f. Locke and Sheper Hughes 1996) to impose the parameters and means for the re-constituting of the individual who experiences ill health.

Some of these boundaries are biologic in nature, such as body mobility, having sight, and control over other physical dimensions, such as weight loss. Others are more psycho-social and involve management of the body in times of distress; seeking health care advice and assistance, negotiating or re-establishing status, and the coming to terms with community perceptions of the individual.

The cases of Andrew and Aunt Rachel illustrate a cultural approach to making sense of illness and the decision-making process for restoring a state of

wellness. In the process of healing Andrew underwent a multifaceted process. As he attempted to mediate the community's perception, his overall goal was to re-create his self-esteem and to restore his social status. Having accepted that the biomedical procedure of dialysis would prolong his physical self, he turned to the forthcoming marriage between him and Rosie as the next step in his transformative process. In other words, by undergoing successful cataract surgery he resumed his status as a married male. In having his sight restored Andrew re-established himself as the head-of-the-family at the same time.

The healing process for Aunt Rachel was also multi-fold, with one major difference. Whereas Andrew's re-constituting of self was internally generated within the confines of community dictates, for Aunt Rachel the discourse of health in the community created the framework for her restorative process. In a sense, the Dithkalay community became a buffer for Aunt Rachel - a framework that enabled the people involved to find a solution. In the absence of a concrete biologic diagnosis (via IHS practitioners), the health-related talk concerning Aunt Rachel's situation focused on social relationships, in a manner similar to Andrew's. In turn, having established that her waning of power and accompanying poor health was socially based, it was up to the collective community to re-store order. The transformative process for Aunt Rachel drew on the collective efforts of the social community, the men by holding a Native American Church meeting on her behalf and through the women's counsel to Christa.

For both Andrew and Aunt Rachel the community established a social etiology for their illness. Andrew's loss of power was directly related to his prior position as a politician and by his association with the other middle-aged men

who were now totally disabled or deceased. Aunt Rachel's loss of power was by virtue of her relatedness to a community member (her daughter) engaging in inappropriate behavior.

Significantly, even though each example's illness causality was explained through social relationships, the avenues for restoring good health did not resort to ethnomedical remedies alone. In the medically pluralistic world of the Dithkalay, the various medical sectors do not compete. Indeed, the differing medical resources are viewed as complimentary and equally efficacious alternatives. The only distinction that may favor one system over another is in the realm of episodic illness. But even within the Dithkalay's definition of episodic illness the boundaries for treatment can be fluid. For example, if an individual suffers a broken arm the most likely resort is to visit the local IHS Clinic and have the fractured arm placed in a cast. But, if he or she consumes a peyote tea rather than consuming the prescribed pain-relieving medication, then the boundaries between the medical systems are not so discreet.

The primary means by which the Dithkalay negotiate and/or mediate the illness experience in its totality is through a discourse of health. The dialogic process for health-related decision-making incorporates a multiplicity of variables. First, the dialogue surrounding the illness experience is a subjective one; it is laden with reference to both the physiological dis-order of the individual and socio-cultural perceptions of that. Thus, Dithkalay cultural beliefs guide their perceptions and interpretations for symptomolgy, causality and resolution. Furthermore, medical pluralism informs the availability of varied resources and remedies. The discourse of health among the Dithkalay does not isolate the

community from the larger Anglo society and any potential benefits that may be accrued from the relationship as it was created through historic circumstance.

Second, the dialogic interaction validates the parameters within which health-related decisions can be and are made. Health-related talk among the Dithkalay reinforces both the responsibilities of family and other potential health-care givers and maintains the restrictions on cross-gender relations. In the social milieu in which it is employed, a discourse of health strengthens the larger analytic level of the Dithkalay community, or as put forth by Locke and Sheper Hughes; the "body politic."

Third, a discourse of health that conforms to differentiations in the body based on gender, family, or social relationships empowers the people involved to recreate the opportunities for a re-constituting of the individual and formulates a sense of out-come predictability. To maintain a sense of continuity, both the individual and his or her family undertake the necessary obligations to accommodate the alterations. These actions, in turn, buttress community-understood gender separations and the integrity of the extended family as the basic social unit.

