WHY DO INDIGENOUS PRACTITIONERS SUCCESSFULLY HEAL?

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Abstract—The authors report findings from a follow-up study of patients treated by a shaman (t'aang-ki) in Taiwan, and relate these to early findings from a much larger study of indigenous healing in that Chinese cultural setting. Ninety percent of patients treated by indigenous practitioners suffered from chronic, self-limited, and masked minor psychological disorders. The last group, involving "somaticization" of personal and interpersonal problems, accounted for almost 50%, of cases. In the follow-up study, 10 of 12 consecutive cases treated by this indigenous healer rated themselves as, at least partially, cured. This occurred in spite of any significant symptom change in several cases, and in the face of considerably worsened symptoms in one case. In these cases, behavioral or social gains were responsible for the positive evaluation of therapeutic efficacy.

INTRODUCTION
The study of indigenous healing may be important to the general anthropologist for the light it throws on a particular culture. It may be important to the medical anthropologist for the understanding it provides of a given society's system of health care. But the cross-cultural investigation of indigenous healing holds further significance for the medical anthropologist. Here the interest of the medical anthropologist is virtually the same as the chief concern of those clinicians who pursue cross-cultural research. They seek to elucidate universal as well as culturally-particular features of the healing process; and they wish to compare indigenous healing with professional medical and psychiatric care.

The chief research questions are straightforward and have been known for quite some time: Is indigenous healing effective? And if so, how? What role do cultural factors play in bringing about that efficacy? how does the efficacy of indigenous healing compare with that of professional clinical care? what does that comparison tell us about the nature of the healing process? and can we learn anything which holds further significance for the medical anthropologist for the light it throws on a particular culture. It may be important to the general anthropologist for the understanding it provides of a given society's system of health care or to the treatment of sickness in different societies?

Yet, while the questions are clear, the answers are not. What we now possess are impressions, anecdotes, unsystematic findings, and strong opinions. The limited material I present below, frail thing that it is, nonetheless represents one of the few attempts I am aware of to systematically follow-up patients treated by an indigenous healer in order to determine, first, if this particular form of indigenous healing is effective; and, then, how it might work. In attempting to answer these and other questions listed above, I have tried to avoid using ready-made explanations, such as the timeworn and essentially unproven psychanalytic theories which (to my mind) have introduced so much obscurantism into this subject. Instead, I present the complex issues involved in how we evaluate therapeutic efficacy as the central problem in the cross-cultural study of healing. The explanations I propose for understanding how the indigenous healing described in this paper works are anchored in a theoretical framework, which I outline below, whose hypotheses the field research seeks to test. That framework, based on reading of the cross-cultural literature concerning illness and clinical care, compares explanations provided by patients, families, practitioners, and researchers to interpret healing as part of a general analysis of the health enterprise in Chinese and other large-scale developing and developed societies.

Before examining the research framework, I wish to stress the inadequacy of our present understanding of the healing process. This is in part a function of the early stage we are at in medical anthropological research and theory. But it also results from an enormous distortion in clinical research and theory. For researchers in clinical medicine, healing is an embarrassing word. It exposes the archaic roots of medicine and psychiatry, roots which are usually buried under the biomedical science facade of modern health care. It suggests how little we really know about the most central function of clinical care. It resonates too well with the criticisms leveled by patients and consumers generally at modern health care. It raises questions which deal with human values and meanings that are not easily reduced to technical questions which can be answered with simple biological explanations. And it strips away the illusion that biomedical research is the only scientific approach to health care problems. Instead, the question of healing makes it apparent that much of clinical science can only be approached from the perspective of social science.

There seems to be a radical discontinuity between contemporary clinical care and traditional forms of healing. Cross-cultural and historical studies of medicine disclose two separate, but interrelated, healing functions: control of the sickness and provision of
meaning for the individual's experience of it [2]. Modern professional health care attends solely to the former. In fact, the biomedical education of physicians and other modern health professionals, while providing them with knowledge to control sickness, systematically blinds them to the second of these core clinical functions, which they learn neither to recognize nor treat. This leads to the well-known panoply of problems in clinical management, which arise from inattention to or poor performance in clinical communication and the supportive aspects of care: patient non-compliance and dissatisfaction, inadequate and poor care, and medical-legal suits.

For example, we now know that the quality of doctor-patient communication is a major determinant of compliance and satisfaction [3]. We know that attention to communication and the "caring" aspects of clinical practice has led patients to prefer treatment by chiropractors over treatment by orthopedic surgeons for low back pain [4]. We know that in the surgical treatment of peptic ulcer disease, surgeons and patients maintain two entirely separate lists of criteria by which they evaluate surgical outcomes as successful or not, and that inattention to the patient list caused surgeons to call a success what patients call a failure [5]. Non-medical eye specialists are increasingly capturing a larger part of the patient population concerned with routine eye problems because they appear to patients to give "satisfactory" care [6]. In Taiwan, only modern professional doctors are sued for malpractice (at one of the highest rates in the world); indigenous practitioners are virtually never sued. In all, it has been argued that the curves of increasing biomedical, technological advance in clinical care, and patient dissatisfaction with the quality of care, are inversely related [7].

The dilemma posed by modern clinical care can be put quite neatly into the following terms. Let us call disease any primary malfunctioning in biological and psychological processes. And let us call illness the secondary psychosocial and cultural responses to disease, e.g., how the patient, his family, and social network react to his disease. Ideally, clinical care should treat both disease and illness. Up until several decades ago, when their ability to control sickness began to increase dramatically, physicians were interested in treating both disease and illness. At present, however, modern professional health care tends to treat disease but not illness; whereas, in general, indigenous systems of healing tend to treat illness, not disease. This is a hypothesis to be tested against our field research findings. Should it prove true, then it would appear to pose obvious and far-reaching effect that all health care explanatory models, including those of modern professional medicine and psychiatry, are culture-laden and freighted with particular social interests. And so is our present understanding of healing.

From the perspective of health care systems and their clinical functions, healing is the sum of the activities of the entire system of health care. This insight leads to a seeming paradox: though desperately sought after and uncertain in outcome on the individual level, healing as a cultural process must occur. The indigenous healing described below is an illustration of this. From our perspective, it also should contain three interrelated sectors: popular, professional, and folk. The popular sector is composed of individual, family, and social nexus arenas in which decisions about illness and care are made and treatment is carried out. The folk sector is the non-professional, usually non-bureaucratic specialist arena of health care. Together these two sectors comprise indigenous healing: except, as in the case of Chinese and Indian societies, where there are indigenous professional systems of care. Seen from this perspective, family-based care is the most important and extensively used type of care. In most societies, it provides most of the clinical care and is the locus of decisions about, and evaluations of, such care [9]. Yet anthropological and clinical studies of indigenous healing frequently fail to focus on it, and public health planners often do the same, limiting the legitimated domains to professional health care. Folk healing is a much smaller and less important domain of indigenous care, but because it is easier to study, it has received the lion's share of research attention. When studying healing it is essential to describe which of these sectors one means.

There are five basic clinical functions performed by health care systems, which cut across all three sectors and which constitute the healing process [10]. These core clinical tasks are:

1. Cultural construction of illness from disease:
2. Use of systems of belief and values for choosing between health care alternatives and evaluating treatment outcomes:
3. Cognitive and communicative processes used to cope with disease/illness, including perception, classification, labeling, and explaining;
4. Therapeutic activities per se;
5. Management of a range of potential health care outcomes: cure, chronic illness, impairment, and even death.

