Diagnosis and Distress in Navajo Healing

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Abstract: In contemporary Navajo society, traditional Navajo ceremonies, Native American Church prayer meetings, and Navajo Christian faith healing are all highly sought-after resources in the everyday pursuit of health and well-being. What is the nature of affliction among patients who turn to such forms of religious healing? Are these patients typically afflicted with psychiatric disorder? In this article we discuss 84 Navajo patients who participated in the Navajo Healing Project during a period in which they consulted one of these forms of healing. We present diagnostic results obtained from the Structured Clinical Interview for DSMIV (SCID) administered to these patients. We then present an ethnographically augmented analysis comparing the research diagnosis obtained via the SCID with a clinical diagnosis, with the diagnosis given by religious healers, and with the understanding of their own distress on the part of patients. These analyses demonstrate how a cultural approach contributes to the basic science and clinical understandings of affliction as well as to discussion of the advantages and limitations of DSM categories as descriptors of distress and disorder.

Key Words: Culture and psychiatric disorder, diagnosis, psychiatric anthropology, psychotherapy analogy, Navajo mental health

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What is the nature of affliction among patients who turn to religious healing? Moreover, how can we conceptualize such affliction in a way that is of value to psychiatrists and other mental health care professionals who in the course of their duties encounter patients who may have had, or may still be having, recourse to religious healing? This question is markedly different from that of whether religious participants suffer from or are protected from pathology of various types by virtue of their religiosity (Schumaker, 1992). It is a question that has, at least for the past 5 decades, more often been answered in terms of an analogy between ritual healing and psychotherapy, with the assumption that the distress addressed by those who have recourse to such healing corresponds to the kinds of emotion and mental disorders addressed by psychotherapy (Csordas, 1994, 2002; Frank and Frank, 1991; Kiev, 1964).

Several empirical considerations add complexity to the psychotherapy analogy. First is the commonplace observation that in many systems of religious healing, there is no explicit distinction among physical illness, emotional illness, or dilemmas and obstacles of living (Csordas and Lewton, 1998; Kiev, 1964). Second is the difficulty of identifying and labeling problems across cultural and religious boundaries in a manner that corresponds adequately to the distress experienced and expressed by patients, and such that the distillation of symptoms into a diagnostic entity does not entail a denaturing of the existential situation of a patient (Good, 1992, 1994; Kleinman, 1980, 1988). A final factor is the often tenuous correspondence between diagnoses generated by different systems—medical and psychiatric systems that aspire to objective validity on the one hand, cultural and religious systems whose validity are contextually specific on the other. Over the last several decades, these considerations have been evident as repeated revisions of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association struggle to take into account cross-cultural variations in psychiatric disorders (Kirmayer, 1997; Mezzich et al., 1996).

We approach the question of the nature of affliction using data from the Navajo Healing Project (NHP), a 10-year study of therapeutic process in 3 forms of religious healing practiced by contemporary Navajo Indians (Csordas, 2000). Our intent is to understand the manner in which problems presented to healers can be understood from different cultural/diagnostic standpoints, and to raise the question of how those standpoints can serve both to mutually inform one another and to critique one another's assumptions. The goal is to contribute to a comprehensive existential understanding of the nature of affliction.

ETHNOGRAPHIC CONTEXT

The Navajo, or *Diné* in their own language, are an Athabaskan people who, along with the kindred Apache peoples, migrated south from Alaska and Canada to what is now the American Southwest approximately 500 years ago, roughly the same time as Spaniards were migrating north from Mexico into the same region. The contemporary Navajo Nation is located geographically in the "four corners" region where New Mexico, Arizona, Utah, and Colorado meet. The Hopi Indian reservation is adjacent, in fact completely surrounded by the Navajo reservation, and immediately to the

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west is the Grand Canyon National Park. According to the 1990 census, the American Indian population of the Navajo Nation (including resident members of other Indian tribes but not people of other racial categories recognized by the census) was 148,983. Results of the 2000 census showed an Indian population of 173,987. This represents a population growth of over 16% in 10 years, though it is impossible to say what proportion of that might be accounted for by improved enumeration techniques. In addition, although precise figures are not available, as many as another 50,000 Navajos live in various other regions of the United States, many maintaining close ties to their homeland.

Navajo society was traditionally organized around a system of exogamous matrilineal clans, the 4 original clans created by the deity Changing Woman having developed into a highly complex system of subclans augmented by adopted clans representing groups of foreigners who at various historical moments have been incorporated into Navajo society. Traditional subsistence is based on a combination of farming with corn as the principal crop, and livestock husbandry with sheep as the principal animal. In the twentieth century these were supplemented by artisanship (silversmithing and rug weaving) and wage labor, first in railroad construction and mining of coal and uranium, and more recently in service occupations with the Bureau of Indian Affairs, the Indian Health Service, and the Navajo Nation government. In general, though Navajos remain an economically poor people, their land, resource, and population base mark them as relatively well off in comparison to many other American Indian tribes. The Navajo are also characterized by considerable cultural and linguistic viability—traditional ceremonial life is lively, and the Navajo language is taught in public schools and spoken daily by a substantial proportion of the population.

METHOD

The NHP was an ethnographic study of therapeutic process among healers and patients representing 3 forms of healing: traditional Navajo ceremonies, Native American Church peyote meetings, and Navajo Christian faith healing prayers (Csordas, 2000). Each of these forms of healing is highly nuanced in terms of practice and experience, and in everyday life among the Navajo the 3 are intertwined with one another and with conventional biomedicine.

Four teams, each consisting of an ethnographer and an interpreter, were assigned to the 4 quadrants of the Navajo reservation and recruited subjects who participated voluntarily after informed consent was obtained. In the first phase of the research the teams interviewed 95 healers representing the 3 religious traditions. In the second phase, 84 patients were recruited to the study by the ethnographic teams after having been recommended for participation by their healers, having been referred by fellow patients (often family members), or having been solicited by Navajo members of the project staff through their own social and kinship networks. Interviews were conducted in English or Navajo according to the participant's preference.