Finally, how an individual "feels" about his or her body becomes a part of the discourse on health. Because daily life revolves around what the body can or cannot do, an illness disruption can result in uncertainty. Unpredictability produces feelings of chaos, creates a sense of a dis-ordered world, and challenges expected understandings of the embodied world. The relationship between the individual and his or her culture or society becomes paramount. Thus, for the Dithkalay, the discourse of health is not just about the re-making or re-constituting of self (associated with an illness experience) as it is a

transformative process to restore the individual within his or her physical, psychological, and socio-political worlds of experience. Thus, a discourse of health is also a dialogic process for and about reaffirming indigenous beliefs in the unique, bounded Dithkalay community .

Chapter Five

Recapitulation and Applicability

Certain characteristics of both the illness experience and the human need to resolve that condition are probably universal. Because ill health - whether temporary or long term - is a part of the human experience, the need for resolution may be based on a shared biological heritage of all peoples. Other characteristics surrounding the experience of ill health are culturally variable and result from a specific socio-cultural environment wherein health-related behavior and decision-making processes are learned.

Dithkalay peoples learn socially appropriate ways of speaking about health (and with whom it is permissible to do so) as children. As children, the Dithkalay continue to be socialized in ways that conceptualize the human life cycle as cyclical. They also acquire the skills necessary for a role in intra-family responsibilities, an understanding for bounded cross-gender relationships, and a quadpartite worldview - all of which influence health-care decision-making in a culturally distinctive way. In contrast, Euro-Americans are enculturated in a manner that emphasizes linear progression, individualism, self-reliance, and a tripartite view of the world. Illness narratives and the discourse of health evidence these differing perspectives about the self and the embodied world. Thus, in the regulation of health-related discussions and in the structuring of health care decision-making processes there are differences between Dithkalay Indians and Anglo-Americans.

A number of separate, yet connected, aspects influencing the health-related practices among the Dithkalay are identifiable. One aspect is the

interconnectedness between health-related behaviors and culturally based perspectives that are specific to the Dithkalay. During the developmental years of a Dithkalay child, members of the extended family are responsible for guiding and encouraging him or her to gain and have control over the body as an integrative mechanism for the accumulation of personal "power." Prior to attaining power, the decisions about a child's health and well-being are the responsibility of grandparents and parents. Children, absent of "medicine power," are viewed as dependent and vulnerable; they are weak in their ability to protect themselves against the infiltration of "evil-ish powers" and are vulnerable to potential illness. Elders who have succumbed to such things as a debilitating illness or senility are also viewed as weak and vulnerable. In this state of health, the responsibility for health-related decisions and health care assistance are once again assumed by the individual's family members. Thus, in the Dithkalay's cyclical worldview, the vulnerable state of powerless-ness is associated with the beginning and ending phases of the human life cycle. The Dithkalay re-affirm this cultural belief through discourse that includes baby metaphors and a reciprocal kin term, "Zohn," for a grandparent and a grandchild.

The presence or absence of medicine power situates the individual Dithkalay within the socio-cultural integrative network of the community and is a dominant variable in developing both social and political status. Adults, broadly categorized as being between the ages of twenty and sixty, are particularly concerned with all aspects of medicine power; most especially with the accumulation and retention of power. Symbolically represented by control over the physical and/or social body, the degree(s) of personal power can alter status. Inappropriate verbal outbursts, such as Margaret displayed, disrespectful inquiry

that intrudes on another person's autonomy or the occasional over-consumption of alcohol represent a lack of control over the self that usually results in decreased status. Thus, a wide range of both social and somatic conditions are indicators for remission(s) in power. Conversely, restoring power is accomplished (and its presence is confirmed) by re-establishing proper social relations or a positive health outcome.

