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THE IMPACT OF ALLOPATHIC BIOMEDICINE ON THREE “CULTURE-BASED” TRADITIONAL HEALING SYSTEMS

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Abstract

The U.S. Office of Alternative Medicine (OAM) of the United States National Institutes of Health held a 1985 conference to evaluate research needs in the field of complementary and alternative medicine (CAM). Its resulting guidelines have been used in this essay to describe three “culture-based” traditional healing systems and how they have interacted with allopathic biomedicine over the past several decades. After a brief description of Puerto Rican folk healing, it provides a first-hand observation of traditional Balinese shamanism and its encounter with Western psychiatry, the Andean Kallawayaya system of healing and its interface with biomedicine, and Mexican-American Curanderismo and its long history of interaction with European medicine and, more recently, biomedicine in the United States. These systems are examples of “ethnomedicine,” a term that refers to the comparative study of medical systems in various cultures, focusing on beliefs and practices concerning sickness and health. It involves the observation and description of hygienic, preventive and healing practices, taking temporal and geographic references into account. From a post-modern perspective, it permits inspection of a “dominant” medical or healing system with those that lack equal power, and the outcomes of a clash between these systems.

Key words: Balinese shamanism, Curanderismo, Ethnomedicine, Kallawayaya,

Introduction

The term “ethnomedicine” refers to the comparative study of medical systems in various cultures, focusing on beliefs and practices concerning sickness and health. It involves the observation and description of hygienic, preventive and healing practices, taking temporal and geographic references into account.

Typical ethnomedical topics include causes of sickness, medical practitioners and their roles, and the nature and efficacy of specific treatments. The explosion of ethnomedical literature has been stimulated by an increased awareness of the consequences of the forced displacement and/or acculturation of indigenous peoples, the recognition of indigenous health concepts as a means of maintaining ethnic identities, and the search for new medical treatments and technologies. In addition, Kleinman (1995)

found ethnographic studies an “appropriate means of representing pluralism...and of drawing upon those aspects of health and suffering to resist the positivism, the reductionism, and the naturalism that biomedicine and, regrettably, the wider society privilege” (p. 195).

This essay will focus upon three “culture-based” medical systems and how they have interacted with allopathic biomedicine over the past several decades. After a brief description of Puerto Rican folk healing, it will provide my first-hand observations of the traditional Balinese healing system and its encounter with Western psychiatry, the Andean Kallawaya system of healing and its interface with biomedicine, and Mexican-American Curanderismo and its long history of interaction with European medicine and, more recently, biomedicine in the United States.

Puerto Rican folk healing: My introduction to ethnomedicine

My interest in ethnomedicine was stimulated by a visit to a public community mental health center in Cayey, Puerto Rico in 1979. I was informed that mental health professionals were meeting with spiritistically-oriented folk healers twice a week for several years, and I was invited to sit in on one of the meetings. I was told that the first week of encounters were devoted to lectures by representatives from both groups, while the second week focused on case conferences in which both groups gave input regarding clients seen at the center. From this point on, the folk healers were accepted as members of a team that typically included a physician, a psychologist, and a social worker (and sometimes a psychiatrist was available for consultation as well). While I was in attendance, the discussion was about the significance of dream reports and how best to access and understand them. The folk healers used them to identify a client’s “helping spirits,” while the mental health professionals used them to understand a client’s psychological and interpersonal conflicts and problems. The group agreed that these two approaches to dream interpretation were not contradictory.

Koss (1979) studied this process and concluded that folk healers were highly motivated and committed to their work. She also noted that their approach to therapy was more emotionally charged than Western-trained psychotherapists, and that they employed rituals and herbal remedies with notable results. Clients of folk healers were urged to develop spiritually; sessions were focused on the meaning of life and the individual’s connection to God and to the cosmos. The clients’ families often were called in, and advice was freely given. The Western-trained psychotherapists worked exclusively with the physical-world aspects of the case rather than the spiritual dimensions of a client’s life. However, Koss’ observations convinced her that the collaboration of Western psychotherapy and folk healing practices complimented each other, as they addressed different systemic levels of the clients and their world.

Koss described a client who had been seen by both Western-trained mental health professionals and folk healers. When brought to the center, she was given medication for depression and visual hallucinations. The folk healers “exorcised” eight malevolent spirits. Despite the seriousness of the case at the outset, the client’s rapid improvement allowed her to be discharged a week later and resume her classes at secretarial school. The two types of practitioners worked cooperatively, addressing themselves to various aspects of the client’s belief system and behavior.

Koss was surprised to discover that the mental health professionals themselves often sought counseling from folk healers. One psychologist consulted with a folk healer during divorce proceedings and was given instructions on how to contact his spirit guides to help him in court. With the aid of the folk healers the psychologist worked through his problems forming close relationships and eventually married again. He told Koss that the folk healing practices had been far more effective in his case than any cognitive-oriented psychotherapy he had previously received.

Koss (Koss-Chiono, 1992) later followed-up with clients who had received Western psychotherapeutic treatment in Puerto Rico and compared them with the clients of folk healers, finding that the latter group reported greater improvement. Clients who visited the folk healers (some 60% of all Puerto Ricans she questioned) also had higher expectations, which might have influenced, and perhaps biased, reports of improvement. Koss noted that folk healers did somewhat better than Western-trained psychotherapists on mood and behavioral complaints while psychotherapists were more successful with clients who complained of thought disorders. The example cited above demonstrates this differentiation; the psychologist in question was working through a mood and behavioral complaint, namely his difficulty in forming close relationships.

Koss' research reflected and reinforced my own observations and conclusions. In addition to a viable psychotherapeutic or medical intervention, treatment will be effective if various interpersonal variables are at play, variables that have been well-stated by such psychiatrists as Frank and Frank (1991) and Torrey (1986).

Hallmarks of effective treatment

In his exhaustive study of cross-cultural practices, Torrey (1986) concluded that effective treatment inevitably involves one or more of four fundamental hallmarks:

1. A shared world view that makes the diagnosis or naming process possible;
2. Certain personal qualities of the practitioner that appear to facilitate the patient's recovery;
3. Positive patient expectations that assist recovery;
4. A sense of mastery that empowers the patient.

A similar list has been prepared by Frank and Frank (1991) who contended that three main factors are present in an effective healing process: (1) the installation of hope through "naming" the problem and making the diagnosis in a context understandable by the client; (2) emotional arousal, dynamic healing techniques, and the creation of catharsis, hope, and confidence; (3) a feeling of control and a sense of mastery gained by the client in regard to the problem identified.