Obviously, there are wide cross-cultural and cross-sector variations in these activities. For present purposes, there is no need to be overly formal about these core clinical activities, but it is essential to recognize that through them social and cultural factors become major determinants of healing. Paradoxically, the cultural patterning of illness is a therapeutic activity. Healing efficacy is not a straightforward result, but rather is determined by evaluations, which are tied to the beliefs and values of different sectors of health care systems and which therefore might be (and often are) discrepant. Healing is viewed differently across cultures and in different sectors of health care. It is not the same thing for practitioner and patient. This is an argument to the effect that all health care explanatory models, including those of modern professional medicine and psychiatry, are culture-laden and freighted with particular social interests. And so is our present understanding of healing.
become clear that the tensions built into health care systems can generate important problems in clinical care, problems which relate to conflict between different views of health care needs and objectives. It is, therefore, not unexpected that when it comes to health care, patients and healers as if they were independent of the context of clinical care. They (and the healing process) must be located in specific cultures and the sectors of particular health care systems. Nor can we bring explanatory models to bear on illness and healing without first recognizing that they, too, are bound to these contexts. The goal, then, of cross-cultural studies is to work out an overarching comparative science into which health concepts and activities can be translated and analyzed. This remains a distant, though necessary, objective. Inattention to this fundamental theoretical problem, however, is a major reason why cross-cultural studies of healing have failed thus far to advance our general understanding of clinical care and to specify how their findings are to be translated into practical clinical strategies which can be applied in different cultural settings, including our own.


The research described now forms a small part of a much larger and still ongoing comparative study of illness beliefs and practitioner–patient relationships in indigenous and professional forms of health care in Boston and Taiwan. More specifically, it is part of a comparison of clinical communication and its influences on compliance, patient satisfaction, and course of illness amongst patients treated by Western-style doctors, Chinese-style doctors, and a variety of folk healers in Taipei. The last group included shamans (tâng-kis) [12a], fortune-tellers, interpreters of ch'în, physiognomists, and temple-based ritual experts. In all several hundred patients were studied, including approximately 25 who were treated by several tâng-kis in Taipei. The 13 cases described below are part of this last group.

Through other studies, I had the opportunity to observe approximately 25 shamans in Taiwan (15 in the capital city of Taipei and 10 in market towns and villages). I was able to interview 10 shamans in detail, none of whom exhibited major psychopathology, which would seem to be incompatible with the skills which being a shaman requires. In the course of this research, I observed nearly 500 patients treated by shamans. My impression is that roughly half of these cases presented with health problems, a quarter with personal and family problems, and a quarter with business, financial, and assorted other social problems. Many shamanistic consultations dealt with crises, and crisis management seemed to be a major function of the practice of shamans. More than three quarters of cases were women, some of whom brought sick children or the clothes of sick children for treatment, and some of whom came on behalf of other family members (usually males suffering sickness or some other misfortune). Most patients were from the lower-class and poorly educated, but a few were middle-class. Of their sickness complaints, psychological symptoms were extremely uncommon, and most complaints appeared to represent minimal or self-limited (spontaneously remitting) sicknesses. Chronic disorders, usually not of a life-threatening kind, and somatization of psychological and interpersonal problems. In all, I saw only two cases of major psychopathology treated by tâng-kis. Neither was effectively treated, and tâng-kis told me that their treatment was not effective for such disorders, especially chronic schizophrenia, which they did not like to treat and referred to psychiatric hospitals.

Although shamans (wu) are described in the Chinese classics, and seem to have operated throughout ancient China, in more recent times they have been particularly prevalent in Fukien Province, from where most Taiwanese trace their ancestry [12b]. In traditional Chinese society, shamans were one of a group of Taoist specialists, which also included: Taoist priests, magicians, and female spirit-mediums who commune with the dead. These same four types of Taoist practitioners are found in the syncretic (Taoist–Buddhist) Taiwanese folk religion, though their functions overlap [13]. Tâng-kis (literally, divining youth) may be male or female, may be recruited via self-selection or selection by older tâng-kis or the community, and may or may not undergo formal training, under a Taoist adept or an experienced tâng-kis [14]. The tâng-kis undergoes trance, in which he acts as if he were possessed by one of the gods of the Taiwanese folk religion. His words and behavior when entranced are believed to be the god's. His therapeutic efficacy is believed to be the god's own efficacy. Tâng-kis frequently work with assistants, who interpret their advice (which is sometimes unintelligible or clothed in special terms) for the clients. In my experience, there can be marked differences between tâng-kis: some spend more time explaining to clients; some emphasize rituals; some specialize in prescribing herbs or Chinese medicines; and some are renowned for their skills in treating certain kinds of problems (e.g., sickness, and particular kinds of sickness).

Rural tâng-kis often practice in the village they live in, where they farm, fish, etc., like other villagers during the day, but function as shamans at night and on special occasions. Urban tâng-kis are often professionals, who do no other work. They can make a considerable amount of money, though most seem to remain at lower-class and lower-middle-class levels. I have seen several tâng-kis in Taipei earn the equivalent of $200.00 U.S. per week, and one who earned that in one night. Even after these sums have been shared with assistants and others who help operate the small shrines where tâng-kis practice, this is still a very large income by Taiwan standards. Thus, it is not surprising that these folk healers are popularly viewed with considerable ambivalence, and are sometimes accused of being charlatans and fakes. That ambivalence is heightened by the fact that tâng-kis are still feared by some as potential sorcerers.

The popular ideology holds that tâng-kis should be poor and illiterate; that they should make no income from their services which should be performed because the god wishes to "save the world and serve the people"; and that they should have experienced
employs: ghosts, gods, or ancestors are the cause of sickness to a state of cure. (3) The patient is told 
what atypical for several reasons, but his therapeutic 
structure similarity with modern clinical care and 
and man (doctor), they rarely refer patients to other practitioners. 
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disorders, and tâng-kis have repeatedly told me that 
their gods can cure cancer and other life-threatening 
disorders.

Finally, healing rituals in the tâng-ki's shrine, independent of specific content, seem to have three definable stages. (1) The patient's problem is named. Usually, it is labeled as an external entity e.g. a possessing ghost. (2) The appropriate ritual is performed to treat the problem, and herbs and practical advice are given as well. The patient is told that he is passing through a crisis (again outside himself). But often the patient does not understand the symbolic meanings associated with this ritual movement from a state of sickness to a state of cure. (3) The patient is told that he is healed. That the bad spirit or ghost possessing him (and thereby causing his sickness) is gone, and with it has gone his disorder. This tripartite division of healing rituals is typical of traditional healing rituals in many cultures and even shares a general structural similarity with modern clinical care and psychotherapy [19].

The subject of shamanism in Chinese culture goes well beyond the limited focus of this paper. I mention some of its characteristics only to help the reader feel more familiar with the tâng-kis whose patients we follow-up and report on below. Interested readers are referred to other descriptions of tâng-kis in Taiwan [18]. Several other general points about shamanistic healing in Taiwan are worth noting. The popular ideology holds that a shaman should be able to tell the patient his symptoms and should not need to enquire about them. This restricts history taking to a minimum. Since urban tâng-kis (unlike their rural colleagues) usually do not know their patients, this handicaps the tâng-ki. Tâng-kis rarely obtain follow-up information about their patients. Most assume if the patient does not return then it is an indication that he is healed. But patients hold the opposite view: if treatment is ineffective they do not return. Although shamans tend to spend more time explaining to their patients than do professional practitioners, this is not always so, and fairly often one finds that patients do not understand the tâng-ki's explanations anymore than they do Chinese-style or Western-style doctors' explanations, albeit this is not usually so. Although tâng-kis seem to appreciate the pragmatic orientation of most of their patients, who usually employ several different kinds of treatments at once and who say that healing requires both god (tâng-ki) and man (doctor), they rarely refer patients to other practitioners. Not infrequently, they state that they can cure all disorders, and tâng-kis have repeatedly told me that their gods can cure cancer and other life-threatening disorders.

The specific supernatural explanations the tâng-ki employs: ghosts, gods, or ancestors are the cause of the individual's sickness and need to be placated, exorcised, negotiated with, etc. These are the components of the clinical reality culturally constructed and socially legitimated in the tâng-ki's shrine. This clinical reality, including the explanatory models used to interpret sickness and justify treatment, is distinct from that found in the practice of other folk healers or professionals. It has much more in common with popular cultural beliefs in Taiwan, however, than do the professional clinical realities constructed in the offices of Western-style and Chinese-style doctors [16]. Nonetheless, all of the clinical realities in Chinese culture have certain important similarities which distinguish them from clinical realities found in the U.S. [17].
The shrine's gods at the highest level. The cult member moves upward until his "master" is one of the gods on this highest plane.