For the Dithkalay, recovery following a loss of power is a physical, psychological, and social encounter. Community members view the individual's illness experience through a cultural lens that emphasizes an autogenous process, the obligations of family members to assist, and a gender-specific social arena. When an individual Dithkalay attempts to re-store order to self following an illness disruption, he or she must adhere to the community's established parameters that both define restored good health and the appropriate pattern for restoration. While Monika's continued depression prevented her from doing so, Andrew was very successful. Even though Andrew still required dialysis, his successful cataract surgery permitted him to be both independently mobile and to resume his position as the head of the extended family. However, the inability of an adult Dithkalay to fully recover following an illness episode or to successfully re-establish or re-negotiate his or her identity within their community-specific health-related framework can result in decreased status or a re-categorization of the individual within the community. Such was the case of Mike. Unable to resolve his poor state of health resulting from debilitating diabetes, Mike accepted the community's re-categorization of him as a "sugar-baby." Thus, worldview, age, gender, family, and community-held

perceptions are all important components in Dithkalay decision-making processes.

Dana's story describing the various remedies that she used to "cure" her grey feet points to the second identifiable aspect - the community's practice of medical pluralism. Like most other groups of Native peoples, the biomedical sphere as represented by Indian Health Service or the Veterans Administration, constitute but one option of many at the disposal of the Dithkalay. The ethnographic data collected and presented here demonstrates that the Dithkalay have not accepted biomedicine uncritically. While the Dithkalay value biomedical treatments (most specially for episodic illness or accidents), ethnomedical remedies retain their efficacy both medicinally and socially. Grandparents, who take their grandchildren to the local IHS clinic for regular check-ups and immunizations, may also administer mild doses of peyote tea to reduce fever or relieve discomfort. The efficacy of peyote as an indigenous remedy is measured both individually and collectively, as in the services of the Native American Church. Thus, the socially integrative and perceived health benefits accrued from using indigenous treatments also influence Dithkalay health-related decisions and practices.

In contrast to the process used by the Dithkalay is the health care decision-making process among Euro-Americans. Anglo perspectives on health-related decisions are designed to fit with or operate within the socio-cultural perspectives of the more dominant Euro-Western culture. While there are many elements that comprise a Euro-Western worldview, two of those elements have significance for heath-related decision-making; a scientific paradigm and the emphasis on individualism or personal responsibility.

Biomedicine "as a culture system" (c.f. Hahn 1995, Kleinman 1973, Rhodes 1996), has embraced these two elements as guiding principles for both practitioners and patients. In this framework, biomedical practitioners tend to assume that patients both acknowledge the authority of a diagnosis based on scientific research (via the health history and/or laboratory testing), as well as individual ownership and responsibility for health-related decisions and recovery. Indeed, physicians may expect that "by argument and education the patient will accept the real state of affairs and choose the only rational course of action" (Kirmayer 1992:326). On the part of patients, the science of medical discourse and the objectification of the person, in a sense, negates the social uncertainty that the individual associates with the illness experience. In Helman's words, a person "goes to the physician because s/he is ill and s/he goes home with a disease" (1994:86-94). In the biomedical system, disease is a disfunction of the physical body, with proper treatment function may be re-stored. Consequently, health care decisions and the subsequent behavior(s) belong to the individual patient and patients grant great authority to biomedical personnel, especially in relationship to treatment. As this study illustrates, a Euro-American paradigm does not, however, completely fit with the views of health and the illness experience as understood by the Dithkalay.

While my study has focused on medical pluralism and cultural differences with respect to health, it is clear that there are other aspects of health practices that differ between Anglos and Dithkalay Indians. First, there are ideological differences as to the responsibilities of patients as individuals versus family and community obligations to provide assistance. Among Euro-Americans, the appropriate pattern of an illness resolution is that the diagnosis, treatment, and

potential outcome are first discussed with the individual patient (Davenport 2000, Hahn 1995). Attempts by biomedical personnel to use a similar strategy with the Dithkalay both minimizes the obligations of family members to advise and assist the person experiencing ill health and ignores the role of the community.

Second, there are differences in the assignment of illness causality. Biomedical etiologies, guided by principles of biologic disfunction, somatic expressions, and efficacy of treatment tend to categorize mental or "social" distress as a psychiatric disorder. From within the realm of western psychiatry, illness categories (such as depression) are considered biological entities (O'Nell 1996, Storck, Csordas and Strauss 2000). The Dithkalay do not subscribe to a mind-body dichotomy for ill health. Therefore, socially–based etiologies may be established by family or community members when an individual continues to "feel bad," displays emotional distress, or when a biologic basis for his or her ill health cannot be established, such as in the case of Aunt Rachel.