If a traditional medical system yields treatment outcomes that its society deems effective, it is worthy of consideration by Western allopathic biomedical investigators. This is especially true for those who are aware of the fact that allopathic biomedicine is the dominant health care paradigm for less than 20 percent of the world's population (Mahler, 1977). However, what is considered to be "effective" varies from society to society (Krippner, 2002).

It is also important to note that allopathic biomedicine places its emphasis on "curing" (removing the symptoms of an ailment and restoring a patient to health), while traditional medicine focuses upon "healing" (attaining wholeness of body, mind, emotions, and/or spirit). Some patients might be incapable of being "cured" because their sickness is terminal. Yet those same patients could be "healed" mentally, emotionally, and/or spiritually as a result of a practitioner's encouragement to review their life, finding meaning in it, and become reconciled to death. Patients who have been "cured," on the other hand, may be taught procedures that will prevent a relapse or recurrence of their symptoms. An emphasis upon prevention is a standard aspect of traditional medicine, and is becoming an important part of biomedicine as well (Krippner & Welch, 1992).

A distinction can also be made between “disease” and “illness.” From either the biomedical or the ethnomedical point of view, one can conceptualize “disease” as a mechanical difficulty of the body resulting from injury or infection, or from an organism's imbalance with its environment. “Illness,” however, is a broader term implying dysfunctional behavior, mood disorders, or inappropriate thoughts and feelings. These behaviors, moods, thoughts, and feelings can accompany an injury, infection, or bodily malfunction – or can exist without these factors. Thus, one may refer to a “diseased brain” rather than an “ill brain,” but to “mental illness” rather than of “mental disease.” Cassell (1979) goes so far as to claim that allopathic biomedicine treats disease but not illness; “physicians are trained to practice a technological medicine in which disease is their sole concern and in which technology is their only weapon” (p. 18).

Every human population, in every era, builds a specific worldview or “mythology” through its own culture. Specific views of the body, health, and sickness stem from this model of the world. Therefore, comparisons between allopathic biomedicine and indigenous ethnomedicine can be made while considering these models. In the social and behavioral sciences, a “model” is an explicit or implicit explanatory structure that underlies a set of organized group behaviors. Their use in science attempts to improve understanding of the process they represent. Models have been constructed to describe human conflict, competition, and cooperation. Models have been proposed to illustrate such topics as the etiology of mental illness, the spread of disease, the interaction of personality dynamics and family interactions.

The U.S. National Institutes of Health Model

A rough comparison can be made between ethnomedicine and folk healing, on the one hand, and complementary and alternative medicine (CAM), on the other. Both are examples of “culture-based treatment” that exists outside of the paradigm of allopathic biomedicine. The use of CAM in the United States is extensive (e.g., O’Conner, 1995), even though mainstream practitioners hesitate to recommend most of the currently available treatments.

In April 1995, the Office of Alternative Medicine (OAM) of the United States National Institutes of Health held a conference on research methodology. The charge of this conference was to evaluate research needs in the field of complementary and alternative medicine (CAM), and several working groups were created to produce consensus statements on a variety of essential topics. The panel on definition and description undertook a dual purpose: To establish a definition of the field of complementary and alternative medicine for purposes of identification and research; to identify factors critical to a thorough and unbiased description of CAM systems, one that would be applicable to both quantitative and qualitative research (O’Connor, 1995).

CAM is a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well being. Boundaries within CAM and between the CAM domain and the domain of the dominant system are not always sharp or fixed (O’Connor et al., 1997).

The second charge of the panel was to establish a list of parameters for obtaining thorough descriptions of CAM systems. The list was constructed on 14 categories, first conceptualized by Hufford (1995):

1. Lexicon. What are the specialized terms in the system?

2. Taxonomy. What classes of health and sickness does the system recognize and address?
3. Epistemology. How was the body of knowledge derived?
4. Theories. What are the key mechanisms understood to be?
5. Goals for Interventions. What are the primary goals of the system?
6. Outcome Measures. What constitutes a successful intervention?
7. Social Organization. Who uses and who practices the system?
8. Specific Activities. What do the practitioners do? What do they use?
9. Responsibilities. What are the responsibilities of the practitioners, patients, families, and community members?
10. Scope. How extensive are the system's applications?
11. Analysis of Benefits and Barriers. What are the risks and costs of the system?
12. Views of Suffering and Death. How does the system view suffering and death?
13. Comparison and Interaction with Dominant System. What does this system provide that the dominant system does not provide? How does this system interact with the dominant system?
14. Evaluation. Are there data available that demonstrate the efficacy of the healing system? What research methods are appropriate for investigating the system?

For illustrative purposes, I will apply the National Institutes of Health criterion number 13 to three traditional healing systems, asking two questions: What does this system provide that the dominant system does not provide? How does this system interact with the dominant system? I will use the examples of Balinese shamanism, Andean Kallawaya medicine, and Curanderismo folk healing.

Traditional Balinese Shamanism

On the island of Bali, Indonesia, there are many rituals and ceremonies that focus upon healing. In traditional Balinese practice, the name of the main temple ceremony is *nyimpen*, and the dance of Calon Arang often is performed during *nyimpen*. The story of Calon Arang concerns an evil widow and her only daughter who were banned to the forest for allegedly practicing black magic. There are several variations of this story but all focus on her revenge against the people of the ancient Hindu Javanese kingdom of Daha after its Raja insults her by retracting an offer to marry her beautiful daughter. Apparently, the Raja has no need for an additional wife, much less one with such a formidable mother. Calling up her demon legions, she transforms herself into a frightening figure with ponderous hanging breasts, bulging eyes, a long flamed tongue, and a mass of unruly flowing hair. Waving her magic cloth, she has become Rangda, the queen of the witches, and wreaks havoc with her powers. Understandably, this is one of the most powerful plays in sacred Balinese drama and its performance is always charged.

When I saw this dance performed in 1985, the dancers seemed oblivious to the outside world as they enacted the great battle between the forces of the witch and those of humankind. It started with the

lesser characters, who, when faced with defeat, called upon the aid of higher forces, which transformed them into more powerful beings. Each of the succeeding transformations was met with mounting tension on the faces of the crowd and was supported by the growing crescendo of an orchestra playing traditional Balinese music with equally traditional percussion instruments. Children who were dozing suddenly woke up. The climax finally came when the Barong, a mythical creature who frequently comes to the aid of human beings, at last faces his arch-adversary, the malevolent witch Rangda, and the dancers shift from their usual sense of identity to become players in this cosmic drama.