Healing sessions begin at night, seven days per week. They last from just after dinner often until the early hours of the morning. The shrine has one large room which can hold about 30 people comfortably and a large altar table and altar. It opens to the street along one entire side, and cult members and clients commonly spill over onto the street. Each night there are usually 10-30 new patients, and 20-30 cult members. The shrine's activities can be divided into two parts: the hour or so when the t&g-ki, entranced, consults with new clients; and the rest of the time, during which cult members and patients socialize and pray and trance. When cult members are actively trancing, it is a wild and colorful scene. Informants have described it to me as one of the most exciting experiences they have had. This must be especially true for lower-class mothers and grandmothers, who are otherwise trapped within the confines of the family. Cult members do not merely trance: they dance, jump around, sing, exhibit glossolalia, and sometimes engage in activities with strong sexual overtones. For example, men and women touch and massage each other; they jump around together: women rub the inside of their thighs and men exhibit rapid thrusting movements of the pelvis; at times the ecstatic frenzy of the trances resembles orgasmic behavior. All of this is very unusual public behavior in Chinese culture, unsanctioned in any other place. In their trance and interictal behavior, cult members are expected to display behavior characteristic of the gods who possess them. While entranced it is not unusual to see individuals express strong emotions, especially sadness and anger. Cult members say they feel relieved and happy after trancing. At the beginning of each healing session, and off and on throughout the night, there is a lot of socializing between the cult members. And sometimes members of their families also are present.

New clients register with one of the t&g-ki's assistants when they first attend the shrine. They are asked to name, address, problem, and the eight characters (pu-ziu) associated with their birthdate. The last is used because the t&g-ki calculates their age, and -ziu indicates a certain age and prays, asking the god about his problem. The patient throws divination blocks to learn if the god will answer his question. After the divination blocks indicate the god's consent, the patient waits for the t&g-ki to go into trance and for the assistant to call him/her. The t&g-ki may ask a question or two, but usually does not. He (the god speaking through the t&g-ki) informs the patient what is causing his problem. He then prescribes various therapies: he gives the patient ashes to drink, charms to eat or wear, sometimes he prescribes herbs, Chinese medicines, or food therapy. At the end he pronounces the patient cured or orders him to return regularly to the shrine and become possessed (indicating that a god wishes to possess him is causing his problems). His explanations frequently mix supernatural, classical Chinese medical, popular medical, and even Western medical ideas. His therapeutic advice may contain a similar mix. The two commonest rituals he performs each take less than one minute. In one he writes a charm in the air over the patient which is believed
to transfer power to the patient and drive away bad spirits or ghosts. In the other, he rapidly moves his hands in front of the patient from head downward to mid-body and from feet upward to mid-body. He then grasps at the space over the mid-body and makes a throwing motion as if he were throwing something to the ground. The meaning here is that he is cleansing the patient of bad spirits and ghosts. Sometimes, he will massage middle aged and elderly patients.

After spending five minutes with the tâng-ki, the patient returns to his seat in the shrine. There he will sit quietly: meditating, praying, or resting. The patient will remain in the shrine for several hours. During that time he will be treated by several cult members, who, during their trances, will massage him, give him further divine advice, and attempt to get him to trance and/or jump. Other cult members, who are not entranced, will give the patient and the family members who most likely have accompanied him, friendly and reassuring advice, or will ask them to tell their stories. Clients will disclose full accounts of their problems to sympathetic listeners several times at least. They and their family members may be given certain things to do, such as burning large amounts of spirit money to propitiate a god or an angry ancestral spirit, or buying special foods to offer to the gods which they will later take home and eat. Sometimes, the tâng-ki and his cult members will direct their treatment activities more to the oldest or most responsible-looking female family member accompanying the patient than to the patient.

On seven consecutive nights in this shrine, there were 122 new clients: 54 (45%) came seeking treatment for sickness; 33 (27%) came to have their fate determined and bad fate treated; 24 (19%) came because of business or other financial problems; and 11 (9%) came with questions concerning personal and family problems. Some of the clients with questions about their fate also were concerned about personal and family problems. Most clients were lower-class, two-thirds were female, and all were Taiwanese. At least 25% of the cases were young children or infants. Of the sicknesses complained of, by far the most common problems were acute, but not severe, upper respiratory or gastrointestinal disorders, probably viral. Chronic disorders, such as low back pain, arthritis, and chronic obstructive pulmonary disease were present; but more prevalent were chronic, non-specific complaints, labeled "functional" or neurasthenia by Western-style doctors, but which seemed to me to represent somatization with depression, anxiety neurosis, hysteria, or other psychological problems. Most infants came with a history of irritability, poor sleep pattern, and prolonged unexplained crying. Such cases were diagnosed to be suffering from "fright", and were treated with a ritual which calls back the soul that is believed to have been frightened away. A client might spend anywhere from the equivalent of fifty cents to $5.00 U.S., depending on the treatment he/she received and the amount of incense and paper money he/she had to burn. These charges are comparable to, but usually somewhat less than, charges in Western-style doctors' and Chinese-style doctors' offices. Nonetheless, they are considerable expenditures for many lower class families.

FINDINGS FROM THE FOLLOW-UP STUDY

We attempted to follow-up 19 consecutive clients treated for complaints of sickness over a three-night period in this shrine. Several patients were interviewed before their interaction with the tâng-ki, most were not. All patients were visited at their homes two months after their initial visit to the shrine. Follow-up interviews could not be completed with seven cases: two gave wrong addresses; three refused to be interviewed; and two had moved to addresses too far away to be followed. Of the 12 patients who were interviewed at home, one (No. 3) gave very brief answers to most of our questions and refused to answer some of them; and another (No. 4) had been treated at the shrine many times before and was the only return patient in our sample. All the others were new patients. Each patient was interviewed with the same format and questions. Each interview took at least 30 minutes. We asked patients to evaluate their treatment in the shrine: was it effective or not? To what did they attribute its efficacy (or lack of it)? Had they experienced symptom or behavioral change? Why did they evaluate their treatment as effective (or not)? We asked if their improvement could have been the result of the natural course of the sickness. We asked them about intercurrent treatment from other health care agents for the same problems. We obtained brief histories of the onset and course of their disorders, and attempted to work out our own quick assessment of patients' current physical and psychosocial status. Our evaluations were limited because we were unable to perform physical exams, blood tests, X-ray examinations, or psychological tests, either initially or at time of follow-up.

Besides the analysis of the follow-up evaluations of these 12 cases, we add a full description of a 13th case. That patient, Mr. Chen, was examined by us at some length before he was treated by the tâng-ki. We also observed some of the treatment he received at the shrine, which lasted over many sessions; and we were able to follow Mr. Chen's course at home and at the shrine over a period of 7 months. We present his case in order to fill out the necessarily superficial presentation of the other cases justified in focusing special attention on this particular case, because it is typical of many other cases we studied in both indigenous practice and modern clinical care. It also provides us with an opportunity to discuss several salient issues in clinical practice in Taiwan, issues which hold considerable cross-cultural significance.

Several notes of caution. Our sample size is obviously very small. It would be inadequate to base generalizations upon this data were it not for the virtual absence of other follow-up studies of indigenous practice, and that these findings are in line with our findings from studies of other indigenous healers as well as impressions gained from observation of large numbers of patients treated by tâng-kis. Nonetheless, it is likely our results are skewed toward more positive evaluations of healing, since it is reasonable to assume that the clients who refused to be interviewed were more likely to harbour negative evaluations of their treatment. However, even with these cautions in mind the results are striking and provocative.
reported (or their family members reported) at least partially effective treatment. Six patients (50%) regarded themselves, or were regarded by family members, completely cured. Only two patients (17%) are listed as treatment failures. One evaluated her treatment a failure, but her mother felt the treatment would be effective if tried for a longer period of time. The father of one child evaluated his daughter's treatment at the tâng-ki's shrine completely ineffective, and implied that it had allowed her sickness to worsen. Nonetheless, an 83% rate of cure (even partial cure) is impressive and would seem to be evidence in favour of the efficacy of this indigenous practitioner's treatment. Or is it?