Finally, there are differences in cultural knowledge as it is conveyed and expressed in medical discourse. Because Anglos and Dithkalay Indians are enculturated differently, their shared cultural knowledge is limited (c.f. Spradley 1980). More importantly, Anglos rarely interact with the Dithkalay within the latter's socio-cultural sphere. Consequently, Anglos have no direct knowledge of what cultural understandings the Dithkalays are speaking about. Aunt Rachel's experience at the local IHS clinic illustrated the rift that can and does take place in a cross-cultural dialogue about health. In all these ways, Dithkalay Indians experience difficulty in their health-related cross-cultural interactions. Therefore, it is not so surprising that cultural differences quite often lead to miscommunication between Dithkalay patients and biomedical practitioners.

It seems most likely that the communicative differences emanate from differing ideologies and worldviews. Until very recently, there has been conflict between those proponents who demanded that natives unequivocably accept biomedicine and its treatments and native peoples who continued to practice their indigenous remedies (Rhoades,Everett, Hammond, et.all 1987). Deeply entrenched as a part of the colonial experience, it was suggested, for example, that a reliance on biomedicine would improve the state of Native Americans' health because the improvement would be based on scientifically reliable facts and treatments (see for example Commissioner's Report, U.S. Bureau of Indian Affairs 1888; 1926). Accordingly, along with an improved health status, infant mortality rates would decrease and age-related longevity increase. Thus, among both biomedical practitioners and some Anglos, native peoples who continued to practice ethnomedical remedies, while either excluding or incorporating biomedical treatments, were viewed as "non-compliant" (Holm 1993).

However, when attempting to resolve an illness experience the fact that biomedical facilities and treatments are used does not guarantee that "science" will produce a positive illness outcome (Becker and Kaufman 1992, Estroff 1993). Dorothy's story of her mother's death illustrated this point. In spite of numerous tests and procedures, biomedical practitioners failed to develop a diagnosis and, therefore, a treatment that might have prolonged her mother's life. Often non-native peoples who become ill with a terminal disease, such as cancer, engage in ethnomedical remedies or undergo treatments not yet approved by the United States Food and Drug Administration. Some of these practices are thought to be "desperate" attempts on the part of the person experiencing ill health because a Euro-American paradigm assumes the

superiority of biomedicine as "knowledge" over alternative practices and remedies as "beliefs" (James Young 1992).

Medical discourse that pre-supposes the superiority of biomedicine to resolve biologic disfunction often results in miscommunication between patients and practitioners; particularly if the patient is of a non-western orientation, such as the Dithkalay. At the heart of this miscommunication is the dilemma surrounding the power and authority of biomedicine and its practitioners in determining efficacy of treatment. In asserting their authority, often times clinicians misunderstand or dismiss the concerns of their Dithkalay patients. In turn, Dithkalay patients often feel uncertainty with both the diagnosis and proposed treatment offered by biomedicine. Indeed, perhaps it would be more accurate to say that when miscommunication occurs between Dithkalay patients and biomedical practitioners, the misunderstandings validate the utility of Dithkalay reliance on multiple medical systems.

In the Dithkalay community the various medical traditions are viewed as separate and non-competitive cultural domains. The Dithkalay's practice for selecting one or more of the various systems are the result of health-care decisions made within their specific economic, political, and socio-cultural context. Dithkalay ideas about how to maintain or re-gain good health do include biomedicine but they do not negate the use of a variety of other medical systems including the Native American Church, peyote tea, and/or the "laying-on-of-hands" at the local Holiness Church. Because the boundaries between these varied systems are fluid and are constantly being negotiated and re-negotiated through dialogue and practice, Dithkalays engage in acts of self-determination.

