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ORIGINAL ARTICLES

THE PEYOTE WAY: IMPLICATIONS FOR CULTURE CARE THEORY

Kathleen W. Huttlinger, Ph.D., R.N.,* and Dennis Tanner, Ph.D.**

The development and provision of culturally sensitive and meaningful nursing care is a challenging yet essential element in our rapidly changing health care environment. This article describes the use of the theory of Culture Care to assess, understand, and plan care for an aphasic Navajo man who followed very traditional ways. It is an example of how nursing praxis can be applied to a clinical setting. A description of a Navajo peyote ceremony serves to illustrate the importance of incorporating traditional healing practices into nursing and collaborative care for individuals from diverse cultural backgrounds. It also describes how the participation in the Native American Church benefitted the client and his family. By using the Culture Care theory, the authors were able to make predictions about the influences of a culture specific expression, the peyote ceremony, had on the client’s care.

Cultural beliefs and the meanings that are associated with expressions of health and illness comprise an important element of nursing care (Leininger 1985; 1990; 1991; Stasiak, 1991). One of the goals of nursing theory is to be able to apply it to the practice setting “in order that a body of scientific and humanistic knowledge can be used to improve nursing care practices” (Leininger, 1988, p. 17). The purposes of this paper are threefold and interrelated. The first purpose is to describe a case study which involves a Navajo man with aphasia and to demonstrate how the theory of Culture Care (Leininger, 1985; 1991) can be used to develop and implement a plan of care that reflects the complex nature and wide diversity that is associated with cultural interpretations of health and illness. The second purpose illustrates the way in which Leininger’s culture

care meanings and action modes (1988) serve as a guide to achieve an understanding of a client’s involvement with the peyote ceremony of the Native American Church. The third purpose describes details of the actual ceremony that were not secret in order that readers might gain an appreciation for the significance of a traditional healing method.

Background

The use of the peyote cactus among Navajo Indians in Northern Arizona remains an important element in their religious and healing ceremonies (Aberle, 1982; Brito, 1989; La Barre, 1969). Since documentation in the literature of peyote use by Navajo people is scarce, the authors felt very fortunate to have been able to associate with individuals who were comfortable in sharing information about their religion including the peyote ceremony.

Peyote is a cactus from which the drug mescaline is derived. Mescaline is a stimulant as well as a hallucinogenic. Its use by Native Americans in religious and healing ceremonies was sanctioned by a court decision in 1970, PL 95-341 (Stewart, 1987). The use of peyote for healing purposes is only one part of a larger peyote cult that associates peyote use with shamanistic rivalries, tribal celebration, witchcraft, and in Plains tribes with war and conflict (Aberle, 1982; La Barre, 1969).

There is one major Peyote ceremony that is used for illness situations by Navajo people. They believe that the peyote is an elixir for various physical, mental and spiritual conditions (Aberle, 1982; Wagner, 1975). Most often Navajos use a combination of healing options available to them for treating illness and disharmony. These options may include biomedical and more traditional practices such as the Peyote ceremony for the treatment of illness (Sandner, 1978; Sobralske, 1985). Wagner (1975) stated that one basic premise followed by most Navajo people is that an individual's physical, mental, and spiritual well-being follows from the controlled focusing of supernatural power, and that all of the Navajo treatment techniques are avenues to the achievement of well-being. The Native American Church serves as a vehicle or means for the use of peyote. It is believed

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that peyote is stored in the body as part of the blood and that the accumulated affects of stored peyote results in a transformation of the person to a state of physical, mental, and spiritual well-being (Wagner, 1977). Although references in the literature have indicated that the ingestion of peyote is associated with taking-God into the body (Wagner, 1977), no mention of this association was indicated by informants for this paper.

**Theory of Culture Care Diversity and Universality**

A brief synopsis of the theory of Culture Care Diversity and Universality reflects a comprehensive framework that focuses upon the “universal and diverse features of care” across culture groups (Leininger, 1991, p. 3). In particular the theory serves to describe, explain, and predict differing values and lifeways. It is based upon the premise that “culture is the blueprint for thought and action and is a dominant force in determining health-illness caring patterns and behaviors” (Leininger, 1970). The earlier levels that were associated with the model can, and are still being used by many clinicians to assist with culture-relevant interventions. The levels serve to provide a frame of reference for the identification of factors that are associated with various culture perceptions of health, illness and care. Each level represents a unit of cultural analysis. For example, level 1 examines social structure, world view and environment; level 2 explores cultural values and beliefs of health and care; level 3 describes health-care systems and care; and level 4 examines roles, functions and activities of health providers and outcomes (Leininger, 1993).