It is fascinating that of the 10 patients whose treatment was evaluated by themselves or family members to be effective: one reported no symptom change at all; one infant and one adult experienced only minimal symptomatic improvement; while a fourth patient actually experienced worsening of her symptoms. Two of these patients experienced some behavioral change (they felt psychologically better after being at the shrine), but the other adult did not and the infant gave no sign of such change. Furthermore, in several cases (e.g. No. 6, No. 10, and No. 11), there was some discrepancy between different family members' evaluations of whether or not the tâng-ki's treatment had been effective. These cases raise a serious question about how evaluations of therapeutic efficacy are made. Clearly our patients positively evaluated their care for different reasons. In some cases symptomatic change was the chief determinant. While in others behavioral change was most important. For example, cases No. 4 and No. 6 experienced no symptomatic change, but derived psychological benefits and probably also social benefits (e.g. they got out of the house, away from family problems, socialized with friends, enjoyed the exciting atmosphere, etc.) from their treatment. Other patients explained to us that negative evaluations of their treatment in the shrine might prejudice the gods, whose favours they were seeking, against them, and thereby worsen their disorders. Other patients apparently could not bring themselves to challenge the tâng-ki and the cult members, who had repeatedly and emphatically told them they were cured. Indeed, in this shrine and others, if one asks patients to evaluate their treatment while they are still in the shrine, immediately after being treated, one obtains uniformly positive evaluations. That is why home visits at a later date are necessary. In case No. 1 certain problems improved, while others did not, but the overall impression was one of effective treatment. We have not exhausted all the issues surrounding these evaluations of the efficacy of healing. They illustrate the special criteria patients use to evaluate their treatment. These criteria differ amongst patients and even amongst family members. They are quite different from those we employed, as a comparison between our evaluations and patients evaluations demonstrates. Such a comparison also reveals differences in the criteria indigenous and Western physicians employ to evaluate therapeutic success. It is worth noting that no patients were willing to say that natural course of the disorder was responsible for their improvement (after we explained the concept to them), even though several admitted that this was a possibility. As we shall see in the Comments, these results also point to the strong influence of culture on evaluations of therapeutic efficacy.

The tâng-ki essentially regarded all of these cases as cured (at least in part), since those who returned to the shrine told him that they were, while those who were not helped did not return, which he took to mean they had been cured. Furthermore, cure also meant to him that the supernatural agencies causing these problems were appropriately treated, and this he felt had happened in each case. In the cases of "fright", (ching, kia); or shou ching "catch fright"), he evaluated cure not so much by the condition of the infants as by the responses of their mothers. Here alleviation of the distress of a key family member was a criterion of cure.

Our evaluations suggest that the question of efficacy in this case sample is problematic. To begin with, what was effectively treated? In one case we have a naughty child who (to our minds) is not sick at all. Effective treatment of a sickness may be a similarly irrelevant concern in the two cases of "fright". These infants may have had some minimal, sci-or-nice sickness, but just as likely were cranky or "colicky" for reasons having nothing at all to do with sickness. Several patients seemed to be suffering from self-limited disorders (possibly viral syndromes) which probably improved spontaneously, as part of the natural course of such disorders. We thought that two, and possibly three, of the patients were suffering from somatization. Their somatic complaints were secondary manifestations or symbolic expressions of underlying psychological disorders. Evaluation of therapeutic efficacy in these cases depends on what happens to the underlying psychological problems. In the two cases with hysteria, treatment seemed at least partially successful. Finally, several patients who reported symptom relief were receiving other therapies, including Western drugs known to be effective for these specific symptoms. Thus, from our perspective, only a few of the cases seem to provide evidence in favour of the efficacy of this indigenous form of healing. We do not find conclusive evidence to show that a single case of a biological-based disease was effectively treated by the tâng-ki's therapy alone.

It is of particular interest that the only patients who did not evaluate their treatment to be effective both suffered from severe acute disorders, one somatic and one psychological.