Certainly, in the process of making a decision and then by taking action human agency is employed. But medical pluralism (by its very nature) provides the Dithkalay with additional arenas for agentive action. Because biomedicine reflects Euro-Western values, most likely it is the emphasis on individualism that has allowed for medical pluralism to persist and to provide meaningful alternatives to biomedicine for the Dithkalay. Medical pluralism provides an everyday opportunity to engage in a discourse of health. Informed as it is by cultural discourse, the Dithkalay's discourse of health re-affirms their community-specific beliefs and gives them control over their cultural construction of health and its related decisions.

However, in contrast to the emphasis on individualization at the social level, historically the Federal government has "delegate[d] much more power and authority to biomedicine than to alternative systems" (Baer 1995:494). The Indian Health Service, as an agent of the state, reflects this larger political economy and is less tolerant of individual and community autonomy. By using the various health-care systems in the way(s) that they do, the Dithkalay can exert control over their construction of health and they can resist biomedical hegemony. Thus, medical pluralism provides the Dithkalay both empowerment and culturally appropriate treatments. The Dithkalay's practice of medical pluralism argues against their subordination as a native people, at least within the arena of health. To be more explicit, my claim is that in the medically pluralistic world of the Dithkalay, discourse about health and their culture-specific process for making health-related decisions is a major mechanism that has enabled them to maintain their cultural distinctiveness - in spite of their immersion in the larger Anglo culture over the past 100 years.

Applicability

Using discourse analysis as a means to examine the illness experience in its totality and as a communicative process between patients and health-care practitioners is not unique, nor is a model that incorporates multiple levels of experience and interaction or the influence of culturally-informed patterns of structure. These methods are, however, put forth here in combination with new data. The conclusions that emanate from this study suggest that there are some crucial aspects of culturally-distinct health-oriented behaviors that are not readily understood by members outside an indigenous community.

This study has two principle implications. One contributes toward our understanding of health-care decision-making among medically pluralistic peoples. The other contributes to our understanding of how that process unfolds among a group of people with a non-western cultural orientation.

There are several reasons why the cultural differences underpinning health care decisions in medically pluralistic native societies are resistant to the hegemonic processes that give precedence to biomedicine over other health practices. Initially, notions of what constitutes good health and being an active and/or integrated member of a society vary greatly between one socio-culture group and another. When ill health occurs, regardless of whether the symptoms are biological or psychological in expression, people use a discourse about health to make sense out of their lives and what is happening to them. Health-related dialogue, then, serves as a medium for verbalizing, mediating, and at times, manipulating the illness experience and its perceived outcome to conform with cultural understandings.

Additionally, in the same way that people construct their narratives and dialogues in a culturally meaningful way, a discourse of health reflects the worldview into which those individuals have been enculturated. Even the form in which the narrative or dialogue is expressed reveals a specific framework and has cultural relevance. Among the Dithkalay, an appropriate narrative or dialogue contains four crucial elements: there are references to the individual, family affiliations, orientation with the community, and a "spiritual" aspect - that having to do with "medicine power." This study of the Dithkalay in conjunction with Becker's (1997) study of American patients suggest that a culturally constructed conceptualization of order informs health-care decision-making. The process of dialogic interaction, particularly in health-related discussions, is instrumental in the transmission of cultural values.

Finally, and perhaps most importantly, a discourse of health provides the means for the interactive process that all people actively engage in to re-make or re-constitute the self following an illness disruption (c.f. Good 1992). In the very process of re-affirming or re-constructing the self, people egage in acts of self-assertion. Through dialogue, people can resist the impressions and categorizations that others may impose on to them. In some situations, an individual may elect to alter his or her perceptions of self-identity based on altered circumstances or abilities. In other situations, he or she may choose to remedy the situation by altering his or her presentation of self to others (c.f. Goffman 1959). Through health-related talk and behaviors people become empowered to resist and be agents of change. Issues of resistance and agency are all the more poignant in multi-pluralistic societies. Where multiple systems for illness resolution are available, the very process of selecting one or more

systems over others, or in tandem with each other, empowers people both individually and collectively. Medical pluralism produces a discourse of health that presents multiple avenues for resolving the illness experience. Medical pluralism creates numerous arenas of interaction for the individual self, the social body and the body politic (c.f. Lock and Sheper-Hughes 1996) in the formation of culturally constructed health-care decisions. In a medically pluralistic world, health-care decision-making processes become the avenue for empowerment, cultural persistence, and resistance.