NHP interpreters were an integral part of the ethnographic teams during the 10 years of the project, consulting and participating in research meetings in which issues of translation were discussed. We considered and discarded the idea of standardized translations of ethnographic and diagnostic (SCID) interview protocols based on (1) previous experience with attempts to standardize both ethnographic questions and a symptom checklist, (2) narrative and conversational qualities of the interviews that allow flexibility in when questions are asked and improvised follow up questions, (3) Navajo cultural style that registers standardized questions as stilted and awkward, and (4) discomfort on the part of interpreters with questions in written Navajo even when they were literate in what was traditionally an oral language. The same interpreters worked with participants for both diagnostic and ethnographic interviews, thereby facilitating translation by increasing contextual understanding of each person's individual narrative.

For each patient, the ethnographic team conducted a series of open-ended interviews developed for use in this project, called Distress and Illness in Navajo Experience. The Distress and Illness in Navajo Experience encompasses demographics and family context, life history and illness history, current illnesses and healing experiences, and expectations for the future. We included observation of an event of ritual healing conducted for the patient and experiential commentaries on that event following the Interpersonal Process Recall format (Csordas, 1994; Elliot, 1984, 1986). We conducted follow up interviews at intervals of 6 months and 1 year to determine the longer term effects of ritual healing.

We also successfully completed a psychiatric diagnostic interview with 78 of the 84 participants, using the Structured Clinical Interview for DSM (SCID-NP), a semi-structured interview specifically for nonpsychiatric patients. Training for NHP SCID interviews was provided by the National Center for American Indian and Native Alaskan Mental Health Research in Denver, Colorado. Interviewers were trained to reliability using a series of videotaped interviewers coded by an expert panel, and in addition performed supervised interviews before beginning fieldwork. Interviews were conducted by 2 research team clinicians (a psychiatrist and a doctoral level clinical psychologist) with extensive experience treating Navajo patients in the Indian Health Service. We note that in practice the instrument has a flexible narrative format, such that reliability assessment is not simply a matter of interpreting a standardized protocol, but would require 1 readministration of the interview to each patient by 2 clinicians at least as experienced in Navajo mental health care as the NHP team members. Moreover, focus on reliability begs the question of the SCID's conceptual adequacy and the validity of the categories of disorder it purports to measure, central concerns of this article. We addressed these issues by asking clinician interviewer to prepare a supplementary clinical narrative to accompany the formal SCID assessment, and this narrative forms a key aspect of the analysis presented here. In a future publication we will present a methodological comparison of narrative and interactive dimensions of the SCID and ethnographic interviews with NHP participants.

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The SCID consists of an open-ended information-gathering component and separate algorithmically structured modules exploring mood, thought, anxiety, and substance use disorder symptoms across the patient's lifespan (Spitzer et al., 1992). It facilitates assessing patients across 4 of the 5 dimensions (axes) of psychiatric clinical status: (1) primary psychiatric disorders; (2) developmental and personality disorders (not addressed by SCID questions); (3) relevant medical disorders; (4) severity of psychosocial stressors; (5) level of adaptive functioning (can receive a score of 1–100). A variety of recent articles report use of the SCID in community or clinically based studies with distinct cultural groups and sometimes small numbers. Examples include studies of disorders associated with trauma among 19 survivors of the massacre of a church congregation in South Africa (Ogden et al., 2000), among 59 Cambodian refugees (Hubbard et al., 1995), and among 38 refugees from Afghanistan (Mghir et al., 1995); postpartum depression in 959 Chinese women in Hong Kong (Lee et al., 2001); depression, anxiety, and alcohol abuse among indigenous residents of an Arctic community (Haggarty et al., 2000); the relation of stigma to depression and somatization among 80 psychiatric outpatients in India (Raguram et al., 1996; Weiss et al., 1995); psychoses and affective disorders among 42 psychiatric inpatients in China (Wilson and Young, 1988); schizophrenia, mania, and depression among 60 psychiatric inpatients in Turkey (Mete et al., 1993). These studies are explicitly interested either in particular disorders, in determining the disorders associated with a particular stressor as in the work on trauma, or in discriminating among disorders present in a particular community or clinical population.

SCID DIAGNOSTIC RESULTS

Demographic characteristics of the patients are reported in Table 1. Nothing in the data suggests that these characteristics are atypical of Navajos who have recourse to ritual healing. Patients ranged in age from 16 to 84 years of age with nearly half (49%) age fifty or above. Yet although the Navajo population as a whole is younger than the U.S. with a median age less than 25 years old, it is not surprising that older people with more significant health problems and greater resources to obtain ritual healing would be prominent. Also of note is that our population reflected a substantial diversity of educational experience with 30% of patients completing less than 6 years of formal education and 27% completing more than 2 years of college work. Again not unexpectedly, over a third (38%) of the patients spoke only the Navajo language during the interviews with another 10% speaking both Navajo and English. At the time of the interviews, 33 of the 84 patients were involved primarily with Traditional healing ceremonies, 21 with Native American Church meetings, and 30 with Christian healing ceremonies. Two patients dropped out of the ethnographic study before completion, 2 patients declined the SCID interview after completing the ethnographic interviews, 1 patient consistently gave evasive answers such that the interview as a whole was deemed invalid, and 1 patient died in a motor vehicle accident.

Table 2 shows the proportion of patients who met criteria for SCID diagnoses in the major Axis 1 categories of mood disorders, anxiety disorders, and alcohol or substance abuse disorders. Insofar as our interest includes levels of distress that might prompt recourse to treatment we report subthreshold results as well as those that meet threshold criteria for DSM diagnoses. We draw attention in particular to the lifetime rates of alcohol use, major depression, and PTSD, the 3 most common diagnoses we found among participants in Navajo ritual healing. The prominence of these 3 diagnoses corresponds to findings of a major psychiatric epidemiology study reported by Beals et al. (2005 a,b) for a randomly selected general population sample of Native Americans in the Southwest ($N = 1446$). The fact that the NHP participants constitute a group in treatment rather than a representation of the general population accounts for the lower rates (depression 10.7%, PTSD 16.1%, alcohol abuse 14.1% and dependence 9.8%) observed by Beals et al. (2005a, p. 103). On the other hand, rates for both PTSD and alcohol dependence were notably higher among both Southwest Indians and nonrelated Indians of the Northern Plains region than for the general population of the United States as determined by the National Comorbidity Study (Beals et al., 2005b, p. 1726–1727). Rates for depression were generally lower than in the NCS, though the researchers recognize that this was likely an artifact of the CIDI (Beals et al., 2005b, p. 1726–1727, 2005c, p. 1719–1721), a lay-administered instrument both clinically less sensitive and culturally less flexible than the SCID. In general, the epidemiological researchers reported significantly higher lifetime rates of any psychiatric disorder among the Indian nations as compared with the NCS sample (Beals et al., 2005b, p. 1726–1727).