Denny Thong (1993), a psychiatrist who organized the first mental hospital on Bali, and whom I interviewed during my visit to Bali in 1985, describes what occurred during a performance of this dance that he witnessed:

One of my staff was bringing to me another glass of the thick Balinese coffee that I had been using to keep from falling asleep at that late hour. Suddenly, without warning, he threw the glass over his shoulder, stood upright as if in anger, and quivered with wide-open eyes. Abruptly he proceeded to turn and walk to a nearby papaya tree, which he pulled out of the ground. That seems to have been some sort of signal because afterwards many others in the crowd, including a member of the orchestra, experienced the same radical transformation. My first frightening impression was that utter chaos had broken out. (p.79)

Overwhelmed by this sudden and unexpected turn of events, Thong sat bewildered with no idea of where to look or what to do. Fortunately, the Balinese themselves had no such problem. Ignoring the disorderly behavior of the more violent trance dancers, they focused their attention once more on the stage and its surroundings. The players still were dancing, still in an altered state of consciousness, but one that was less intense. The gamelan played on but only with the mesmerizing continuous deep rhythm of the large gongs. Thong's most striking observation was that despite all the wailing and untamed antics, nobody was hurt. He recalled:

This led me to the conclusion that this was no true chaos; instead it was a wild but nonetheless orderly form of behavior. It was only at this point that I turned around to ask my Western companion, Christopher, a question about his feelings concerning this primal scene. The result was my second shock of the night when I saw Christopher sitting upright with the same dazed look in his eyes as the dancers. At that moment...all the trance dancers gathered before the Baron [a spiritual entity] who began to lead a procession around the temple. Dear Christopher joined in as well. (pp. 79-80)

It took the efforts of a *pemangku* or village priest to gently bring Christopher and the other people back to their ordinary state of consciousness. With his assistants, and armed only with holy water, the *pemangku* wandered through the crowd sprinkling the entranced revelers; the sacred water quickly revived them.

In Thong's (1993) opinion, the Balinese people's repressed emotions find an outlet in the dance and drama – an outlet the culture has provided for them to abreact, either vicariously or directly. Classical dance and drama in Bali, based on legends and myths, are well attended and the more contemporary dramatic presentations are even more widely attended. In both, the classical and contemporary performing arts one can encounter every possible Balinese emotion – love, joy, anger, reverence. One can observe intrigue, sexual passion, jealousy, and the violation of all the cultural taboos. Not only do the players benefit from expressing these emotions and breaking the taboos, but the audience attains catharsis as well. From Thong's perspective, the other Balinese arts – painting, sculpture, the creation of festival offerings – help the Balinese to maintain a healthy frame of mind. They have retained their vitality and without these practices and the related cultural manifestations, the uniqueness of Bali would have crumbled long ago.

Could this phenomenon be categorized as "mass hypnosis?" Such a label would be less than accurate because there was no direct goal-orientation of the entranced individuals. Could the phenomena reflect the capacity of all performing arts to invite emotional reactions? This is part of the explanation, but the full accounting, in my opinion, must consider the role of cultural mythology. The fervent belief in the Hindu deities and their allies provides a context for exceptionally dramatic shifts in awareness, hence potential changes in one's psychological and physiological condition. Bali is a Hindu outpost in a Muslim country, hence the retention of the island's cultural mythology is of special significance, one of preserving a special set of beliefs and traditions.

I personally have seen *balian*s (Balinese shamans) enter both transpersonal and other altered states during healing and exorcism ceremonies. The *balian taksu* is a healer with mediumship talent who alters consciousness to assist in the diagnosis of the ill and unfortunate. Sometimes, the diagnosis is *bebai* in which an evil spirit has been sent by a sorcerer. The victim's rival has paid the sorcerer to practice *bebainan*, or black magic, for purposes of revenge or jealousy. Thong concluded that in the "altruistic trance states," a dancer responds to the needs of another person or a group of people. This state is usually reached during or after the performance of a ritual and, in Bali, would encompass all hypnotic-like phenomena during religious or healing ceremonies as practiced by the *balian*. The practitioners in this group rarely show signs of overt psychopathology.

"Egoistic trance states," on the other hand, are entered in response to an individual's personal needs. They are not preceded by a ritual and tend to occur spontaneously. In Bali, this state is believed to be brought about by the possession of an individual by a *bebai* or evil spirit. People who demonstrate this state usually have emotional problems that typically fall into the psychiatric category of "hysterical reaction." In other words, Thong's concept of the altruistic trance state is likely to be transpersonal in nature while the egoistic trance state is not.

Explorations of Integration of Balian Ethnomedicine with Conventional Medicine

Shortly after my visit to Bali, Thong established a Family Ward as part of his psychiatric hospital. This involved organizing his 180-person staff into a traditional *bazaar*, the island's smallest unit of social organization, a unit that may contain as few as a dozen or so men and women. It is customary for members of a *bazaar* to work together toward a common goal. He took on the role of the *klian banjar*, or community leader, and named several other assistants, using the traditional names and roles. A small temple was constructed, and the staff was told to identify the deity who would empower the temple. Some remarkable dreams and healings were attributed to Djero Gede, and a local *balian* confirmed that this powerful deity, indeed, had empowered the temple. The next step was to hold a *piodalan*, an annual festival, which was a great success, replete with dances, shadow puppet plays, and traditional foods. Soon, families and friends of patients came to worship in the temple and attended the annual *piodalan*. The overt purpose of these festivities is to honor and placate the inhabitants of the spirit world; the covert purpose is to maintain Bali's cultural mythology in the face of the island's Muslim's neighbors as well as the presence of Western tourists and a bureaucracy that attempts to present Indonesia to the world as a "modern" society (Thong, 1993).

This type of experience led Thong to evaluate the mental health system that he and other psychiatrists trained in Western worldviews had superimposed upon Bali. After observing his Balinese patients' devotion to the Hindu panoply of deities and other spiritual entities, he realized that his adherence to Western methods and models "was often illogical and even absurd." Hospitals in Bali included large halls with two rows of beds on either side, an arrangement the Balinese would consider "uninviting" and "terrifying," since certain rules forbid them to sleep with their heads pointed in certain directions (p. 63). He noticed that some patients were frightened by curtains that separated them from their families. More

important, Thong realized that the logic of the two approaches was discordant; the “shared world view” that Torrey (1986) found to be a cornerstone of patient recovery was missing, much to the detriment of the Balinese in need of treatment.