The present Sunrise model reflects a level of nursing knowledge that has incorporated many transcultural research studies, philosophical considerations, and clinical applications (Leininger, 1991). Culturally congruent care can be guided by: 1) cultural care preservation and/or maintenance; 2) culture care accommodation and/or negotiation; and 3) cultural care repatterning or restructuring (Leininger, 1991). All or one of these modes of action may be utilized by the nurse at any one time. Using such plans of nursing care reflects a decision-making process that actively involves clients.

**Case Study**

The following describes a case study of a Navajo male, Mike (fictional name) who was experiencing post-traumatic aphasia. This case study illustrates the importance of integrating traditional healing systems into biomedical and nursing treatment modalities and demonstrates how the theory of Culture Care (Leininger, 1975, 1988, 1991) can be applied to a practice setting.

Mike was a 50 year old Navajo man who fell off the roof of his house and suffered a closed head injury to the left, temporal-parietal region of the skull. He was taken to a hospital where diagnoses of left subdural and intracerebral hemorrhage and a skull fracture were made. He was kept in the hospital where surgery was performed to remove a hematoma from the brain. Following the surgery, Mike experienced mild gait disturbances, disorientation to place, time, situation and person, severe receptive deficits in all modalities, preservation (continued and automatic repetition of an activity, word or phrase that is no longer appropriate) and fluent, predominantly phonemic jargon.

Mike was a traditional Navajo man who lived in a very remote area of Northern Arizona. He could not speak or write English and all communications between Anglo health care workers and nursing personnel were conducted through Native translators and English speaking family members. He was seen on a regular basis by a speech-language pathologist who developed a trusting relationship with the client and his family. During this association, Mike’s family stated that Mike was a strong believer in the “peyote way” and had been a member of the Native American Church since birth.

Following hospital discharge, Mike underwent treatment for his aphasia at a regional rehabilitation center where he was seen by a speech-language pathologist and by nursing staff. Although he never expressed dissatisfaction with his rehabilitation treatments, the nursing staff and speech-language pathologist noted that he frequently appeared depressed and despondent. Family members who were attending to him told the staff that he was unhappy. Approximately four weeks after his accident, his wife notified the speech-language pathologist that Mike was going to participate in a healing ceremony as part of the Native American Church. At the time of his healing ceremony, he had improved in orientation to place, situation and person, but remained disoriented to time. There were no significant changes in expressive output, perseveratory tendencies or verbal receptive capabilities.

**Aphasia**

Aphasia refers to an abnormal neurological condition in which an individual’s language function is defective or absent and is most commonly associated with a malfunction of the speech areas that are located in the cerebral cortex of the brain (Doody, 1991; Luria, 1970). This abnormal neurological condition is exhibited by a deficiency that may be sensory or receptive and can result in language spoken by the affected individual that
is not understood by others (Levin, 1981). The deficiency may also appear as an expressive or nonfluent condition, in which case the individual cannot form or express words and phrases. Both receptive and expressive aphasia may be complete or partial and affect specific language functions. Most commonly, the condition is a mixture of incomplete expressive and receptive aphasia. Aphasia may occur following a severe head trauma, prolonged hypoxia, brain disease or cerebrovascular accident. It is sometimes transient, as when swelling in the brain follows a stroke or injury. As soon as the swelling subsides, language may return. Intensive speech-language therapy, and effort by the client and the client’s family in transient aphasia cases, have proved to be successful in restoring language function (Caplan, 1987; Darley, 1982; Levin, 1981).

Another common symptom of head trauma is disorientation. Disoriented individuals have difficulty perceiving the correct place, time, situation and person. Many, if not all people with head injuries demonstrate confusion with disorientation at some time during their recovery. In most instances, confusion and disorientation are noted immediately after their accident. However, some people may experience general confusion and disorientation as an ongoing and persistent symptom of head trauma. A person who is disoriented to all four aspects of reality is said to be disoriented times four (D X 4).

Of the four aspects associated with disorientation, disorientation to time appears to be the most common type. Time is vulnerable because it is an abstract concept and is intangible. A person who is disoriented to time may be confused about when to eat meals and may therefore believe that noon is when breakfast is served, for example. In addition to exhibiting confusion with respect to the timing of events, many people who are disoriented have difficulty judging the passing of time. For example, a person may not be able to state exactly how much time has passed since a particular event has occurred such as when they ate their last meal. This person may believe only a few minutes has passed when in actually several hours have passed.