Breaking down the results in Table 2. by sex, among men ($N = 31$) in the NHP 12.9% reported alcohol abuse and 54.8 dependence, whereas among women ($N = 47$) 6.4% reported alcohol abuse and 21.3% dependence at some time in their lives ($p < 0.001$). In the psychiatric epidemiology study the corresponding proportions were 21.7% and 17.0% for men, and 8.0% and 4.1% for women (Beals et al., 2005a, p. 103). In the NHP, 16.1% of men and 38.3% of women reported major depression at threshold levels, whereas the epidemiologists determined corresponding rates of 8.5% for men and 12.3% for women (Beals et al., 2005a, p.103; but see previous paragraph on methodological difficulties with the epidemiological study). Among NHP participants, 16.1% of men and 23.4% of women reported PTSD at threshold levels, whereas comparable levels in the epidemiological study were 11.7% for men and 19.5% for women (Beals et al., 2005a, p. 103). Note that despite the difference in magnitude of rates for all 3 diagnoses, the gender proportions are in concordance across the ethnographic and epidemiological studies.

By age, in the NHP for those under 30 ($N = 16$) lifetime alcohol abuse was 6.3% and dependence 47.3%, for those 30 to 49 ($N = 23$) abuse was 4.3% and dependence 47.8%, and for those 50 and over ($N = 39$) abuse was 5.1% and dependence 17.9%. The half of participants

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TABLE 1. Patient Demographics ($n = 84$)

	Traditional		NAC		Christian		Total	
	n	%	*n*	%	*n*	%	*n*	%
Age								
≤19	2	6.1	1	4.8	2	6.7	5	6.0
20–29	3	9.1	7	33.3	3	10.0	13	15.5
30–39	8	24.2	3	14.3	4	131.3	15	17.9
40–49	4	12.1	3	14.3	3	10.0	10	11.9
50–59	5	15.2	3	14.3	8	26.7	16	19.0
60–69	7	21.2	4	19.0	4	13.3	15	17.9
70–79	4	12.1	0	0.0	5	16.7	9	10.7
80–89	0	0.0	0	0.0	1	3.3	1	1.2
≥90	0	0.0	0	0.0	0	0.0	0	0.0
None reported	0	0.0	0	0.0	0	0.0	0	0.0
Gender								
Male	17	15.5	9	42.9	8	26.7	34	40.5
Female	16	48.5	12	57.1	22	73.3	50	59.5
Marital status								
Single	5	15.2	7	33.3	4	13.3	16	19.0
Married	22	66.7	9	42.9	19	63.3	50	59.5
Widowed	1	3.0	0	0.0	3	10.0	4	4.8
Separated	1	3.0	1	4.8	1	3.3	3	3.6
Divorced	0	0.0	2	9.5	3	10.0	5	6.0
Live with partner	3	9.1	2	9.5	0	0.0	5	6.0
None reported	1	3.0	0	0.0	0	0.0	1	1.2
Education								
Grades 0–5	10	30.3	6	28.6	9	30.3	25	29.8
Grades 6–8	3	9.1	0	0.0	1	3.3	4	4.8
Grades 9–12	6	18.2	2	9.5	4	13.3	12	14.3
High school graduate	0	0.0	1	4.8	5	16.7	6	7.1
1–2 yr. College	7	21.2	3	14.3	3	10.0	13	15.5
2–3 yr. College	2	6.1	6	28.6	3	10.0	11	13.0
College graduate	5	15.2	3	14.3	4	13.3	12	14.3
None reported	0	0.0	0	0.0	1	3.3	1	1.2
Occupation								
Rancher/farmer	3	9.1	4	19.0	1	3.3	8	9.5
Unskilled labor	6	18.2	5	23.8	5	16.7	16	19.0
Skilled labor	1	3.0	2	9.5	4	13.3	7	8.3
Changer/roadman/minister	1	3.0	1	4.8	1	3.3	3	3.6
Craftsperson	1	3.0	1	4.8	3	10.0	5	6.0
Government[a]/professional	8	24.2	2	9.5	5	16.7	15	17.9
Homemaker	2	6.1	1	4.8	2	6.7	5	6.0
Student	2	6.1	2	9.5	3	10.0	7	8.3
Other	2	6.1	1	4.8	0	0.0	3	3.6
None reported	7	12.2	2	9.5	6	20.0	15	17.9
Language of interview								
Navajo	13	39.4	8	38.1	11	36.7	32	38.1
English	14	42.4	13	91.9	17	56.7	44	52.4
Navajo and English	6	18.2	0	0.0	2	6.7	8	9.5

[a]Either federal, state, tribal, or chapter government occupations.

under the age of 50—those less likely to have a traditional cultural background or to be fluent in the Navajo language—were more likely to have a lifetime diagnosis of alcohol abuse/dependence than those over 50 ($p < 0.001$). This age difference was less significant for a cutoff age of 40 ($p < 0.04$) and not significant for a cutoff age of 30. The authors of the psychiatric epidemiology study point out that this pattern is also evident in the NCS and other national datasets, though in their own work they found virtually the opposite. The findings pertain to males

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TABLE 2. Patients Meeting DSM-IV SCID Criteria (N = 78)

	Subthreshold		Threshold	
	N	%	*N*	%
Mood disorders				
Current major depression	NA	NA	7	9.0
Lifetime major depression	6	7.7	23	29.5
Dysthymia (current only)	3	3.8	2	2.6
Lifetime bipolar disorder	0	0.0	1	1.2
Anxiety disorders				
Current PTSD	NA	NA	4	5.1
Lifetime PTSD	9	11.5	18	23.1
Current other anxiety disorder	NA	NA	4	5.1
Lifetime other anxiety disorder	79	0.1	16	20.5
	Abuse		**Dependence**	
Substance Abuse	*N*	%	*N*	%
Current alcohol use	0	0.0	2	2.6
Lifetime alcohol use	7	9.0	27	34.6
Current cannabis use	0	0.0	1	1.3
Lifetime cannabis use	5	6.4	4	5.1
Current use any other drug	0	0.0	1	1.3
Lifetime use any other drug	6	7.7	7	9.0