As a result, Thong initiated a Family Ward, which consisted of four compounds, each of which could house one patient and his or her family. In this way, active participation of the family would be encouraged. The compounds were built of traditional materials, and each had its own entrance. During the day, patients would engage in ordinary activities, such as farming, carpentry, and similar enterprises. They could cook for themselves, using the kitchen and utensils that were supplied. The staff would spend a good part of the day discussing patient’s problems, answering their questions, and listening while they expressed their feelings. The plan was to limit Family Ward admissions to first-time patients and to keep them for a maximum of two weeks. The rationale was that these patients were suffering from an acute psychotic reaction that would subside quickly, and then would be manageable on an outpatient basis. If there were no improvement, patients would be transferred to the Regular Ward. Patients and their families would be taught how to administer their own medication.

Both the patients and their families were allowed to utilize the services of *balian*s and other traditional healers, if they so chose. One local *balian* was especially popular. He was a retired high school principal and his treatment consisted of pressing a number of points on the skin, beginning at the neck. With some, there was no reaction, while others writhed in pain. The *balian* concluded that these patients were the victims of *bebian* and administered the appropriate treatment. Thong remarked, “Astonishing enough... several patients whom he treated showed remarkable improvement after his treatments” (Thong, 1993, p. 68).

At the end of one year, Thong and his staff evaluated the results of the Family Ward. Fourteen patients had been admitted, nine from Bali, and five from the surrounding islands. Of the former, eight recovered and one was sent to the Regular Ward; among the latter, four recovered and one was sent to the Regular Ward. Those who recovered were sent home, some for short periods of time as outpatients; none of them reappeared for additional treatment. Most of the patients were diagnosed with one form of schizophrenia or another, while one was suffering from depression, and another from drug addiction. The average amount of time spent in the Family Ward was forty days.

One patient was a 19-year-old girl with no schooling who had suffered an acute psychotic attack. In desperation, her parents took her to a local physician who immediately took her to the new psychiatric hospital. She refused any food or drink unless it was given by a family member. She reported hearing voices of deities who ordered her to fulfill certain religious tasks. Her family shared her belief system and when she was admitted, seven of her brothers insisted on joining her. After sixteen days, and after the administration of anti-psychotic medication, she returned home with her brothers. Apparently, the voices had stopped and she decided to take an active role in her local temple. Thong (1993) wrote,

This case reminds me of the priest of Batur temple whom I described earlier. If we had admitted these patients into the [Regular Ward], thus branding them as mentally ill, it would have had dire consequences. The status of the individual would have suffered and the family would have endured a significant financial burden because they would have had to conduct special ceremonies to cleanse the patient of the spiritual pollution attributed to the [Regular Ward]. (p. 69)

Soon, Thong’s project aroused considerable controversy in the national capitol of Jakarta. The Indonesian Medical Association accused him of “dabbling with superstition and unscientific methods” (p. 68). At the end of 1987, Thong was ordered to close the Family Ward, and he was transferred to another island. In 1988, he arrived in Ujung Pandang, Sulawesi, where he continued to practice psychiatry and to write about his experience in Bali. I edited his story after it was translated by Bruce

Carpenter. Our book, *A Psychiatrist in Paradise*, was published in 1993. However, it was never stocked by any bookstore in Indonesia.

This case differs from the successful integration of folk healing and Western psychotherapy Koss and I observed in Puerto Rico. In the latter case, the experiment had been sanctioned by medical and government authorities; in the former case, one psychiatrist (Thong) had taken it upon himself to initiate the Family Ward. In Puerto Rico, the attempted integration took place in several mental health centers; in Bali, Thong only had one hospital in which to initiate the Family Ward. In Puerto Rico, a “modern” society already existed and could afford to reach out to folkloric representatives; Indonesia, on the other hand, was still attempting to shed its folkloric past and present at least a façade of modernity.

Andean Kallawaya Medicine

In 1996, I spent five days in La Paz, Bolivia and surrounding areas interviewing practitioners of a unique form of ethnomedicine, the Andean Kallawaya system. I interviewed several Kallawaya practitioners including the president of the Bolivian Society of Traditional Medicine and the president of the La Paz Association of Traditional Spiritual Kallawaya Practitioners. The former group has thousands of members (about half of them women) while the latter is an affiliated group. Female Kallawaya practitioners typically do not leave their homes, thus their patients must come to them. However, this restriction is not severe since the patient's preference usually is home visitation, far from the influence of hostile spirits and unfamiliar surroundings and near to familiar animals, plants, and land. Western-style hospitals are dreaded, in part because the color white is associated with the death and burial of infants.

Kallawaya herbalists trace their tradition back to the legendary Tiahuanaco cultures of 400-1145 C.E., continuing through the eras of other pre-Inca cultures, the Inca Empire, and the Spanish conquest, to present times.

In ancient times, these people saw no division between themselves and their environment. However, rivers and valleys created natural boundaries or *ayllus*, the ecological and cultural units of Kallawaya society. Kallawaya healers were once identified with certain *ayllus*, referred to as *Qollahuaya*, “places of the herbs.” The communities in the lower slopes (3,200 to 3,500 meters above sea level) grow barley, beans, corn (or maize), peas, and wheat. Those in the central communities cultivate *oca* (i.e., *Oxalis crassicaulis*) and many varieties of potatoes on rotated fields that are 3,500 to 4,300 meters high. Those of the highland communities (4,300 to 5,000 meters) herd alpacas, llamas, and sheep. Traditionally, *ayllu* members from the three levels exchange produce and provide each other with the necessary foods to maintain a healthy and balanced subsistence.

Traditional Kallawaya follow three injunctions: *ama swa*, do not steal; *ama llulla*, do not lie; *ama khella*, do not be slothful. Kallawaya also believe in a principle of nature they refer to as the “boomerang law”: if you harm others, malevolent acts will return to you. Living by these precepts is believed to be fundamental in establishing and maintaining harmony within the community.

The goal of the Kallawaya medical model is to maintain and restore the harmonious relationship of community members, the community as a whole, and the natural environment. The Kallawaya practitioner must assure the availability of medicinal plants and proficient healers, expert in dealing with health, sickness, the natural realm, and the world of spirits. Prevention involves the practice of moderation in daily life, and the maintenance of trust among members of the community.