The existence of multiple medical traditions in native communities does not mean that all Indian peoples will utilize medical pluralism. Nor does it mean that the medical practitioners of the various systems will accept their patients' use of those multiple systems. However, a recent study among Navaho Indians does suggest that the practice of medical pluralism in indigenous communities can serve as a means for resisting cultural hegemony and, therefore, as an avenue for cultural persistence.

Similar to what I observed among the Dithkalay, researchers of "The Navaho Healing Project" identify that the Navaho Indians' cultural understanding for order rests on a quadpartite model (see Csordas, et all 2000). While the Dithkalay's model revolves around a cultural ethos of "power," the Navaho model is oriented to the four cardinal directions and their four sacred mountains. (This difference in orientation makes sense, I think, in light of the differences in historic geographic location and economy between the two groups.) Among the Navaho the four-part model takes form in the four modes of healing that comprise the Navaho medically pluralistic healing system; traditional, Christian, Native American Church, and biomedical realms. Guiding the Navaho's varied, and

sometimes simultaneous, use of the healing systems is an overarching principle of "harmony and beauty;" a principle that the Dithkalay express through their use of the word "respect."

While there are similarities in the research findings, there is one difference between the Navaho Healing Project and this study; the difference is one of focus. Specifically, Csordas, et. all focus on the therapeutic "healing process as a culture system" to investigate medical pluralism, whereas I have investigated the process of health-care decision-making to address the practice of medical pluralism.

In this study I have dealt with the cultural perspectives that influence health care decision-making in a Native community and how that process is expressed in their discourse of health. In Chapter two, I discussed the idea that the worldview of the Dithkalay is structured around a culturally-informed pattern and that the transmission of that structure is accomplished through dialogue. A culture-specific worldview, whether it be quadpartite, tripartite, or some other form, organizes health-related discourse and the accompanying health-related decisions and practices.

In Chapter three, I examined how health-related dialogue reiterates and bolsters other community-specific understandings such as gender-specific interactions and family obligations. Here, maintaining the proper order for social relationships is accommodated through open-ended dialogue. Most important is the open-endedness of health-related talk because it creates avenues for moving among the various medical systems that are available to community members.

A close examination of the two examples in chapter four illustrated the complexity entailed in a community-specific decision-making process. Cultural beliefs about illness do not limit the use of available medical systems to one at a time. Nor are the various systems prioritized based on an illness causality or based on efficacy of the various treatments available within a particular medical system. Instead, the boundaries between the various systems are fluid. In the process of health-care decision-making, the boundaries of the various systems are constantly being negotiated and re-negotiated. In turn, the fluid boundaries between the medical systems creates an arena for negotiating and re-negotiating the identities of people within the cultural ideas specific to the community. Thus, the dialogue of health is also a discourse of culture.

Within contemporary anthropological perspectives, such notions of how gender, community, culture, and health are interrelated and co-construct one another are not unique (Becker 1992, Good 1994, Helman 1994, Rhodes 1996, Turner 1990). What is significant is the way(s) in which these aspects co-vary. Through health care decision-making, groups of people can and do affirm their cultural distinctiveness and resist amalgamation into larger, more dominant social orders. In a culturally homogeneous community, with both indigenous etiologies and biomedical perspectives, available policies, decisions, and treatments form a dynamic and interrelated system that empowers both the individual and the collective group. With this in mind, it is likely that the culturally appropriate health-care decision-making processes of Dithkalay peoples, and other indigenous peoples like them, will continue to be a primary site for maintaining and asserting their distinctive communities in contrast to the process of globalization, one hallmark being the preeminence of biomedicine.

ENDNOTES

Notes to Chapter one (pages 1 - 45)

1. See Agar and MacDonald (1995) for a discussion of both the utility and limitations encountered with focus group interactions and a form of ethnographic data.

2. Copies of the Dithkalay genealogies that I constructed as well as copies of the recorded interviews are housed in the Dithkalay Tribe Culture Program office. I also provided copies to the individuals who participated.