(Women in no age category exhibited rates above 10%), with the youngest age cohorts showing lowest lifetime dependence, males 35 to 44 highest at 44.9%, and males 45 or over next highest at 33.8% (Spicer et al., 2003). Lifetime threshold rates of major depression in the NHP were 18.8% among those under thirty, 30.4% among those 30 to 49, and 33.3% among those 50 and over. The psychiatric epidemiology study reported negligible age differences among women, and slightly lower rates for men 45 and over (Beals et al., 2005c, p. 1719). Lifetime threshold rates of PTSD in the NHP were 31.3% for those under 30, 39.1% for those 30 to 49, and 10.3% for those 50 and over. The psychiatric epidemiology group presents a useful breakdown of exposure to traumatic events by age, but no age breakdown of the PTSD diagnosis per se (Manson et al., 2005).

In the NHP, among married participants (N = 51) alcohol abuse was 11.8% and dependence was 29.4%, among those widowed/separated/divorced (N = 11) abuse was 9.1% and dependence 36.4%, and among the single (N = 16) abuse was 0% and dependence 50%. The psychiatric epidemiologists reported lower risk for married Southwest Indians, corresponding to findings of the NCS (Spicer et al., 2003, p. 1792). Lifetime major depression in the NHP was 27.5% among the married, 45.5% among the widowed/separated/divorced, and 25% among the single. Lifetime PTSD was 23.5% among married participants of the NHP, 9.1% among the widowed/separated/divorced (though 45.5% in this category reported subthreshold symptom levels), and 31.3% among the single.

Comparing the 3 healing traditions in the NHP, we found significant differences in lifetime rates of alcohol abuse/dependence. Among those in Native American Church healing (N = 20) abuse was 10% and dependence 60%, among those in Traditional Navajo healing (N = 31) abuse was 6.5% and dependence 38.7%, and among those in Christian healing (N = 27) abuse was 11.0% and dependence was also 11.1% ($p < 0.005$). Lifetime major depression was 20.0% for Native American Church participants, 35.4% for Traditional Navajo participants, and 25.9% for Christian participants. Lifetime PTSD was 25.0% for Native American Church, 19.3% for Traditional, and 25.9% for Christian.

Finally, a view of these results from the following 3 interrelated perspectives addresses the presence of psychiatric disorder in ritual healing, a necessary determination if what we have called the psychotherapy analogy can be said to be salient:

1. Only 23.1% (N = 18) of NHP participants were free of any lifetime psychiatric distress, whereas 33.3% (N = 26) had a current threshold or subthreshold diagnosis of some kind of mood, substance abuse, or anxiety disorder. An additional 23.1% (N = 18) had a lifetime comorbidity including 2 categories of diagnosis (4 having both a substance abuse and depressive disorder, 5 having substance abuse and an anxiety disorder, 9 having depressive disorder and an anxiety disorder), and 20.5% exhibited lifetime comorbidity including a diagnosis in each of the 3 categories.
2. Within contemporary Navajo society these forms of healing are on a par with and equivalent to biomedical primary care obtainable in clinics of the Indian Health Service. To be specific, from the standpoint that religious healing is an indigenous sector within Navajo society's health care system (Kleinman, 1980), the NHP participants constitute a pool of patients with recourse to a cultural equivalent of primary health care. In fact, the rate of occurrence of major depression as a current diagnosis among participants in the NHP was 9.0% (N = 78, results based on the SCID), and in a study among patients in a primary care setting in the same time period occurrence was virtually identical at 8.9% (N = 106, results based on the IDD; Wilson et al., 1995). In comparison, results for the general United States population in primary care were 13.5% (N = 425, results based on the CES-D; Coyne et al., 1994).
3. Of 23 NHP participants with current DSM-IV SCID diagnoses, 4 (17.4%) had also received conventional mental health care, and of the total 84 participants 21 (25%) had received such care at some time. The majority described these services as "counseling" or "rehab," though 3 explicitly mentioned treatment by a psychiatrist and 4 acknowledged having taken psychopharmacological medication.

None of these observations can be taken to mean that any patient in ritual healing was explicitly being treated for a named psychiatric disorder. They do require recognition that Navajos and other American Indians co-utilize ritual healing (not infrequently more than one type) and conventional mental health services (Csordas and Garrity, 1994; Novins et al., 2004). They also require closer ethnographic investigation of the cultural forms in which distress is presented in ritual healing, the task to which we now turn.

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ETHNOGRAPHICALLY AUGMENTED RESULTS

A culturally informed understanding of the relation between diagnosis and distress in a community requires us to consider the range of problems presented for treatment by ritual healing. We determined that for 46.4% of NHP participants ($N = 48$) the principal problems or primary complaints for which they sought healing could be categorized into what biomedicine would recognize as a physical problem, including subcategories of chronic illness such as kidney problems, migraine headaches, diabetes, and cardiovascular problems (21.4%, $N = 18$), musculoskeletal pain (14.3%, $N = 12$), acute illness such as skin rashes and sores, respiratory infections and TB, exhaustion, and toothache (10.7%, $N = 9$), and injury (10.7%, $N + 9$). Problems categorizable as emotional affliction or cognitive distress together accounted for another 31% of cases ($N = 26$), and included subcategories of grief (9.5%, $N = 8$), emotional conflict/life problems such as family problems and social reintegration after military service (8.3%, $N = 7$), dizziness/trouble/thinking/bad dreams (7.1%, $N = 6$), alcohol/drug abuse (6.0%, $N = 5$). A category in which the primary purpose of the ritual was to ensure the success of a life endeavor or the positive outcome of a medical procedure accounted for 9.5% of cases ($N = 8$). Finally, instances in which the patient was playing proxy for an absent individual who was the identified patient accounted for 2.4% of cases ($N = 2$).