Kallawaya healers mediate between the ill person's body and the environment, attempting to restore the balance that has been lost. However, restoration of this balance is dependent on a number of

factors: the sickness itself, its severity, and the cooperation of patients and their families. The confidence and the faith of the patient are key factors because herbal treatment is a slow process that requires a great deal of patience. Beliefs about sickness and recovery are thought to activate the self-regulatory mechanisms that are fundamental to regaining one's health. In addition, considerable emphasis is placed on prevention; proper nutrition is seen as essential to the maintenance of one's balance.

Kallaway practitioners often travel to parts of Argentina, Chile, and Peru that claim to need their services, but always in small groups rather than alone. Most Kallaway practitioners are males, but talented females are admitted to the profession as well. If the patient cannot go to the healer, the healer will go to the patient. In La Paz, there are clinics where patients can visit a Kallaway practitioner. The function of these clinics is diagnosis and treatment regardless of its location.

Practitioners in the Kallaway tradition are specialized according to specific skills and functions. *Herbalarios* collect medicinal plants; *yerbateros* prepare these plants; *curanderos* apply the plants and other medicines; *yatiris* (also known as *amautas*) are spiritual healers; *partidas* are midwives. Over time, Kallaway practitioners began to perform more than one function, hence many of these traditional divisions have become less rigid. Nevertheless, all practitioners mediate between the environment and the patient and, in some cases, the community as a whole.

A common folk method of diagnosis begins by tying a guinea pig to a patient's stomach or kidney area. A coca leaf preparation is placed over the head of the patient followed by a joint prayer affirming belief in the procedure. The guinea pig is removed and cut open so that its internal organs can be observed. Any anomaly of these internal organs is regarded as a representation of the patient's sickness. A small lesion in the animal's lung is most serious as it is thought to indicate a terminal condition in the patient. This procedure did not originate with the Kallaway, but still is used by some practitioners. Its use depends not so much on its effectiveness as it does on the patients' expectations; old traditions die hard and, as Torrey (1986) and Frank and Frank (1991) have noted, patient expectation is an important aspect of recovery.

Another folk tradition that is taken seriously by some Kallaway healers involves examining a patient's side for small scars that resemble puncture marks. These marks, in combination with certain behavioral symptoms, indicate an invasive condition, marked by high temperatures, brought on by sorcery or *kharisiri*. The marks suggest to the practitioners that malevolent spirits have entered the patients' body, usually near the liver, to steal their fatty tissue. These malevolent spirits can take the form of human beings, referred to as *karikari*; they live on fat and usually strike when their victims are not fully aware, such as when they are intoxicated (Bastien, 1992, p. 71). One practitioner told me that sorcery is quite rare and did not exist until the Spanish conquest; it is often attributed to the malignancy of the invaders. From the biomedical point of view, the Europeans brought microbes with them against which the natives had no resistance; from their point of view, the Spaniards were accompanied by malevolent spirits who not only destroyed untold thousands of their ancestors but who left a legacy of sorcery that still infects the land.

Some practitioners use patients' dreams for diagnostic purposes because dreams represent the spirit communicating with the body. A voyage may be postponed due to negative signs in a dream, and as such, nightmares may predict serious health problems. An important decision might be made on the basis of a positive dream. One person's dreams might even be an omen of things to come for the entire community. The patient's behavior provides important clues for diagnosis and treatment. In general, a calm patient is healthy; crying and screaming may be signs of *susto* or "soul loss." The symptoms of *susto* vary, but include depression, anxiety, laziness, loss of appetite, shaking, fever, nausea, hearing noises in the ears, and passing gas.

A practitioner's treatment is highly individualized but the importance of a balanced diet is generally emphasized. Practitioners advise their patients to "eat food from the area and during its season;" some fruits may be eaten before they are fully ripe for medicinal purposes.

The Kallawaya healers employ more than one thousand medicinal plants, about one third of which have been deemed effective by allopathic biomedical standards, and another third of which have been judged "likely" to be effective (Bastien, 1992, p. 47). These plants are divided according to the three distinct "weathers" that Pachamama (Mother Earth) and Tataente (Father Sun) have given to their *ayllu*, namely hot, mild, and cold.

The fungus of corn or bananas produces a substance similar to penicillin that is used for local infections. More serious infections are treated by a preparation similar to tetracycline yielded by fermented soil; this preparation is also used for ulcerated skin and chronic conditions.

Coca leaves are ubiquitous in Kallawaya medicine and play a major role in many of the healing procedures because it is believed that the plant grows between the world of human beings and the world of the spirits. A coca and quinine mixture has been used to treat malaria – most notably, as Kallawaya healers tell the story, during the digging of the Panama Canal, a triumph that brought them to the world's attention.

Kallawaya medicine generally is accompanied by rituals involving prayers, amulets, and *mesas* - ceremonial fabrics on which objects are arranged, most often from left-to-right, symbolizing the journey from sickness to health. Llama fetuses are commonly used in the preparation of *mesas* because the llama is a sacred animal. Amulets are placed on the *mesa* or worn around the patient's neck, giving him or her confidence and spiritual power, especially when a patient complains of some type of deprivation. Various amulets represent health, love, wealth, or equilibrium with Pachamama and Tataente.

Mesas are used to prevent sickness or imbalance, often for the entire community. When they represent offerings to the spirit world, they are burned after their use. The so-called *Pachamama Mesa* can be burned on any day of the week, frequently for weddings or when crops are planted. The *Mesa Gloria* or *Mesa Blanca* is composed of 12 pieces of cotton on a white background and is burned on a Wednesday night in response to a thunderstorm. Sets of four figurines are placed on the *mesa* (e.g., four figures of horseshoes, houses, and llamas, four dice made of sugar, four pieces of St. Nicholas bread).

The *Awicha Mesa* or *Chulpas Mesa* is burned on Tuesdays or Fridays in honor of deceased members of the community. This practice is performed to console their spirits and relates to the *chulpas* (the preparation of corpses for traditional funerals). The care of the deceased reflects Kallawaya concern for spirits of the dead; indeed, it is believed that people who stroll through areas while funerals are being arranged sometimes fall sick because they offend these spirits.