Findings from our other studies support these results. For example, on two other consecutive evenings in this shrine, there were 16 cases who presented with health problems. Fifteen involved somatic complaints, compared with 11 out of 12 in this study. The 16th patient was suffering from catatonia, but the treatment was organized around a relatively minor skin lesion which she had rather than for her major mental disorder. (The tâng-ki told us he could not cure severe or chronic mental illnesses.) Here is further evidence for somatic preponderance amongst complaints treated by this indigenous healer. And we have evidence that, in Taiwan, indigenous and professional practitioners principally see patients who complain of somatic symptoms. Even in the Psychiatric Clinic of the National Taiwan University Hospital.
<table>
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<th>Case</th>
<th>Presenting health problem</th>
<th>Symptom change</th>
<th>Behavioral change</th>
<th>Other treatment</th>
<th>Patient's evaluation</th>
<th>Patient's attribution</th>
<th>One evaluation</th>
<th>Long-term evaluation and attribution</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>25 year old mother with (a) chronic rhinitis, (b) upper GI complaints, (c) acute sensation of numbness at head. Neutrocytosis diagnosed in past. Now an occasional pill user. <em>Pathogenic.</em></td>
<td><em>Feels better</em></td>
<td><em>Feels better</em></td>
<td>(1) and (2) being treated by Western-style doctors and self-medication (still takes medicated)</td>
<td>Partially effective</td>
<td>God and doctor effective</td>
<td>Hysteria with secondary somatic complaints, (2) and (3) complaint (1) is mild chronic disorder, Somatization decreased and psychological status improved</td>
<td>Cure. A god wishes to possess patient.</td>
</tr>
<tr>
<td>2</td>
<td>24 year old mother with mild chronic lower GI complaints of 20 years duration. Past history of multiple non-specific somatic complaints. No regular pill user. Who transies and jumps around.</td>
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<td><em>Long-standing treatment in Western-style medical clinics and self-treatment (now no longer uses either)</em></td>
<td></td>
<td><em>Effective</em></td>
<td>God effective</td>
<td>Hysteria and chronic functional GI complaints</td>
<td>Cure. A god wishes to possess patient.</td>
</tr>
<tr>
<td>3</td>
<td>13 year old boy brought in by mother because he does not listen to her. Behaves badly and does not study hard enough. No symptoms. Mother thought he might be due to illness or bad fate.</td>
<td><em>None</em></td>
<td><em>Lessens</em></td>
<td><em>Lessens</em></td>
<td><em>God effective</em></td>
<td>No sickness. Behavior problem with related family and school problems. Behavior improved and family problem improved</td>
<td>Cure. A god wishes to possess patient.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>11 years old female with positive and deformities due to anesthetics. Occasionally brought to stone by family for &quot;behavior&quot;, because she enjoys teasing and for god's help. Poor family, could not afford medication therapy. Patient also has mild mental retardation.</td>
<td><em>None</em></td>
<td><em>Slightly better</em></td>
<td><em>Slightly better</em></td>
<td><em>God effective</em></td>
<td>Chronic physical and psychological problems. Psychological and family gains from treatment at shrines</td>
<td>Annual care. He told her long before that the god could not cure this kind of problem completely.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>31 year old married man with chronic pain in joints. First treated by Western-style doctor. Then by Chinese-style doctor. Then by Japanese. Present has history of psychosomatic complaints and anxiety problems</td>
<td>Partially relieved</td>
<td><em>Several</em></td>
<td><em>Several</em></td>
<td>Both god and medicine effective</td>
<td>Most Holy phlogistics 2. UBB* of chronic irritation from psychic smoking. Possibility of psychosomatically based complaint.</td>
<td>Upper respiratory infection</td>
<td>Cure. <em>Ученики</em> is, according to the traditional notation, treated with medieval-like alchemy and herbs.</td>
</tr>
<tr>
<td>Case</td>
<td>Presenting health problem</td>
<td>Symptom change</td>
<td>Behavioral change</td>
<td>Other treatment</td>
<td>Patient’s evaluation</td>
<td>Patient’s attribution</td>
<td>Our evaluation</td>
<td>Tung-k’s evaluation and attribution</td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td>6</td>
<td>61 year-old female with hypertension and chronic noise and pain. The latter got better but patient became increasingly weak and short of breath. She is a regular clinic member of Shime. Patient has long history of chronic functional complaints</td>
<td>Worsening of symptoms</td>
<td>Feels happier</td>
<td>Treated by Western physician for her hypertension and still takes medicine</td>
<td>Partially effective (patient visited hospital but did not think it was effective)</td>
<td>God effective</td>
<td>Hypertension with worsening congestive heart failure and inadequate medical treatment. History of mental status consistent with system.</td>
<td>Cure. Requires repeated ritual treatments and regular attendance at shrine because god keeps testing her with symptoms</td>
</tr>
<tr>
<td>7</td>
<td>1 year old infant brought by its parents because of fever and cough of 3 days duration</td>
<td>+</td>
<td>+</td>
<td>Went to two different Western-style doctors over 5 days. Injections of antibiotics did not go back after visit to shrine</td>
<td>(Parents)</td>
<td>Father, god, mother and doctors effective</td>
<td>URI, Cure. Either spontaneous remission or secondary to antibiotics.</td>
<td>Cure. Ashes, charms, ritual for calling back the soul</td>
</tr>
<tr>
<td>8</td>
<td>4 month old baby with transient irritability and restlessness with poor sleep pattern. Nodder or specific symptoms. Mother thought it was ‘tricky’ to have a baby’s soul called back. If there was fever she would have taken baby to doctor</td>
<td>+</td>
<td>+</td>
<td>None</td>
<td>(Mother)</td>
<td>God effective</td>
<td>Treatment of viral symptoms. Spontaneous remission.</td>
<td>Cure. Ritual for calling back the soul</td>
</tr>
<tr>
<td>9</td>
<td>3 month old baby brought by grandmother to shrine for treatment of upper respiratory infection</td>
<td>Partial (ill has symptoms of URI)</td>
<td>+</td>
<td>Parents took baby to several Western-style doctors for injections</td>
<td>Grandmother and parents</td>
<td>God effective (grandmother) and god effective (parents)</td>
<td>URI, Partial improvement. Natural course of illness or secondary to antibiotics.</td>
<td>Cure. Ashes, charms, rituals</td>
</tr>
<tr>
<td>10</td>
<td>2 month old baby with poor sleep pattern and frequent crying. No fever or specific symptoms. Grandmother took her to temple for treatment of ‘tricky’ by calling back the soul</td>
<td>+</td>
<td>+</td>
<td>None</td>
<td>(Grandmother)</td>
<td>God effective</td>
<td>Transient colic. Spontaneous remission.</td>
<td>Cure. Treatment: ritual for calling back the soul</td>
</tr>
<tr>
<td>11</td>
<td>22 year old single female with depressed affect and suicidal thoughts. Long-standing personal and family problems. Brought to shrine against her will by mother</td>
<td>Has been treated by Western-style and Chinese-style doctors. Has seen a psychiatrist once but presently refuses psychiatric care. Family supports her in this</td>
<td>+</td>
<td>(Patient)</td>
<td>Mother feels Chinese medicine and Tung-k’s would be effective if tried longer</td>
<td>Nothing has been of help. (Daughter admits to mental stress. Mother says it is a physical problem causing depression.</td>
<td>Depressive syndrome, acute. Long-standing severe personality problem (borderline personality). No treatment has been effective</td>
<td>Cure. Treatment: ashes, charms, rituals</td>
</tr>
<tr>
<td>12</td>
<td>6 month old girl with flank pain, fever, discoloration and bloody urine. Girl’s symptoms got progressively worse while she was at shrine</td>
<td>Worsening at shrine</td>
<td>+</td>
<td>After their daughter got worse at shrine parents took her to hospital where she was treated as inpatient</td>
<td>(Father’s evaluation of shrine. He said however doctor was effective)</td>
<td>Doctor effective “god is useless for disease” (father)</td>
<td>Acute renal disorder. Cure. Patient’s condition worsened at shrine. No testing after one month of professional medical treatment</td>
<td>Cure. Treatment: ashes, charms, rituals</td>
</tr>
</tbody>
</table>
70% of patients with documented psychiatric disorders present with somatic symptoms [22]. This points to the fact that most psychological care in Taiwan is disguised as the treatment of somatic problems.

Of the 15 cases mentioned above: four had chronic cardiac and chest diseases; six had mild or moderate viral-like, self-limited disorders; and five were experiencing somatization. Of the last group, two suffered from anxiety neuroses and three had major family and other interpersonal problems. These findings are supported by analysis of approximately 100 cases we followed who were treated by different kinds of indigenous practitioners. Almost 90% were: (1) non-life-threatening, chronic diseases in which management of psychological and social problems related to the illness were the chief concerns of clinical care; (2) self-limited diseases; and (3) somatization. The last group accounted for almost 50% of cases. The overwhelming majority of these cases were satisfied with the indigenous care they received and believed it to be at least partially effective. However, many cases with severe acute diseases were not satisfied with indigenous care and did not believe it to be effective. Clearly, then, indigenous care is effective for certain kinds of problems but not for others. Intriguingly, in our research in Taiwan about half the case loads of private Western-style doctors were made up of the same kinds of disorders that were preponderant in the practices of indigenous practitioners. But here we found patient satisfaction to be considerably less and evaluations of efficacy much lower than is in the treatment of severe acute disorders, where Western-style practitioners are rated by patients as very effective. However, we have already noted, indigenous practitioners are thought not to be effective. These evaluations fit with patient choice of treatment. In 115 families in Taipei questioned about specific sicknesses they had experienced, more than 90% of all problems were first treated at home. Thereafter, severe acute disorders were brought to Western-style doctors, while chronic disorders were brought to either Western-style doctors or indigenous healers. Self-limited sicknesses and somatization cases tended to end up more frequently in the treatment settings of the latter than in the clinics of the former, though many were brought to Western-style doctors as well.

Two further findings are worth reporting. Of 100 cases treated by indigenous healers, at least three had negative effects on the patients’ diseases. In two cases, patients with marked hypertensive cardiovascular diseases were ineffectively treated while there was progress in worsening of their congestive heart failure. Both cases were delayed from receiving effective care because of indigenous treatment. In another case, an indigenous healer ineffectively treated a young girl with severe hepatitis, and in so doing delayed her from receiving adequate diagnosis and potentially lifesaving therapy. In our experience, however, such situations are distinctly unusual: most cases who suffered from serious disorders for which there was effective modern treatment and no effective indigenous treatment, but who were receiving indigenous treatment anyway, were concurrently receiving the appropriate treatment from Western-style doctors. Families of patients and most (but, unfortunately, not all) indigenous practitioners whom we encountered were generally quite sensitive and knowledgeable about those disorders for which indigenous treatment was clearly ineffective but for which modern treatment was effective. Nonetheless, this problem remains a disturbing and potentially dangerous issue.

Finally, on several occasions we met patients with chronic incapacity (e.g. hemiplegia from cerebrovascular accidents or paralysis secondary to infantile polio, as in Case No. 4 above) and even terminal diseases (e.g. hepatic carcinoma) who had been discharged from modern health care facilities as untreatable and who were receiving active treatment from indigenous practitioners. These patients, and their families, reported that they felt psychologically better and experienced active social lives in place of vegetating existences, because of indigenous care. This was definitely true of three patients we followed who were treated in the therapeutic milieu of the tâng-kí’s shrine.

THE CASE OF MR. CHEN

Mr. Chen, our patient, is a 44 year old married Hakka male. He is a lower middle-class master woodworker with a primary school education who lives with his wife and five children in a poor but newly developed urban district on the edge of Taipei. He came to this shrine (his first visit here) to be cured of a chronic recurrent illness. He was introduced to the shrine and its tâng-kí by several of his neighbors who belong to the tâng-kí’s cult, who, like Mr. Chen, belong to Taiwan’s Hakka minority [23]. Mr. Chen’s neighborhood includes more than 100 people who have been treated at this shrine. He knows dozens of individuals who claim to have been cured by this tâng-kí’s chief god.