Given these general categories of complaint, what we earlier called the psychotherapy analogy is already intuitively compelling if in general ritual healing is understood to address demoralization and psychosocial dimensions of all forms of medical and psychiatric problems. In a stronger form, the analogy could be construed as a claim that the patient in ritual healing is typically afflicted by a specific underlying psychiatric disorder, and that this is implicitly addressed by the psychotherapeutic element of healing. In fact, 29.5% ($N = 23$) of the 78 participants with whom we completed the SCID were diagnosed with a current disorder at threshold levels. Notably, however, those whose primary complaint we reported as psychological distress were not overwhelmingly over-represented in this total: in the psychological distress category 9 of 26 participants or 35% had SCID diagnoses, while in the physical distress category12 of 48 participants or 25% had SCID diagnoses. Moreover, although 4 of the 6 participants reporting "emotional conflict or life problems" had current SCID diagnoses, no subcategory lacked at least one participant with a detectable psychiatric disorder—not even the "proxy" category, where in one case a significantly disturbed patient stood in for her infant daughter.

These results suggest that ritual healing in contemporary Navajo society does indeed address psychiatric disorder and psychiatric sequelae of physical illness, insofar as a proportion of patients do meet threshold criteria for psychiatric disorders as defined by DSM-IV. However, ritual or folk healers across cultures are known for not making strict distinctions between physical and mental affliction, and work with a more or less elaborated indigenous nosology. Moreover, as we have seen with NHP participants, patients in any healing system only rarely present the healer with an explicit self-diagnosis, often coming forward with a series of problems or complaints. In what follows we put the DSM diag-

TABLE 3. Multiple Realities of Diagnosis and Distress

Sex	Marital Status	Age	Patient Description of Illness	SCID Diagnosis	Interviewer's Clinical Diagnosis (DSM-IIIR Group Only)	Healer Description of Illness
F	Single	18	Baby had possible meningitis as result of witchcraft	1. Major Depressive Disorder with melancholic features 2. PTSD 3. Panic disorder with agoraphobia 4. OCD 5. Social Phobia 6. Multiple simple phobias 7. Status post-alcohol, marijuana and stimulant dependency 8. Status post-hallucinogens (non-peyote)	Breadth of disorders appear somewhat independent: PTSD related to molestation, panic/agoraphobia partially unrelated, major depression sustained and worse post-partum, substance abuse contributed to deterioration	Baby was dropped, causing internal injuries. Baby not taken care of properly due to patient's youth and restlessness
M	Widow	69	Pain in legs, blurry vision, heartburn, dizziness	1. Dysthymic disorder 2. Alcohol dependence, in sustained remission 3. Probable history of PTSD, in remission	Intensive adjustment response with anticipatory bereavement followed by bereavement of wife; anti-social features including cruelty to animals, multiple marriages (10–12)	Lightning Way, caused by exposure to lightning during a ceremony and then having sexual relations with wife too soon afterward
M	Single	22	Grief after father's death, sleepless, suicidal thoughts	1. PTSD (present past month)	1. PTSD, chronic 2. Major Depressive Disorder features	Grief

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noses in ethnographic perspective by juxtaposing the SCID results with the clinical diagnosis of the interviewer, with the healers' diagnoses, and with the patients' understandings of their own problems. Our intent is not to undermine the validity of the psychiatric categories, but to situate them within an understanding of the existential totality of distress in individual cases.

Table 3 shows 3 of the 23 patients who were diagnosed with a current DSM diagnosis at the time the SCID was administered. We choose these 3 for discussion because of their value in showing contrast among diagnostic approaches. Although it must await detailed analysis in future work, we note that across all the cases there is a difference among NAC, Christian, and Traditional Navajo healers. That is, healers in the first 2 systems tend to describe the patient's problem in terms that are pragmatic or accessible in what we would recognize as psychological terms, whereas Traditional healers tend to offer a ceremonial or spiritual explanation, creating a greater challenge to interpretation.

Patient 1. Native American Church

The patient is an 18-year-old woman who lives with her stepfather, mother, and 3 month old baby. She has completed 2 years of high school and speaks only English, but likes traditional Navajo and powwow music. The family members are adherents of the Native American Church, and the healer she consulted is her uncle, an NAC road man (ceremonial leader who heals and conducts participants along the righteous road of life). The all night ceremony was ostensibly conducted on behalf of her infant daughter, although the baby was not present—she was in the hospital being treated for meningitis, and the patient was holding the baby's clothes and a photograph of her as surrogates. Although the baby is a concern for her, it is not the only one. She has bone pain, stomach pain, and headaches; her stepfather, with some diagnostic expertise himself, has determined that her bone pain is attributable to exposure to lightning (cf. Csordas, 1989), and that headaches are a result of witchcraft (cf. Kluckhohn, 1948) perpetrated by her biological father. She recognizes emotional factors in her situation, including arguments with her family in past years, and sexual abuse inflicted on both her and her sister. The patient's mother was concerned that a partially stunted leg would not continue to grow back at the same rate as the healthy one, thereby leaving her permanently imbalanced. She had pain in the underdeveloped leg during the ceremony, which she said was taken away in the course of the prayers. She felt that her contribution to her infant daughter's well-being was "to be strong for her" in 2 senses: she had to endure the "strong" taste of the peyote medicine (which in addition to being powerfully hallucinogenic is quite bitter) itself, and through the effect of the medicine she had to experience in her own body some of the pain her child was enduring at the same moment.

The healer, a close relative, was concerned that the mother had taken the newborn baby to California when the baby had not yet "got rid of its scales." It was reported that in California the young woman had joined a street gang, and the baby was not properly cared for. The relatives brought the baby back to the reservation. During the all night prayer meeting the healer recounted that "We talked to her about why the baby got ill and how she was part of the influence to getting the baby ill." In addition to neglect, this includes having dropped the baby, who sustained injury—an incident which the healer said was revealed to him in vision and confirmed by the relatives. During the ceremony the patient "forgave herself for what she did to the baby and asked for forgiveness of the Lord." The young woman is planning to attend a boarding school away from the reservation, but her uncle the healer judges that "her mind is still young and restless. She could be easily influenced by her friends and people she gets to know. There is that uncertainly in her life that still exist" Therefore he has determined that the baby, who belongs to the family rather than to the mother alone, must stay on the reservation. He explained that "It is just like a medical doctor, you do not get fully released until they know you are fully well; I apply the same principles here. He is still my child. That is how I look at it. I tell that to my aunts and talk on behalf of this baby."