One practitioner itemized the objects he used for his *mesas* – coca leaves, religious figurines, "gold" or "silver" bread (*pan de oro* or *pan de plato*), alcohol, eggs, white flowers, wool, fat, and llama fetuses. If a llama fetus is not available, he may use a pig or sheep fetus. The ingredients of the *mesa* are carefully chosen to represent the elements present in various levels and layers of the cosmos, as well as those folkloric ingredients that connect the present with the Andean past.

Herbal preparations usually are ingested but occasionally are used in conjunction with a "steam box;" the naked patient enters a chamber filled with steam from the medicinal mixture. The active ingredients of the herbs enter the pores of the patient at the same time as the sweat cleanses the toxins.

I observed a patient in one of these steam boxes in the Tambillo Hospital I visited on the outskirts of La Paz. In addition to the steam boxes and their cleansing therapy, the hospital was replete with hundreds of Kallawayaya herbal preparations, all carefully prescribed, measured, and given to patients with thorough explanation.

There is an armamentarium of procedures that do not involve herbs, for example, healing songs and dances. Some of these healing songs are believed to be especially effective in treating insomnia. Specialized dances are frequently utilized to renew the patient's supply of energy. *Susto* (soul loss) is treated in a number of ways; one practitioner mentioned asking Tataente, "am I allowed to heal this condition?" then burning incense, praying with the Christian rosary, and making offerings in the four directions of the compass.

The Kallawayaya society attempts to maintain a balanced environment in harmony with nature. Because prevention of sickness is an important element of the Kallawayaya system, any disequilibrium deserves immediate attention. In rare cases, the community has the responsibility to expel members who endanger the balance. A more common response is to support patients by bringing them food, money, music, and anything else that will maintain their faith and their motivation to recover; this community process is referred to as *ayni*. A festive ceremony for offering group assistance is referred to as a *preste* and is frequently used to treat *susto*. *Ayni* is especially important for people with chronic problems, because it demonstrates community support. A chronic condition often is seen as symptomatic of a person's isolation and separation; social support systems produce a balance that is thought to alleviate this loneliness.

These practitioners are not shamans, even though several shamanic traditions exist in Bolivia. Shamans alter their consciousness to obtain power and knowledge to help and to heal their patients (Krippner & Welch, 1992), a practice absent from Kallawayaya traditions. However, like shamans and even like many Western physicians, Kallawayaya practitioners maintain a wide scope of practice, applying their treatments to patients of all ages as well as to all types of sicknesses.

The rocky road on the way to integration of Kallawayaya ethnomedicine with conventional medicine

In the 1950s and 1960s, Bolivian pharmacists and physicians successfully curtailed the influence of Kallawayaya practitioners through public humiliation, restrictive laws (and imprisonment for their violation), and denial of licenses (Bastien, 1992). Even though some Kallawayaya practitioners incorporated various aspects of biomedicine into their procedures, physicians and politicians portrayed these healers, at best, as members of an antiquated tradition and, at worst, as charlatans. Both the success of Kallawayaya treatment and the increasing surplus of allopathic physicians in Bolivia exacerbated the situation.

Mounting a counterattack, many Kallawayaya healers stereotyped physicians as *kharisris*, mythic figures who steal fatty tissue, the source of force and energy in folk tradition. As a result, however, those Kallawayaya practitioners who had adopted a few biomedical practices often lost patients.

In the 1980s, most Bolivian physicians and nurses discontinued efforts towards integrating ethnomedicine because their superiors did not promote it (Bastien, 1992, p. 38). At the same time, there was a sharp resurgence in Kallawayaya practice as the value of their medicinal plants came to be touted by biomedical research, and because Bolivian farmers could not afford biomedical treatments. (In 1984 the cost of a penicillin injection was about \$10.00 U.S., representing several days' wages for farmers).

In the 1990s, communication between physicians and herbalists in Bolivia improved because of the interest in ethnomedicine; the two groups collaborated on several conferences and even jointly staffed a few clinics. Walter Alvarez, a gynecologist and surgeon as well as a Kallawaya practitioner, was instrumental in helping the Kallawaya of one *ayllu* obtain a clinic staffed by both a physician and an herbalist.

The rise of populist leaders in Bolivian governmental circles has brought renewed respect to traditional healing systems, such as those represented by the Kallawaya practitioners, and even to the growth and use of coca leaves – seen more as a medicine and source of fabric than as a scourge that produces cocaine. For all these reasons, biomedical techniques are finding their way into Kallawaya practice, and Kallawaya herbs are being used along with allopathic medicines without a loss of the Kallawaya tradition's unique identity.

Mexican-American Curanderismo

Curanderismo, or Mexican-American folk healing, is a coherent, comprehensive system of healing. It derives from the synthesis of Mayan and Aztec teachings with Mexico's heritage of Spanish Catholicism, as well as the heritage of Arabic medicine and, ironically given the persecution of witches by the Holy Inquisition, European witchcraft. Its underlying concept is the spiritual focus of the healing; the typical *curandera* (female practitioner) and *curandero* (male practitioner) who subscribe to this worldview place the religious element at the center of their practice. The unique characteristics of Curanderismo include all of these elements (Trotter & Chavira, 1981), reconciling diagnostic categories and treatments from traditions that were once in conflict – on the battlefield (e.g., Spain vs. the Moors, Aztecs, and Mayans) as well as in the church (e.g., Roman Catholicism vs. witchcraft).

Because Mexican-American Curanderismo covers these bases of effective treatment outlined by Frank and Frank (1991) and Torrey (1986), it is not surprising that its survival seems assured. Nevertheless, formal investigations of the practitioners, their worldviews, and their technologies seem necessary before globalization, industrialization, and political opportunism erode the unique aspects of this singular system of healing.

Diagnoses in Curanderismo are made on the basis of the history of the ailment, the symptoms, and retrospectively by the response to treatment. Diagnosis may involve natural, psychological, and/or spiritual procedures. On the natural level, a practitioner can observe the patient and ask questions. On the psychological level, a *curandera* may claim that she can “see” her patient's “aura” or energy body; the size, color, and shape of this “aura” can be important diagnostic signs.

Etiology can be natural, psychological, or spiritual, and these often are intertwined. On the spiritual level, a “spirit guide” often reveals the nature of a patient's problem in dreams. Initial diagnoses often are carried out by the patients themselves or by family members and neighbors. The roles of bacteria and viruses are taken for granted as possible causal factors.

For example, one common sickness is *empacho*, indigestion due to a ball of food being lodged in the intestine or food sticking to the wall of the stomach. A naturalistic explanation is usually given to this problem, but there can also be a spiritual base, e.g., maleficent spirits who refuse to allow a person's normal digestive processes to operate effectively.