Mr. Chen complains of a vague sensation of discomfort in his chest: “a feeling of pressure or tension”. He feels as if his chest muscles are snapping apart. He also complains of being very troubled or anxious (fan-tsao). He describes this feeling as both a psychological and physical one: a disturbing sense of inner tension which he feels is located in his chest, where it produces a physically discomforting sensation which he also experiences as a general nervousness and worry. Even so, he makes it clear that his preoccupation is with the physical components, which he takes to be primary. These include feelings of general weakness, malaise, and also tension in the back of his neck. His is a physical illness, he tells us. But he admits his symptoms either start or worsen when he is worried about business or family problems. As his symptoms worsen, he worries increasingly about his health problem.

Mr. Chen’s illness first began 16 years before. He was then living alone in Taipei trying to establish a woodwork business. Business was poor, and he was suffering serious financial problems. He felt lonely and unhappy. He worried a great deal about failure. Chinese-style and Western-style medicines were unhelpful. He eventually left Taipei and returned to his family’s home in a Hakka region of Taiwan. There he consulted four Western-style doctors, none of whom was able to diagnose precisely what ailment he was suffering from. A Chinese-style doctor told
him that his problem was caused by “working too hard and worrying too much”. That this in turn caused “fire” from his lungs, liver, and heart to “rise up” into his chest, where it “inflamed the nerves” in his chest. This diagnosis impressed Mr. Chen because it could explain both the chest discomfort and the tension. From that time on he considered himself suffering from huo-ch'i ta (excessive internal hot energy). This problem he associated with an excessively hot (symbolically hot) physical constitution, a tendency to irritability and anger, and a variety of nonspecific complaints that he had had. He quite literally could feel heat or “fire” in him when he was worried, burning beneath his sternum—just as the popular ideology says it does.

Although the Chinese-style doctor diagnosed his illness, he was unable to cure him with Chinese medicine. This led Mr. Chen to seek advice from a fortune-teller who told him (as he already feared) that he had “bad fate”. The bad fate, said the fortune-teller, was responsible not only for the illness but also for the inability of the doctors and the medicines to cure the illness. When his fate changed, then Mr. Chen would experience good fortune generally and specifically his illness would be cured by doctors or medicine. The fortune-teller went on to report the “true cause” of his client’s problem: an ancestor—one from the underworld who was not being worshipped by his/her descendants—was “bothering” him. The fortune-teller advised Mr. Chen to find out which ancestor it was, so that he could properly propitiate him.

He immediately realized that the ghost haunting him might very likely be his biological mother. She and his father had divorced when he was four years old. Even though his biological mother had asked him to come to see her when she was dying and to worship her as an ancestral spirit after her death, his father had prohibited him from doing so, a prohibition which Mr. Chen implied had been a chronic source of worry. Mr. Chen confirmed this impression by throwing the divination blocks which landed in the underworld. Mr. Chen's male assistant advised Mr. Chen to find out which ancestor it was, so that he could properly propitiate him.

He immediately went to the tãng-ki’s shrine. (Note that he did this even though it cost him precious time from his work, which he usually carries out seven days per week for at least ten, and often more, hours per day.) After arriving at the shrine (his first visit), Mr. Chen quietly sat off in a corner surrounded by his friends and neighbors, including the tãng-ki’s chief male assistant. They told him that he would be better after eating charms and sacred ashes which were being specially prepared for him by the tãng-ki. His friends frequently reassured him. They repeated the tãng-ki’s advice, which Mr. Chen already had memorized, “You have no problem! You should rest quietly at my shrine... Wait! The god will come to you”.

After waiting a little while, other members of the tãng-ki’s cult, usually people from Mr. Chen’s neighborhood, came up to him and gave him encouraging advice. They told him about their own cases: how they were healed here. They told him that he too would be healed. They related to him stories of clients with problems either similar to his own or much worse, who were “miraculously” cured in the shrine. While he swallowed the charms the tãng-ki had prepared for him, they smiled and said: “Ah! Surely now it will not be long until you are better”. During all this time the tãng-ki had not “officially” consulted with Mr. Chen. But looked over at him every few minutes, when he was not entranced, and smiled, shaking his head affirmatively. Mr. Chen told me that he expected to be cured and that he believed one of the tãng-ki’s gods would make his illness go away.

Initial mental status examination

When I first met Mr. Chen at the time of his initial visit to the shrine, before he had been treated by the tãng-ki, I carried out a full mental status examination. That examination revealed marked anxiety, but no other significant abnormalities. Motor behavior, orientation, speech, and thought structure and content were not remarkable. He did not appear depressed and gave no history of experiencing the somatic concomitants of depression. He was preoccupied with his chest discomfort and frequently rubbed or pointed to his chest. He was circumspect with his answers, and did not give full replies to questions about his family and personal history. His behavior seemed to make his friends also somewhat uneasy.
Mr. Chen showed only quite limited insight into (and interest in) the psychological sides of his illness, favored a somato-psychic rather than a psychosomatic causal sequence. He turned most questions about affect and beliefs into responses about somatic complaints. When questioned about his feelings and other aspects of his personal life, he spoke very generally, actively suppressed most private information, and elaborated hardly at all. In all of these regards, he was like many other Chinese patients I have interviewed, and like non-patient informants as well. These aspects of behavior are unusual when viewed from an American standpoint, but normal when seen from the perspective of Chinese culture.

In summary, Mr. Chen presented no evidence of psychosis or other major psychopathology. He did present considerable anxiety and marked somatic preoccupation. Since I was unable to perform a physical examination or laboratory tests, the history and mental status exam had to suffice as the basis for formulating a diagnosis. My impression was (and still is) that Mr. Chen suffered from an acute exacerbation of a chronic anxiety neurosis owing to psychosocial stress, principally involving financial and business concerns. That same stress had precipitated several earlier acute anxiety attacks. These episodes, including the present one, involved somatization as a secondary manifestation of his primary psychological problem.

Treatment in the tāng-ki’s shrine

Although Mr. Chen spent more than four hours in the shrine at the time of his first visit, the tāng-ki spent very little time with him, less than ten minutes. He was one of approximately 10 new cases the tāng-ki treated while in his trance. The tāng-ki saw Mr. Chen after the latter had been at the shrine for more than two hours. The assistant called out Mr. Chen’s name, date, day, and time of birth; and his problem: health problem. The entranced tāng-ki spoke authoritatively. The god stressed the desirability of Mr. Chen coming to the shrine as often as possible. He then told Mr. Chen that his problems were due to the shrine’s chief god, who was troubling Mr. Chen because he wished to become his master. Once Mr. Chen “allowed” the god to possess him he would become his disciple, and his complaints would go away entirely. Furthermore, the god would protect him (as long as he served the god as a faithful disciple by attending regularly at the shrine) from further episodes of this illness, and would reward him with good health, long life, a large, prosperous family, and success in business. But Mr. Chen must be patient.

The tāng-ki wrote out sacred charms for Mr. Chen. He scooped up some ashes from the large incense pot on the altar table. Both of these were wrapped with his assistant and handed to Mr. Chen, who was instructed to eat them. Then the tāng-ki took his writing brush and several burning incense sticks in his right hand and made passing movements before Mr. Chen as if he were writing a charm over his body. (The meaning of this ritual, which Mr. Chen later told us he did not understand, is that the tāng-ki transfers the god’s power through the illegible character (the sacred symbol) he draws over the client to the client himself, where it heals by improving his fate, driving away evil forces, or acting directly on the sickness, depending on the cause.) The tāng-ki’s last words were repeated several times: “You have no problem.” This is a special blessing to indicate that the client will receive the god’s full therapeutic efficacy and will be healed. Again, Mr. Chen did not understand the special meaning of this term at the time of this first visit to the shrine. Before Mr. Chen returned to his seat, the tāng-ki wafted incense and perfumed resin around his head, something that he does to encourage trance behavior. The chief male assistant encouraged Mr. Chen to let himself relax and to allow the god to possess him. Compared with his treatment of other cases, the tāng-ki’s behavior with Mr. Chen was much less dramatic. He kept his powerful voice low. He did not perform any involved, impressive, or frightening ritual activities, which he did do in other cases. And he made no attempt to focus the concern of his large audience on Mr. Chen, a strategy he sometimes employs in difficult cases. This treatment was much quieter and more private than most I witnessed in this shrine.