The SCID identified a set of 8 interrelated disorders ranging across the mood, anxiety, and substance abuse categories (see Table 3). The psychiatrist who administered the diagnostic interview describes this young woman as "a mildly overweight older teenage girl who was well groomed, cooperative though still cautious with a muted affect and a somewhat slowed psychomotor status; she was slightly guarded, though anxiety did not appear to limit her ability to answer questions in a forthright fashion." He judged that the determinative feature in the young woman's situation was "her insecure early and middle childhood and early adolescence, and her resultant efforts to adjust to or respond to or defend herself from these threats which, led to the PTSD." She allegedly had been subject to long-standing sexual abuse by a biological relative, though her home life at the time of our interviews appeared to be a stabilizing force, with her stepfather providing a secure relationship including support in the ceremonial healing process. She developed significant substance abuse problems during her middle teenage years in an apparent attempt to escape from the anxieties and threats created by sexual abuse within her family. This predisposed her to major depression, which was exacerbated by postpartum stress. The clinical prognosis was guardedly optimistic with respect to moving beyond dangerous habits such as indiscriminate sexual behavior, gang affiliation, and substance abuse in a relatively stable environment that included spiritual development through additional Native American Church and Traditional Navajo ceremonies guided by her stepfather, and the positive appeal of motherhood in the sense that she was able by her account to stop substance use as soon as she found out she was pregnant. Interestingly, in an addendum to his clinical notes, the psychiatrist observed that the patient acknowledged having occasional absences and strange olfactory and visual experiences, suggesting the possible additional presence of a temporal lobe seizure process.

Patient 2. Traditional Navajo

This patient is a 69-year-old man who has recently been widowed. The interview was entirely in Navajo, conducted with an interpreter. He reported considerable pain and swell-

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ing in his arms as the occasion for seeking healing, though he was convinced that his problems originated in an incident that occurred in 1957, when he was 30 years of age. During a traditional Lightning Way ceremony two lightning bolts with a blue-green flash came through the center hole of the hogan (a one-roomed, octagonal, traditional Navajo dwelling). The patient's father was killed by the lightning, and another man in the hogan was "split in half" and killed as well, but reportedly the medicine man who was lying on the floor was not seriously injured. The patient and his brother, who had come into the hogan after drinking alcohol earlier in the evening, were also lying on the floor and sustained zigzag shaped marks on their bodies related to the path of the lightning. The patient interpreted their survival as being "accepted" or initiated by lightning.

The healer elaborated this view, citing several components of the problem. First, since he was in the hogan when the lightning struck, he "breathed in a lot of electrons." Second, "it knocked him out and he saw his own body. The second lightning strike put him back in his body." This disturbance required certain ceremonial interventions to correct. Third, the medicine man presiding at the original ceremony did not perform the correct ceremonies to neutralize the effect of the lightning and the spiritually contaminating presence of the dead body. Fourth, the patient had intercourse with his wife without taking the proper ceremonial means to eliminate contamination by the lightning. The healer said "that infection from the semen that he put into his wife was what killed his wife. She had an infection in the womb. He blames himself." Finally, his now recently deceased second wife was the victim of the same problem. The healer reported saying to the patient "that psychologically you might have been affected by what happened to your first wife. You have transferred this traumatic experience onto your second marriage without first appropriately correcting it." The immediate consequence for the patient of greatest concern to the healer, however, is his bereavement over the loss of his second wife. Says the healer, "Right now I am after the way he feels, breaking up, saying he missed his woman so much."

In this situation we interpret the ceremonial intervention as intended to address not only a supernatural cause of distress, but also a life event understood as having profound consequences ever afterward. The catastrophic death of a close relative by a freak act of nature would, we suspect, have an enduring effect in any culture. In this cultural milieu, lightning is both environmentally common given the climate of the Navajo country, and is highly elaborated in cultural terms as a deity in its own right, one of the powerful Holy People which is a frequent cause of illness and the object of a major ceremony. Moreover, it is understood that not only can the effects of such exposure can ramify through the life of an individual and cause health problems that do not manifest until far into the future, but also that the effects can ramify through the lives of other family members. This is particularly salient when, as in this case, the afflicted person is the male head of a family, who represents other family members in both spiritual and social domains.

The SCID picked up dysthymic disorder, remitted alcohol abuse, and past PTSD as the key diagnoses for this patient, but our psychiatrist felt that these say little about his complex life and experience. In his clinical summary the key terms are stress, adjustment response, and bereavement. In general, he described the patient as a "light-hearted, though earnest appearing and focused older man who still has vigorous strength. He showed a range of affect but mostly was in the light-hearted, interactive mode and demonstrated at times an infectious laugh." PTSD is certainly related to a unique kind of event in his experience, with ramifications of a kind that, as we have just mentioned, are unique to his cultural milieu. The clinician noted dysfunction of affect and a troubled life story which are no less bound to the cultural milieu, for they have to do with an entrenched habit of not obeying some of the rules, forms of respect, and prohibitions that follow automatically from taking part in ceremonies, and assure that a person remains pure and worthy of the ceremony's effect. The patient believes, for example, that he had some difficulty after the lightning death of his father because he did not honor the 4 day purity commitment and reportedly was sexually intimate with his wife during those 4 days. In this light the psychiatrist expressed some doubt as to what extent he is cautious enough to avoid behaviors that could bring him more difficulties from both the traditional and western medical perspectives.