Psychological causes are thought to be behind *bilis*, a malady caused by anger or fear, *envidia* (caused by jealousy), *mal aire* (by imbalances in relationships or in personal qualities), and *caida de mollera* – the perception that an infant's fontanel is too low due to his or her mother's neglect.

Spiritual etiologies abound in Curanderismo: *embrujada* or sorcery involves the participation of demonic spirits while *mal puesto* results from a hex. Sometimes there is a combined etiology: *empacho* can be brought about when a mother forces her child to eat too much or to consume food that the child dislikes.

The patient's behavior is used to help make a diagnosis. For example, if diarrhea, crying, vomiting, and sunken eyes accompany a fallen fontanel, the diagnosis of *caida de mollera* is confirmed. One form of *envidia* is *mal ojo*, which occurs when someone with an “evil eye” stares at the victim because of envy or desire. Symptoms include fever, headaches, vomiting, and drooping eyes. On the other hand, gas, constipation, a bitter taste in the mouth, and a “dirty white tongue” accompany *bilis*.

Specialists generally carry out treatment. Herbal treatments are supervised by the *herbolaria*, *medica*, and *herbalista* while the *señora* prescribes home remedies. The patient's “vibrating energy” may need to be modified by incantations or manipulation. Suggestion, confession, and persuasion are employed; the practitioner may increase patients' self-esteem by getting them involved in group activities and church functions, or asking them to visit a holy shrine. The *magica* combines herbs with such spiritual practices as prayers, chants, sprinkling holy water, burning incense, and lighting candles. Exorcisms are performed by an *espiritista* who is adept at enlisting the help of benevolent spirits and ridding the patient of malevolent ones. The etiology must be accurately made in order to insure the proper type of treatment, as well as to select the most appropriate practitioner.

There are important regional differences in Curanderismo. For example, its model of health emphasizes “balance” in relationships and behavior. But a “balance” of emotional “humors” and the avoidance of an excess of either “hot” or “cold” foods are important as well. An exception is found in southern Texas where “hot” and “cold” humoral treatment is virtually absent. The role thought to be played by witchcraft in a malady also varies from location to location.

Prognosis is favorable if the treatment regimen is closely followed. However, failure to comply may lead to a worsening of the condition or, in the case of such problems as *caida de mollera* and *mal puesto*, to premature death. It is believed that suicide often is the result of metaphysical sources but can also be a failure to find a spiritual approach to life's problems.

The practitioners will vary depending on location; a practitioner who is referred to as a *curandera* in San Diego, California, may correspond to a *señora* in San Antonio, Texas, a *medica* in Santa Fe, New Mexico, and a *parchera* in parts of Guatemala. Most practitioners of Curanderismo are women, but the proportion varies geographically. *Curanderas* typically are “called” to their profession by spiritual entities; they apprentice themselves to a friend or relative until they are considered ready to practice. Most of them are part-time practitioners who do not charge a specific fee but are given a small offering or gift. The setting is often the home of the practitioner and the function of Curanderismo is both diagnosis and treatment.

The goal of the Curanderismo model is to assist the recovery of the patient, restoring his or her “balance” within a social framework that preserves the traditions of the family and the Mexican-American subculture. Suffering and infirmity are seen as an inevitable part of life, and as part of God's plan to instruct human beings and lead them to salvation. Sickness is not seen as a punishment from God but as a challenge.

Integration of Curanderismo with Conventional Medicine

Curanderismo is ubiquitous in the U.S. Southwest as well as in cosmopolitan areas with a sizable Mexican-American population. It varies from community to community, but has become increasingly

visible as a result of the growing number of Latinas and Latinos in the United States as well as their increasing insistence that the physician or mental health practitioner they see for treatment recognize their cultural tradition (Kreisman, 1975; Lewis-Fernandez, 1994).

Hockmeyer (1990) investigated a specific *curandera*, Diana Velasquez, who had a staff position in a Denver community health center. Velasquez' success was attributed to her use of holistic, spiritual, ritualistic healing practices; to her charisma, gender, and ethnicity; to her ability to serve as a model of bicultural adaptation; and to a worldview that she and her clients shared. Velasquez reports that she only had to make minor adaptations in practicing Curanderismo to fit the bureaucratic requirements of the state mental health system.

The cases dealt with by Velasquez were far from simple, ranging from a young woman who had been continually sexually molested by her grandfather to a man undergoing a personal identity crisis when his wife found a well-paying job. She also had to cope with accusations by young "acculturated" members of the Mexican-American community that she was "nothing but a witch." Velasquez' diagnostic categories resemble those found in the U.S. Southwest, including *brujeria* and *embruajada*, both of which she treated with rituals to re-establish balance. She even successfully treated a Western-trained psychotherapist who was suffering from visual hallucinations during the day and insomnia at night, relying on her customary rituals.

Velasquez' experience suggests that the traditional practitioner who works with Western-trained physicians and psychotherapists needs to be well-trained, adaptable, and versed in the worldview of the dominant medical paradigm. From time to time, I hear of mainstream psychotherapists and physicians who seek treatment from the traditional practitioner on their staff. This practice came as a surprise to many researchers who have studied ethnomedicine (e.g., Koss, 1979) but may be as important if not more important in establishing the value and the authority of folk practitioners.

Ethnomedicine and Biomedicine

The World Health Organization (Mahler, 1977) has defined health as "a complete state of physical, mental, and social well-being, not merely an absence of disease or infirmity" (p. 3). Ethnomedicine is noted for its contributions to promoting and maintaining positive health, as much as for treating illness. The value of ethnomedical practitioners and their incorporation into biomedical systems has become widely heralded since the World Health Organization began advocating them, but the effort involved in training folk healers, the reluctance of the medical bureaucracy to accept them, and the decline of ethnomedicine in many parts of the world have discouraged such incorporation. The World Health Organization's goal of available medical care for all people of the earth in the 21st century depends upon granting folk healers professional autonomy as well as educating them to abandon worthless (and sometimes harmful) practices, and to teach them and their communities about effective public health measures (Bastien, 1992, p.27). Many ethnomedical practitioners use adaptive strategies that represent living and dynamic systems, subject to change in response to the community and the environment.