3. Government statistics for poverty income levels do not take into consideration Dithkalay family structure. Government statistics base the income level in relationship to the number of individuals involved. The figure of $16,000 is based on "nuclear" family formation. The composition of the "average" Dithkalay family is three to four adults (usually grandparents and adult children) and four to six children.

4. See Snipp (1986) for an excellent discussion of the factors and data that are used in determining the ethnic classification for Indians/Native Americans.

5. Blood quantum according to Federal guidelines is measured as "Indian ancestry" in toto, only a part of which may be traceable to a Dithkalay ancestor on the Dawes Roll.

6. Rivers accepted Frazier's definitions of indigenous medical practices as outlined in his seminal work, *Golden Bough: A Study in Magic and Religion.* For the interested reader, Wellin (1977) provides a thorough discussion of how the notion that medical practices among non-western peoples were cast as magic and, therefore, framed earlier constructions of ethnomedicine.

7.The Society for Medical Anthropology was established in 1975 as a recognized affiliate of the American Anthropological Association.

Notes to Chapter two (pages 46 - 92)

1. An earlier application of the concept of order in health-related practices may be found in Lyon (1990). In order to illuminate the concept of a "metamedical context," she examines Javanese cultural notions of order as a contributing or guiding principle in their healing practices.

2. A number of Dithkalay attend the local Mormon Church although they are not members. In asking about this practice, I learned that their motivations stemmed from a common interest in family ancestry or genealogies. This is not to say that these participants so not subscribe to the religious principles of the institution. But the individuals that I talked with identify their participation at the social level (genealogical undertakings) rather than the spiritual level.

3. See Campbell (1982) and Ewers (1973) for overviews of Plains Indian epidemics and its consequence for population demographics and health.

Notes to Chapter three (pages 93 -145)

1. The Dithkalay Culture Program office is located at the tribal complex. The program was established in 1991 by tribal resolution and is one of many programs operated by the Dithkalay tribe. Since its inception, the efforts of the Culture committee and program have been directed toward the documentation and preservation of Dithkalay traditions, knowledge, and tribal history. One of the Culture Committee's primary endeavors is to document and create teaching materials for the preservation of their indigenous language. Equally important are the activities sponsored by the program. Some of these activities include the annual youth culture camp, language classes, and classes designed to teach younger adults traditional practices such as constructing moccasins. The program also serves as a liaison between Dithkalay tribal concerns and the larger Anglo world.

2. See for example, Basso's (1988) discussion of the use of place names among the Western Apaches.

3. Although less confining, the behaviors associated with avoidance relationships still persist in the contemporary community. These behaviors do have some practical consequences for accomplishing day-to-day tasks. For example, if a group comprised of both males and females are going to visit the tribal complex of another near-by tribe, two vehicles are required; one for transporting the men, another for the women.

4. Elders relate how marriages in the Dithkalay's past may have been dissolved resulting from the inability of a woman to become pregnant within the first year of marriage.

5. My use of "ideal" versus "real" comes from the work of James Spradley 1980. As he applied it, ideal rules are about the stated rules; the ways things are supposed to be. Real rules, on the other hand, are about the actual behavior; the way(s) in which people really behave.

Notes to Chapter four (pages 137 - 185)

1. Acculturaltion studies attempted to be studies of change in process. Most studies were interested in contact situations, especially between non-Western societies and an industrialized, western group. Some areas of investigation included how change came about, degrees of resistance to change or changes in roles, practices, and statuses.

2. Andrew's reference to "being all taken away" refers to a particular political endeavor that he and two other tribal members were engaged in during the early 1970s. Based on Federal documents and community testimony, three members of the Dithkalay community, including Andrew, were incarcerated for a period of time following their conviction of embezzlement.

3. The fissioning of the military society into two societies was not the result of nor does the membership reflect connections to the three larger socio-political divisions based on the family-related geographic patterning of the community. Instead, the official membership seems to reflect a more traditional perspective where membership in the military societies was voluntary. Traditionally, the members of the military societies drew its members from all of the bands and served as a mechanism for uniting the Dithkalay people at a tribal level.

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