In fact most of Mr. Chen’s “therapy” during this first visit was provided by the milieu not the tāng-ki. He received a great deal of support from friends. When he returned to his seat in the rear of the shrine, his friends and neighbors again formed a small group around him. They told him he would now certainly be cured. They suggested he close his eyes, relax, and try to trance. They also told him not to feel disappointed if he was unable to trance this night, since for one to trance and jump around is like an infant “growing up and learning first to sit, then to crawl, stand, and finally walk.” Mr. Chen did not in fast trance that evening. He remained sitting quietly in his chair, his eyes often closed, trying, as he later told me, to “meditate”. Mr. Chen reported feeling slightly better after this first night’s treatment. He was confident he would be completely cured. He could relate no evidence to support his self-assessment, however. His symptoms were still present. “Somehow I feel better.” (Since he told us this shortly before he left the shrine to return home, we should be cautious about interpreting this assessment. None of the patients treated in shamans’ shrines whom I examined ever told me, while they were still in the shrine, that they did not feel better even if only very slightly so. Many seem to feel really better even if only transiently so; others fear antagonizing the god by making negative comments, especially since they have come to enlist the god’s help; and virtually no one is impolite or stolid enough to reveal openly how they actually feel in the presence of the tāng-ki and other members of the shrine.)

Mr. Chen returned to the tāng-ki’s shrine each night for one week. Thereafter, he returned almost every night for several months, failing to attend only when he was engaged in important business and family obligations. After the second night in the tāng-ki’s shrine he reported feeling a great deal better, and he claims to have felt completely well after the third night there. On neither of these evenings did the tāng-ki formally treat him. The second night one of the female cult members, herself in trance, actively treated him. She forced him (much against his wishes
and to his clear embarrassment) to jump around with her: but he did not trance. On the following night, the cult's chief female healer placed her hands on him, massaging and slapping his arms, legs, and chest. (These movements are believed to help drive out evil influences from the body. This is one of the very few socially legitimated occasions when men and women can touch each other's bodies in public.) Again, he was led away from his chair and forced to jump around. This night he trance. He flung himself around the shrine violently, and eventually collapsed to the floor exhausted after about 15 minutes. He then lay on the floor, not asleep but apparently unable to move, for a similar period of time. When he threw himself on the floor sweat was pouring off his face, his shirt was completely wet and sticking to his skin, and he was momentarily the focus of attention of the many people in the shrine. (While he jumped around, he copied the actions of the shrine's many trancers, who themselves copy the stylized movements of characters in Taiwanese folk opera. But Mr. Chen's behavior was considerably less controlled and more violent than those of the experienced cult members. The latter told us that he would learn in time how to control his trance behavior). Recalling his first trance, Mr. Chen states that he heard people talking around him, and did not feel as if the god was possessing him.

Mr. Chen attributed special healing powers to a handsome, middle-aged Hakka woman, his neighbor and the shrine's chief female healer who, along with the tâng-ki, are the two most charismatic figures in the shrine. Her master is "Monkey", a deified folk hero in Chinese culture, who is reported to possess many magical powers, regarded as clever and cunning, and who is called by the tâng-ki "he who finds out all secrets" [24]. Her healing skills are highly valued in the shrine and were well known to Mr. Chen before he came. She told him he must come back to the shrine each night. Since that time he has returned to the shrine regularly, but has only trance and jumped around on several other occasions. Most of the time he sits quietly in the shrine and meditates: or he speaks with friends. During each of his visits, the tâng-ki's chief male assistant speaks with him at length. This assistant is a very large man who usually acts deliberately and calmly, with a soft smile, radiating warmth and confidence. His slow, methodical movements and quiet speech and Buddha-like smile create a model that is the very opposite of anxiety. He is a close neighbor of Mr. Chen's, and has known him for many years. They may sit together for 45 minutes to an hour, or even more. Mr. Chen's motor behavior and speech become noticeably less quick and intense in the assistant's presence. Since his initial visit to the shrine, Mr. Chen has taken no medication. He has not gone to consult other shamans or other kinds of healers. He believes that his illness has been cured, and that the cure is the result of the shrine's chief god, whose faithful disciple he has become.

Follow-up interviews

Mr. Chen's subjective evaluation. The first follow-up interview with Mr. Chen took place five days after his initial visit to the tâng-ki's shrine and two days after he first trance. We visited him at his home. We also spoke briefly with his wife and children. Mr. Chen first reported to us: "I feel better...I have been cured". He said both the feeling of discomfort in his chest and his feeling of tension had disappeared. Whereas before his chest discomfort often was provoked by hard physical work, it had not bothered him for the past several days in spite of the fact that he had been working very hard. He repeated to us that he had felt slightly better after his first night at the shrine, much improved after the second night, but only after the third night there did he feel completely better. He still remains worried about his business and financial concerns (but no longer about his health). But these worries he distinguishes from the marked tension he had been feeling. He does not feel as if his responsibilities have been lessened or transferred to the shrine's god, indeed he lists them in full for us, but he is more confident now that he can successfully cope with them. He repeats again and again his cure is "strange": it cannot be explained by him or by us. Mr. Chen said we must accept it as something that passes our understanding. The god has cured his health problem, now he himself must work out his business problems.

Objective evaluation. To us, Mr. Chen looks considerably more relaxed, much less outwardly anxious, and less troubled and distressed than at the time of our initial evaluation. His voice is stronger, and he is more assertive. Unlike our first meeting, he maintains eye contact, does not glance away, smiles fairly frequently, and has generally quite good communicative rapport. He carries himself with much more confidence. These behavioral changes are as striking to my Taiwanese research assistant as they are to us.

Mental status examination is remarkable only because it reveals no significant anxiety. Mr. Chen also denies any physical complaints. We observe him hard at work and relaxing with his family. In both situations he acts entirely appropriately, displaying almost none of the signs of anxiety which were so pronounced five days before.

My overall impression is that he demonstrates no significant psychopathology, and that his former anxiety has been largely, and perhaps entirely, relieved, while his physical symptoms are no longer present.

Further follow-up evaluations

Almost three weeks after this first follow-up visit, I saw Mr. Chen again at the tâng-ki's shrine. He looked much the same as when we first met: restless, quite anxious, and preoccupied with his troubles. Although he reported feeling well, he also admitted he still occasionally suffered from discomforting feelings of tension in his chest, along with fatigue and malaise. He remained worried about his business. (To me he seemed a good deal more troubled than at our first follow-up visit.) He told me he comes to the shrine almost every night. As soon as he arrives, he feels better: calmer and less tense. By 11:00 p.m., when he returns home, he usually feels entirely relieved. When he arrives at home, he is able to go directly to sleep, and sleeps soundly until his usual time forawaking. Mr. Chen told me that though his anxious feelings still occasionally return, they are less

Why do indigenous practitioners successfully heal?
severe than before. Moreover, by concentrating on the shrine, and "filling my mind with things concerning the shrine": Mr. Chen claimed to be able to exert some self-control over these daytime bouts of anxiety. He feels especially "good", and even "happy", when he is able to trance and jump about at the shrine in the evenings. His wife encourages him to go to the shrine regularly because he seems to be better after he returns home, whereas he gets worse if he does not go. He reported no significant changes in his health again. He bought both Chinese medicine at a Chinese pharmacy and Western medicine at a Western pharmacy, which the pharmacists prescribed for his symptoms, but neither was effective. He somewhat reluctantly told the tâng-ki about the recurrence of his problem. This was the first time he had formally consulted the tâng-ki since his first visit. The tâng-ki replied that the god was testing Mr. Chen's patience. He told Mr. Chen: "After you are able to trance and jump about regularly, which you are not yet able to do, you will get better". During the trip to the south, the tâng-ki, his chief male assistant, and some of Mr. Chen's neighbors who belong to the cult spent much time with him. The evening they returned (four days before this interview), Mr. Chen's physical symptoms disappeared, though he remained anxious.