However, it is important not to romanticize folk healers and ethnomedicine as an ideal system of treatment. For instance, poisonous heavy metal content is very high in some traditional medicines, including those used by certain ethnic groups in the United States. Here are some examples:

A 1-year-old boy was diagnosed with brain damage by a traditional Tibetan practitioner. The practitioner gave the boy a Tibetan remedy and told him to take it three times per day. After four years, the boy was diagnosed with neonatal asphyxia, and the cause was determined to be the Tibetan remedy, one which had a high lead content (Moore & Adler, 2000).

Ayurvedic medicine, a traditional medicine widely used in India and in some parts of the United States, is usually made of vegetable products, but sometimes of metals and minerals as well. The latter may include lead, mercury, and arsenic, all of which can be toxic if taken over a period of time (Saper et al., 2004).

In some Mexican communities, two remedies known as “Azarim” and “Grotá” are commonly prescribed by folk healers for *empacho* (intestinal sickness). “Litargio” is also prescribed as a deodorant. All three have an extremely high lead content and are harmful even if used for short time periods (Smolinske, 2005). Bartholomew (1995) has made a broader-based analysis of culture-based syndromes and systems of healing, claiming that considerable malpractice and fakery abound.

Physicians who treat diverse ethnic populations need to become aware of traditional medicines often used in these communities. In addition, there is an increasing use by the general U.S. population of folk remedies as alternatives or enhancements to allopathic medical prescriptions. Physicians need to inquire about their use, and to be knowledgeable about both the benefits and the risks.

At the same time, if a Balinese shaman, a Kallawaya healer, or a Mexican-American *curandera* cannot help a patient, there may need to be a referral to an allopathic physician, especially if surgery is needed. In La Paz we were told it was a common practice for referrals to go in both directions.

Most people who use these three systems, as well as comparable systems in other parts of the world, recognize the advantages of biomedicine. Yet, they are often aware of how biomedicine can be used as a political instrument to discriminate against ethnic groups and socioeconomic classes, and to create dependency relations with the industrialized countries who supply (and profit from) allopathic medicines and implements. In this way, the contrast of ethnomedicine with that of allopathic biomedicine enters what has been called the postmodern dialogue. From a postmodern perspective, “official” medicine (i.e., biomedicine) can be contrasted with “traditional” medicine (i.e., ethnomedicine), observing that the latter has had to struggle for legitimacy against powerful forces. Further, the media are prone to ridicule or ignore unofficial “traditional” medicine since it can not sponsor commercials on TV channels, glossy magazines, or radio networks. However, the arrival of the Internet with its many blogs, websites, and data sources has given interested parties an opportunity to discover culture-based remedies and systems generally ignored by mainstream media outlets.

Ethnomedical practitioners attempt to preserve their own way of thinking with its emphasis on living in concord with the natural environment, on balance and harmony, and on community support and spiritual direction. Such concepts generally are foreign to allopathic biomedicine (Hufford, 1995). For example, allopathic biomedicine does not consider the role of ancestral spirits, of “karma,” or of “past lives” on a patient’s medical condition. Instead of viewing illness in a wide temporal, spatial, and social context it tends to deal with sickness in isolation and in a linear fashion that ignores a holistic perspective.

Biomedicine often positions itself as the only authority on what is to be taken as legitimate medical knowledge and practice and, in turn, establishes a particular domain of power. Supporters of biomedicine typically extend this privileged position to economics, politics, and class relationships. Legislation, medical schools, licensing, and medicinal terminology all interact to guard the power of biomedicine. It is no wonder that ordinary people frequently view biomedicine as serving powerful groups in their country while they struggle for a vestige of power over their own lives (Bastien, 1992, p. 17).

The celebrated ethnologist Claude Lévi-Strauss (1955) proposed that the kind of logic developed by indigenous people is as rigorous and complete as that of modern science. It is not the quality of the intellectual process that differs but the mode of expression and application. For example, the cultural myths of pre-Columbian Mexican and Central American societies not only were comprehensive guides to daily conduct but also provided an explanation for the mysteries of the universe. Each mythic episode can be interpreted in several ways according to the context and the listener's understanding. The symbols used are manipulated with such economy that each serves a wide range of philosophical and religious ideas. Quetzalcoatl was the "feathered serpent" who symbolized the transformation of matter into spirit, as well as the god of the winds, the Lord of Dawn, the spirit of the sacred ocelot (a fierce jungle cat), the last king of the Toltecs, and (following the Spanish conquest) Jesus Christ.

The three ethnomedical models of healing described in this discussion emphasize spiritual aspects of health and sickness, a dimension long ignored by biomedicine. I use the term "spiritual" to describe those aspects of human behavior and experience that reflect an alleged transcendent intelligence or process that inspires devotion and directs behavior. The spiritual dimension of life is evident to any person who becomes aware of a life meaning that extends beyond the immediacy of everyday expediency and concerns. The difference between religion and spirituality and can be described as a distinction between adherence to the beliefs and practices of an organized religious institution and a person's relationship to an alleged transcendent reality either with or without regard to a formal religion or creed (Krippner, 2002).

There are now dozens of studies dealing with "spiritual health" in the English language literature (Krippner, 2002). Four major dimensions have been studied in these investigations: meaning and purpose in life, intrinsic values, transcendent beliefs and experiences, and community relationships. For example, some of the studies found lower levels of depression among individuals who manifested one or more of these four dimensions (e.g., Koenig, 1999; National Institute for Clinical Excellence, 2004).

In several studies of African-Americans, high rates of hypertension were observed; the social support given by churches and communities have been suggested as antidotes to this condition (Krippner, 2002, p. 195). The link between physical health and spirituality or attendance at religious services has been affirmed in hundreds of investigations; it is especially apparent in reduced hospital stays, lower blood pressure, fewer heart attacks, reduced stress levels, and enhanced immune functions (Koenig, McCullough, & Larson, 2001; Levin, 1999). However, there are exceptions to these generalizations. Some people feel abandoned by God when they become sick; others refuse to take their children to a medical practitioner for fear of contravening "God's will."

In Summary

There are ecopsychologists who believe that healing the planet is basically a shamanic journey; if so, traditional medical systems can play a vital role in this endeavor. But while herbal medicines, indigenous treatments, and shamanism are becoming faddish in the West, indigenous systems are becoming increasingly endangered. It is crucial to learn what shamanism and related systems of healing have to offer the postmodern world before archival research in libraries replaces field research as the best available method for investigating these healing systems. Their longevity indicates that they have served many groups of people quite well over the millennia. The question remains as to what they can offer a world where allopathic biomedicine is not only revered but also powerful.

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