Patient 3. Navajo Christian

This patient is a 22-year-old unmarried Christian man whose primary residence is in a large city off the reservation. The interview was conducted in both English and Navajo with the assistance of an interpreter. He is dealing with a terrible sense of grief for his father's recent death, and has often contemplated suicide. The patient's father dealt with a long illness coupled with alcoholism and the patient felt it necessary to drop out of college after a year and a half to assist his father through his ordeal. The patient's mother had walked out on the family when he was young and his older siblings were either dead or focusing the majority of their time and effort on their own families. Being young and unmarried, the patient felt a great responsibility to take care of his father as well as shoulder all the financial and social burdens inherent in that role. Since his father's passing, however, the patient has found it difficult to function in daily life. He mentions how he is often brought to tears, especially while driving, because he associates driving with the frequent trips he made with his father during his illness. Taking notice of his, at times, incapacitating bereavement, his relatives urged him to seek out a healing prayer at a local church. When receiving the prayer, the patient felt as if something was being washed off and after the prayer he felt "lighter" as he understood his grief as weighing him down considerably. The patient understood the prayer in its totality as meaningful, not just certain parts of it. He continues to use prayer as an effective means of overcoming his grief.

The healer indicated unfamiliarity with the patient and his father's loss, but was very willing to conduct the prayer for him. He concurred with the patient and his family that the grief for his father's loss was contributing to his difficulties.

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The healer, however, seemed unsure at first as to the effectiveness of the prayer because he had the sense that the patient was "not serious about the Lord". This concern with steadfastness in faith compelled him to address how young people, like our patient, often vacillate when it comes to matters of their own spirituality. For him, commitment to the faith would always lead to better outcomes regarding grief and other emotional turmoil. Although certain of his own commitment to Christianity, the healer did not discriminate against those wavering in their belief or members of other religions in regard to healing prayers. For this, he takes a stance of cautious toleration with the insistence that these patients are merely coming to terms with their awareness of God in the Christian sense. When told that the patient had seen the prayer as effective, the healer soon changed his tone, asserting that the patient was not as noncommittal as he first thought.

The SCID identified PTSD as the single salient disorder present in this case (see Table 3). The psychiatrist administering the diagnostic interview described the patient as "a weary soft-spoken husky young Navajo man with a modern haircut." He also noted that throughout the interview the patient's "affect was muted and there was some psychomotor slowing." The psychiatrist said, "the loss of 2 brothers is a central existential factor in his current situation, I believe, causing the patient to feel all the more responsible. Another probably important existential factor is that his relationship with his father was conflicted and centered on worry over the father's health problems which were related to the father's alcohol abuse." With this assessment, the psychiatrist diagnosed the patient with chronic PTSD with features of Major Depressive Disorder. This loss of close family members led, in the psychiatrist's opinion, to anxiety and depression over being the sole bearer of his family's social and financial responsibilities. When combined with a recent job loss and the fact that his father's spirits seemed to be on the rise in the months before his death these features became all the more apparent. The psychiatrist says the patient "appears to be less settled into his sense of the power or role of spiritual healing in his life than most of the other patients I've interviewed. He's a young man though and we can expect that his awareness of himself and his own healing needs will change as he grows older." This assessment concurs with that made by the healer who felt it necessary to make note of young people's limited spiritual commitment and the connection this has with difficulties with emotional recovery. The psychiatrist's prognosis for the patient is, however, optimistic seeing his renewed involvement in his church, his youth, his ability to find work because of postsecondary schooling, and his sense of family belongingness as all beneficial in establishing a "greater sense of efficacy and hope as he faces his challenges."

DISCUSSION

Our goal in this article has been to understand the nature of distress in ritual healing within Navajo society. To our knowledge there has never before existed a body of narrative and experiential data on such a large group of patients treated by religious or spiritual means in an American Indian nation. Both the cultural distinctiveness of the research setting and the ritual character of the therapeutic context in which we encountered the study participants point toward the conclusion that the task of understanding distress and determining diagnosis requires addressing the existential totality of a patient's experience. Nevertheless, we would argue that this is just as much the case in mainstream society, and that ethnographic augmentation of diagnostic results is valuable in any case. To be precise, it is valuable in terms of both basic science and clinical relevance, and in this discussion we briefly elaborate both.

The basic science relevance of these data is for the comparative study of psychopathology and definition of psychiatric disorders. Scholars have recognized that culture is relevant to psychiatric diagnosis insofar as it shapes the phenomenology of symptoms, is embedded in diagnostic systems and practices, and determines the interpersonal characteristics of the diagnostic interview (Mezzich et al., 1999, p. 458). Most recently this relevance has been highlighted in debates about the importance of culture in defining and revising the diagnostic categories of DSM (Fabrega, 1987; Good, 1992; Kirmayer, 1997; Mezzich et al., 1996, 1999; Spiro, 2001). The pages of this journal have included an account of the limited success on the part of the Culture and Diagnosis Working Group in advocating incorporation of cultural considerations into DSM-IV on the levels of individual disorders, categories of disorders, the multiaxial system, culture bound syndromes, and guidelines for cultural formulations of individual cases (Mezzich et al., 1999). Jenkins (1998) gives a detailed account comparing the Working Group's detailed recommendations for DSM-IV text on schizophrenia and related psychotic disorders with the truncated final text that severely restricts the cross-cultural validity and generalizability of the diagnoses. Using and critically examining the categories in culturally distinct settings can help to expose biases of DSM-IV that "concern ontological notions of what constitutes a real disease or disorder, epistemological ideas about what counts as scientific evidence, methodological commitments to how research should be conducted, and pragmatic considerations about the appropriate uses of the DSM" (Mezzich et al., 1999).

Our intent in using DSM-IV categories was not to establish what was "really" wrong with NHP patients regardless of how they defined their problems in indigenous terms, but to occupy the middle ground between relativist anthropological critics who dismiss psychiatric categories as ethnocentric and universalist psychiatric literalists who grant them an unduly concrete ontological status. On one level we have taken the DSM categories at face value, presenting them in tabular form in terms of the occurrence of disorders among patients participating in the NHP. On this level, while recognizing that cultural shaping of disorders can never be ruled out, such that cross-cultural validity of psychiatric categories is invariably an open question, we endorse Good's (1992) argument that if there is to be a comparative, cross-culturally generalizable understanding of psychiatric disorder, there must be some set of categories at least stable enough to serve

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the purposes of comparison. The categories of the DSM and the ICD are the best we have in this respect, and it is scientifically irresponsible not to make use of them in this manner. On the other hand, to the extent that these categories are the product of a particular cultural milieu and of a particular method of formalization that privileges description over causality and individual symptoms over interpersonal dynamics, their generalizability must be examined with circumspection. This is the case not only with respect to the boundaries between disorders and categories of disorder, what counts as a core symptom and what as a peripheral symptom, and what malleability in a disorder's manifestation can be accepted before it no longer counts as the same disorder. As we have indicated in presenting our ethnographically augmented results, it is also most imperatively the case with respect to how these disorders can be said to make sense in relation to other ways of conceptualizing and experiencing distress, and how they may be altered by such alternative ways of conceptualizing and experiencing.