A second kind of disorientation to reality is disorientation to place. Disorientation to place rarely occurs independently of time. A person who is disoriented to place may not be able to identify where they are and it is common for the person to identify an erroneous city, state or country of residence. They also have difficulty identifying their “present” location such as a hospital or even their own home.

A third kind is disorientation to person one, who in the broadest sense, lost their identity. A person may not recognize family and friends or may only remember certain friends and relatives. The individual may also be confused about the self and think they are someone or something other than what they really are. This kind of disorientation can be complete or selective. Complete disorientation occurs when the individual is unable to identify any person known previously to them. Selective disorientation occurs when a person knows some aspects of their personal life but is confused about others. A person thus may be able to identify their spouse and children but is confused about other personal relationships. Disorientation to person may also include confusion about gender identity. For example, a male may state that he is a faithful wife or a female may believe that she is her father’s favorite son.

A fourth kind of disorientation to reality is disorientation to situation which involves the inability to identify what has occurred with regard to illness and hospitalization. People who are disoriented to person tend to deny that they have had an illness or that they were hospitalized.

Culture Care Theory and the Native American Church

One of the basic premises of the Culture Care theory is that “cultural care values, beliefs and practices are influenced by and tend to be embedded in the world view, language, religious (or spiritual), kinship (social), political (or legal), educational, economic, technological, ethnohistorical, and environmental context of a particular culture” (Leininger, 1991, p. 45). The religious practices that are associated with the Native American Church influence perceptions and understandings of daily life events and experiences including ideas about health and illness. In such a way, patterns of care emerge which are based upon cultural beliefs and practices and which may be in opposition to commonly held practices of the dominant culture.

The Native American Church began in the South Plains in the 1870’s (Brito, 1989; Stewart, 1987). Since that time it has extended its influence to other American Indian tribes around North America. For many, the ceremonies that are associated with the Church are used to cope with the problems that occur with everyday life. There are some indications that peyote and the peyote ceremony has become a favored religious curing ritual, especially among more “traditional” people, than previously used chantways (Aberle, 1982; Wagner, 1975). Wagner (1977) maintained that during the 1970’s, on the Navajo reservation, the Native American Church was in a stage of development that reflected an increase in the number of Church members as well as a “proliferation of ritual forms and beliefs” (p.1).
Members of the Native American Church believe that individuals can drift away from harmony (hozhoni) with God and nature (nature being represented by lesser or sub-Gods) unintentionally (Hutlinger, Kretting, Drevdahl, Tree, Baca & Benally, 1992). With the Navajo, disruption of hozhoni can be manifest in a number of ways including physical illness, mental disturbances and general life-related misfortunes. Such misfortunes may include drought, depletion of sheep herds, an illness in the family, or difficulties at work. It is very difficult for a traditional Navajo to associate the cause of a disease or body malfunction with a physiological process. Thus, with a traditional Navajo individual, it is perceived by them that any treatment of misfortune consists of dealing with causal factors that are attributable to loss of hozhoni and not with the illness or injury as such (Sandner, 1978). Therefore, from a Navajo perspective, Mike had fallen from the eternal way through no fault of his own and his symptoms of disorientation and aphasia were reflective of falling from the eternal way. Church members maintained that if an individual participated in prayer and other ceremonial activities directed toward God, harmony with nature and life functioning can be regained. Mike’s family hoped that he would be able to recover his normal speech and orientation again after he participated in such a healing ceremony.

Reichard (1944) maintained that Navajos wanted to “be natural, good, safe, well and young” (p. 21) and that this ideal was attained in a practical mode. This thought remains consistent today with both traditional and nontraditional Navajo people (Hutlinger, et.al., 1992; Sandner, 1978). For example, many Navajo people still believe that people who deviate from this ideal, experience illness, hardship, abnormality or ill will (Csordes, 1989). Therefore, it is reasonable to expect that the ultimate aim of Navajo curing ceremonies is to restore the ideal and natural harmony.

The Peyote Ceremony: Health Provider as Co-participant

This particular case study is an example of the need to achieve a more in-depth understanding of the role of cultural beliefs and practices. As the authors worked with the Navajo client, they were able to restructure patterns of care, as needed, and to incorporate basic Navajo beliefs and values. In particular, the authors began to realize the important role the Native American Church played in the lives of many Navajos with respect to health and illness care. The authors believed that by observing the ceremony they could add to the general body of knowledge that was generating their care for the client. Expressing interest in and acceptance of the importance of the Native American Church would hopefully serve to enhance interpersonal communication and confidence between the authors, the client and his family.

Following this, one of the authors, a speech-language pathologist, expressed to Mike’s family his interest in the Native American Church and its use of peyote. He was particularly interested in how the client’s participation in a peyote ceremony might affect his communication disorder. He was subsequently invited to observe the special peyote ceremony for Mike but had to agree to keep certain aspects of the ceremony secret. The author agreed and what is reported here does not violate any traditional or sacred rites. A member of the tribal government also attended the ceremony to insure that no secret rites were being carried out in the presence of non-Navajo observers.

Mike and his family arranged for the ceremony to be conducted on the Navajo reservation by a special medicine man known as the “Roadman.” Roadmen are most often very respected people among the Navajo and hold places of high social esteem. Roadmen have a certain amount of freedom for innovation in the peyote ceremony and the only validation needed by him is to have a revelation while under the influence of peyote. The Roadman was paid for his services by Mike and members of his extended family. Payment varies with the length and complexity of the ceremony and with the individual Roadman. Some Roadmen are known to be very expensive while others charge more moderate fees. According to Mike and his family, the average cost of a peyote ceremony is $300. In addition, payment may be made in kind in the form of sheep, cloth, valuable articles, etc. However, all payments, cash and in-kind, are agreed upon in advance of the ceremony.

The services were conducted in a traditional eight-sided Navajo log hogan. The hogan was approximately 25 feet in diameter and was consistent with hogans throughout the reservation. For the Navajo, the hogan is the preferred site for peyote healing ceremonies because it is believed that the “power” which emanates during the ceremony works more effectively in traditional structures with “round” walls. Hogans usually have a smoke hole in the roof and the doors face eastward toward the direction of the sacred rising sun. In this case, the hogan had a wood stove in the center of the floor and provided heat as well as coals for preparing the burning cedar chips that were used in the ceremony.

The actual ceremony lasted fourteen hours. Twenty-four people were present including family, friends, invited guests and the Roadman. Neither photographs or audiotapes were permitted during the ceremony but the author was permitted to take notes and record observa-
The ceremony was conducted in Navajo but two individuals were present who served as translators and explained the events and processes of the ceremony to the author.

Within the hogan, a mound of dirt was formed into a quarter-circle which measured approximately two-and-a-half feet across. At either side of the quarter-circle, an oil lamp was placed to provide light since electric power was not available. The quarter-circle mound was referred to as the moon circle and there was a narrow line scratched out in the center of the circle which was called the “eternal road.” The line representing the eternal road was an important component of the peyote ceremony and symbolized an individual’s “life” travels from birth to death.

When individuals enter a hogan at the beginning of the ceremony, they customarily walk around the interior in a clockwise manner. Walking in such a manner is in keeping with a person’s travels along the moon circle and symbolizes life’s journeys from birth to death.

Another important symbol of the ceremony was the peyote cactus button. The button was placed on the line and represented Mike’s place on the road of life. Mike sat in front of the moon circle with the Roadman sitting to his right and Mike’s wife sitting on his left. The peyote that was used by the participants in the ceremony was provided in the form of a powder and was placed in a tea. The tea was placed on the west end of the moon circle.

All individuals who were to participate in the ceremony entered the hogan and proceeded to walk in a clockwise manner to their places. Once the actual ceremony began, no one was permitted to leave or enter the hogan until the ceremony was concluded. All participants and observers were not allowed to sleep or nod during the fourteen hours that the ceremony took. Most people sat with their backs to the walls of the hogan on blankets or sheep skins. There were two, five minute breaks during the fourteen hours at which time everyone was permitted to move about and stretch.

The Roadman had three assistants who were responsible for keeping the woodstove burning throughout the ceremony for keeping the tea and water circulating among the participants and for handling the corn-husk cigarettes that were used during the ceremony. To serve as an assistant to the Roadman was considered a very high honor. The assistants were also responsible for placing cedar chips on the coals. The odor which the cedar emitted was believed to serve as a purifying agent.

Approximately one hour into the ceremony, peyote was taken by all of the Church members including a ten year old girl. The peyote was taken by individuals in a tea and as a free form powder. The powdered peyote was kept in a jar and passed around to all church members.

Each individual determined the amount to take and this amount was influenced by previous experience and tolerance. Even so, many individuals vomited after ingesting the peyote which was seen as part of the purifying ritual. Most of the church members present took the peyote at least four or five times during the fourteen hour ceremony. It was believed that peyote assisted in making the Great Spirit and other supernatural forces more apparent.

Prayers were offered by the members of the Church and were directed at the Great Spirit and lesser Gods for the benefit of the patient. A flute was used to signal to the Gods that prayers were forthcoming. The prayers were spoken in Navajo and were uttered while a tobacco-mix, hand-rolled in a corn husk, was smoked. The smoke was to provide a medium by which the words were conveyed to the Great Spirit. The prayers were said in earnest, sincere efforts by family and friends to coax the Great Spirit into assisting the patient to return to harmony with nature.