The clinical relevance of the data we have presented pertains to culturally distinctive expressions of distress and patterns of treatment co-utilization. Most recently this relevance has been highlighted in a series of reports emphasizing the clinical implications of cultural diversity on a national scale within the United States (U.S. Department of Health and Human Services, 1999, 2001a,b, 2003) as well as on a global scale (Desjarlais et al., 1995). Our observations that rates of psychiatric disorder are higher in groups treated in ritual healing and primary care than in a tribal population at large, which are in turn higher than in general population of the nation, should be interpreted as identifying a need for mental health services. The manner in which the distress is existentially situated in the life experience of the afflicted points to the configuration those services could take in practice. In this respect we endorse the recommendation in the supplement to the Surgeon General's report on Mental Health: Culture, Race, and Ethnicity that "More explicit attention to the connections between spirituality and mental health in Native communities is especially warranted given the nature and type of problems. How well this is accomplished depends on advances in the science by which healing practices and spirituality are conceptualized and examined" (U.S. Department of Health and Human Services, 2001, chapter 4, pp. 27, 29).

Clinical Sensitivity to the potential consequences of interaction among culturally distinct systems of diagnosis and treatment co-utilized by members of the tribal population is essential to meeting this challenge. Within any society, health care alternatives can be related in at least 4 ways. First, they may be contradictory and incompatible, and hence in conflict or competition with respect to cultural legitimacy. Second, they may be complementary in the sense of addressing different aspects of the same health problem, addressing a problem in a different but compatible idiom, or having an additive effecting alleviating a problem. Third, they may occupy coordinate positions within a societal repertoire of mental health care resources, regarded as suitable for quite different kinds of problems. Fourth, they may be coexistent without contact, serving differently defined needs of different segments of a population. Clinicians should be aware of these forms of interaction among alternatives within the health care system of a tribal or ethnic community, as well as being sensitive to variations among individual patients with respect to preferences about coutilization of alternatives including conventional mental health services.

With respect to both basic science and clinical considerations, there are at least 4 levels on which researchers must weigh use of DSM categories against cultural and existential considerations. First is that of the prevalence of predefined psychiatric disorders in a group such as the Navajo or a subgroup such as Navajos who have recourse to ritual healing. This is the level of our identifying the profile of major depression, alcohol dependence, and PTSD as the most common diagnoses in the NHP, a finding that can be analyzed with reference to conditions for the sociocultural production of psychiatric disorder in Navajo society including poverty and lack of economic opportunity, childhood physical and sexual abuse in dysfunctional families, colonial subjection and undermined cultural identity. Second is that of differing patterns of disorder across cultural settings. This is the level tapped by the psychiatric epidemiologists who found comparable rates of alcohol dependence among Southwest Indian men and both Northern Plains men and women, but substantially lower rates among Navajo women (Beals et al., 2005a,b). This is likely attributable in part to social organizational differences between the patrilineal Northern Plains culture and the matrilineal Southwest culture in which, women occupy a relatively empowered social position and are often the financial and moral centers of the family. Third is the level of inquiry as to whether diagnostic entities are ontologically malleable, with flexible boundaries and mutable configurations of symptoms. The simple fact that the DSM is subject to periodic revisions suggests the necessity of this stance. We must also continue to ask questions such as whether understanding alcohol dependence as an explicitly "white man's disease" alters its character as a diagnostic entity, or experiencing affliction by the ghost of a deceased spouse is adequately glossed as bereaved depression. Fourth is that of psychiatric diagnosis as part of a larger picture. This is the level of existential totality to which we have pointed as the product of the multiple realities described in our ethnographically augmented results, and which is the principal contribution of a psychiatric anthropology in dialogue with psychiatry.

CONCLUSION

Anthropologists have often critiqued psychiatric categories from a relativist standpoint as biased and ethnocentric, and therefore of limited cross-cultural validity. Psychiatrists have often implicitly adopted a universalist standpoint and taken for granted that psychiatric disorders are ontologically stable to the same extent that human nature and biology are stable. Occasionally a critique has been sounded by a psychiatrist who awakes to the dimension of patient suffering and declares the contemporary nosology to be "existentially boring," as did Gary Tucker (1998) in a controversial article

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in the American Journal of Psychiatry. Likewise, occasionally an anthropologist will recognize the value of the conventional nosology as a framework for comparative research that taps into shared dimensions of human suffering, as did Byron Good (1992) in a manifesto for new directions in psychological anthropology. In our study we have both taken psychiatric categories seriously and juxtaposed them to other ways of understanding affliction and distress. The existential complexity we encounter cannot be reduced to comorbidity, but is a product of multiple intersecting realities.

The critical point is this: We have a choice either of understanding the multiple perspectives as critiques of one another, as competing attempts to impose a reading of reality; or of understanding the multiple perspectives as together forming an existential totality, as partial and incomplete approximations of a patient's distress. Stated another way, we have the option of analyzing the patient's situation into separate and discrete syndromes or understanding it in terms of a multilayered existential synthesis. We have the choice of focus on individual manifestations of disorder or spinning out the strands of social/emotional relations. We have the option of concentrating on description or cause, complaint or disorder, diagnosis or distress. In the end we will not want to see these as mutually exclusive options but as complementary approaches. If the demonstration of existential interdependence among the conceptualizations is at some level intuitively obvious, that is all the more reason for systematically demonstrating the importance of the intuition. If the purpose of diagnosis is clinical relevance rather than intellectual exercise, and if understanding the interrelation of multiple perspectives is intended to facilitate the effectiveness of mental health services in culturally distinct groups rather than only to contribute to culture theory, then additional work such as that reported here is essential.

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