During the ceremony, the singing of traditional Native American songs, accompanied by a drum and rattle, were sung as offerings to the Great Spirit on behalf of the patient. In a clockwise and circular progression, beginning with the Roadman, each pair of Church members would offer a song. The song was accompanied in harmony by all present.

During the final hours of the ceremony, both the patient and his wife were permitted to discuss the nature of his illness. Mike produced a long segment of perseverated jargon and was noticeably moved by the opportunity to express himself. His wife explained how Mike’s accident changed her life and her relationship to Mike. She also described the sadness that had overcome their daily lives. At the conclusion of the ceremony, Mike’s wife offered thanks to each individual who attended the ceremony.

**Culture Care Theory: Practice Implications**

In this case study, cultural care was essential to Mike and his family in order for them to face the trauma which had occurred. The perceived health goal for Mike and his family was to restore harmony to their lives. The disharmony for Mike and his family occurred with his accident. Mike’s well-being was an integral part of the total, immediate and extended, family’s well-being. Restoring total harmony was therefore paramount not only to Mike’s health but with that of his family as well.

By using the Culture Care theory as a guide, the authors were able to make predictions about the influences that certain culture-specific expressions, meanings and practices had on Mike’s care. For example, by
knowing that Navajos value harmony between the land, all people and the environment, the authors were able to appreciate and understand the importance of including the family and mother earth in treatment plans. Both providers were also very careful to appreciate and acknowledge the use of silence and the importance of “correct” listening, to observe all rules of etiquette including not asking “too many questions” and avoiding direct eye contact.

The outcome of the peyote ceremony provided an interesting perspective in terms of Mike’s lifeworld and his spatial orientation. Mike’s wife and family reported that he was more oriented and in harmony “in the way of the Navajo.” Family and church members believed that Mike had regained a portion of the harmony with God and nature that had been lost as a result of his accident.

It is important to note that Mike’s speech and language rehabilitation treatments were based upon a biomedical model that focused upon Mike’s orientation to person, place, situation, and time. This approach was less than satisfactory because it was not as valued by Mike and his family as the more traditional healing ways. Following the peyote ceremony, Mike resumed his speech rehabilitation with some minor improvements noticed in the quality of his speech and a significant improvement in quantity (amount). He did not appear as depressed at his speech therapy sessions and smiled often and without encouragement.

From a biomedical perspective, the achievement of reality orientation would include increasing the number of appropriate responses to environmental stimuli and the recognition of time, place, situation and person. To determine the nature and course of the reality therapy, efforts are often made by health providers with the client to identify disorientation, the nature of environmental demands, and to discover the intent of communication attempts by the aphasic person.

As culture care meanings and practices are often very difficult to identify, it is important that the providers of care make an attempt to learn what elements are important to that particular cultural group. In this case, the care providers attempted to provide culturally congruent care to the Navajo client and his family. All attempts were made to preserve and appreciate traditional caregiving practices and observances.

In addition to the above, the authors believe that it may be useful to include and incorporate culture care accommodation and cultural care repatterning. Culture care accommodation can be achieved by integrating particular cultural nuances into patterns of care. For example, in this case study it was important to acknowledge and use periods of silence during interviews and conversations and to give culturally appropriate time (often many minutes) for the client and his family to respond to questions. It was also important to avoid direct eye contact with the client and his family, to involve the family in all aspects of care (allowing family members in the examining room, etc.) and to solicit advice and recommendations from them. Cultural care repatterning and restructuring requires a knowledge of the particular culture in order that a repatterning of caring lifeways can take place. By observing a religious ceremony, the authors were able to become co-participants in the culture care of the client and to incorporate a religious practice, the use of peyote, into a plan of care. However, in this instance, the restructuring of care was focused more on the provider than the client.

Based upon the experience with Mike, the authors maintain that a cultural needs assessment, guided by Culture Care theory, be conducted at the time of initial contact with the patient. In this way, many traditional beliefs, health care practices and other pertinent information related to culture specific care can be incorporated into ongoing and meaningful therapeutic interventions.

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**Quote For The Day**

*I would like to see all health personnel give value to ways of building quality of life based upon the assets and strengths of people rather than on identification of the illness or pathologies. What keeps people well and functioning is important.*  
— Leininger 1983
REFERENCES


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Dr. Neil and Theresa Cooper long time supporters of the Transcultural Nursing Conference chat with Dr. Leininger.