Before going on this two day pilgrimage, Mr. Chen's business had become very active. He felt under much pressure to finish his work; moreover, he wanted to finish it before he left on the journey. At the last moment, he almost decided not to go. But his friends and neighbors persuaded him to go. His wife supported this view. At the shrine they visited, Mr. Chen did not trance, but he felt less tense. Indeed, he told us he had "a good time" on the trip. Mr. Chen's neighbors who belong to the shrine regularly because he seems to be better.

During this interview, I was impressed by the obviously high level of Mr. Chen's anxiety, this time in the absence of physical complaints. Unlike before, he sat in the shrine without closing his eyes and meditating. Nor did he exhibit any signs of trance. Instead, he constantly looked around to gaze momentarily at different people, occasionally took a nervous glance at his watch, and, on the whole, revealed himself to be quite uneasy and easily distracted. Although he did not formally consult the tâng-ki, he spoke with him from time to time when he was not in his healing trance. The chief male assistant sat by Mr. Chen's side for most of the evening, talking slowly, occasionally smiling in a relaxed and easy-going style which contrasted sharply with Mr. Chen's behavior. Just before he departed, he seemed less anxious than earlier in the evening, laughed aloud at a funny story the tâng-ki told those around him, and warmly exchanged formal words of courtesy as he left. To my mind, Mr. Chen was suffering a recurrence, and being treated for it.

Three months later, we again interviewed Mr. Chen at the shrine. This was the evening of a local festival celebrating the birthday of one of the shrine's gods. About 100 people crowded into the shrine and presented offerings of food to the god. It was noisy. Many people, in trance, were jumping about. Mr. Chen was present along with his wife and their youngest child. He told us emphatically that he no longer suffered from an illness. At times he still gets a sensation in his chest but it only lasts a few moments. His business has been doing very well. Outwardly he showed no anxiety. He smiled easily, and talked to me at length with considerable competence and ease. He did not point to or rub his chest. He was quite well dressed, and appeared (just as he purported to feel) prosperous and happy. His wife, who also seemed unconcerned, agreed with her husband's statements about himself. Later in the evening, Mr. Chen went into a trance while sitting on a stool: he rapidly turned his head from side to side, with his eyes and mouth closed, and with both hands slapping his thighs. This lasted for about five minutes. He did not get up and jump or sing with the many cult members who did so throughout the shrine. After coming out of his trance, his face was covered with sweat and he smiled broadly at his three year old son. According to Mr. Chen, his wife, and others at the shrine, he had been free of signs and symptoms of anxiety for several months, and also had not complained of physical discomfort.

One month later, several days before I left Taiwan, I paid a final visit to this shrine. Again it was the time of a festival. There was much noise and excitement. Most of the tâng-kî's cult were present, well over 100 people, including Mr. Chen. He was relaxed and obviously enjoying himself. I did not observe any signs of anxiety, and he neither reported those nor physical complaints to me. He told me he felt well. He reaffirmed that his old illness, "neurasthenia", he called it, was no longer a problem. Indeed, from the time of our last encounter until now, he had experienced no difficulties at all. He had become an active member of the cult, and was assisting with the moving of furniture and ritual objects. Mr. Chen was now part of the shrine's "therapeutic milieu". He even talked with several new clients, offering them support and, in one instance, telling his own story as an example of the chief god's efficacy. He spoke as if his problem had long since ceased to trouble him. With this new client he talked of his "new life" as a member, and contrasted it with the sufferings of his former existence in the "sea of bitterness". Everyone around him agreed that Mr. Chen had indeed been cured. I wanted to question him at length, but he told me he was embarrassed to talk about "bad things" when things were now so "good" with him, his family, and his business. And he reminded me to talk of such things could tempt fate, anger the god, and induce a change in fortune. At that moment the tâng-ki came by and told us: "Is it not enough Mr. Chen is well? Must you trouble him more? He is cured! The god cured him. What more do you need to know?"

Miss Sung performed a 7 month follow-up, at which time she found Mr. Chen to be unchanged. He was, and had been throughout this time, free of somatic complaints. He did not appear anxious, and
denied experiencing any acute anxiety states. Mr. Chen was still an active member of the tâng-kî's cult [25].

**COMMENTS**

The follow-up cases illustrate the complexities surrounding cross-cultural evaluations of treatment outcomes. First, studies of indigenous forms of clinical care place certain constraints on the analytic tools the researcher can use to evaluate illnesses and treatment responses. It would have been helpful in these cases to have carried out our own physical examinations, given certain psychological tests, and reviewed X-rays, EKGs, and blood test results, but none of this was feasible. On the other hand, studies that have attempted to do this have so drastically altered the treatment situation that what they ended up studying was not actual indigenous practice. Secondly, as we have pointed out, almost all anthropological assessments of therapeutic efficacy dispense with follow-ups entirely, and rely simply on the subjective report of the patient, almost immediately after he is treated, or on the ethnographer's independent judgement. Both approaches are inadequate, since anthropologists usually do not possess the training to make such assessments (and when they make them usually fail to specify how these assessments were made), and treatment outcome simply cannot be evaluated immediately after treatment is performed because, for reasons already mentioned, most patients are constrained to affirm at least some level of treatment success while they are still in the treatment setting, and because such assessments give no sense of the effect over time. Furthermore, in most situations it remains unclear what illness is being treated. It is abundantly clear that a chronic recurrent illness, like Mr. Chen's disorder, requires study for a considerable period of time so as to be able to examine the effect of therapy on its chronic course and to rule out spontaneous remissions.

To make much of a single case, or a single series of cases, is particularly dangerous. Although Mr. Chen's case is one of many I have followed, generalizations based on independent cases (even a fairly large number of them) can be quite misleading since strong biases operate in indigenous treatment settings to select unrepresentative cases—those with more impressive illness manifestations and treatments, and immediate responses. Retrospective studies (which make up much of the literature) are notoriously unreliable; but even prospective evaluations, such as Mr. Chen's case, can be unreliable because there are so many important variables which are difficult or impossible to control: type of illness, age, social class, prior treatment, concomitant treatment by other kinds of practitioners, etc. Comparative research requires matched patient groups, but this is difficult to achieve in field studies. And, of course, there is a strong observer bias. Almost everything in the treatment setting encourages the researcher, like the patient, to affirm the success (even if in quite limited terms) of treatment.

To my mind, these problems usually make it impossible to carry out rigorous studies of indigenous healing which are comparable to the best studies of treatment outcomes in modern medical settings both in the U.S. and cross-culturally. Such scientifically rigorous studies can be carried out in Taiwan at the National Taiwan University Hospital's outpatient psychiatry clinic, where only a small fraction of cases are treated, but not in shamans' shrines, fortune-tellers' offices, and chi'en interpreters' temples, where the great majority of cases are treated. When the treatment intervention is psychotherapy (modern or traditional) the problem of determining outcomes even in a modern treatment setting is considerable. All of which leads me to argue not against doing such studies, but for recognition of their serious limitations. For example, in the follow-up study of 12 consecutive cases, our results were almost certainly skewed toward more positive evaluations of treatment, as we already noted, because we were unable to complete follow-up with seven cases, three of whom refused follow-up and it is reasonable to assume, for these three cases, that their evaluations would have been more negative. It has been my general experience, moreover, that patients treated by indigenous practitioners tend to resist follow-up interviews much more than do patients studied in Western medical practice. Research fits better (although not always very well) with the expectations of patients treated by modern professional medical practitioners than with those who seek indigenous treatment, especially sacred, temple-based treatment. We have already pointed to some of the difficulties resulting from subjective patient evaluations of the efficacy of healing. They confound the different criteria for evaluating treatment that are used by practitioners and researchers.

These concerns make it essential to confront a fundamental question: What is healing? Clearly it is a somewhat different thing for the patient (and perhaps family), practitioner, and researcher. Indigenous practitioners in Taiwan believe most cases are successfully treated, since few return for treatment, and they believe failure to return is an indication of treatment success. This runs directly counter to the popular patient viewpoint that you don't return to the same practitioner if you derive no therapeutic benefit. For the practitioner, treatment may be directed at the female family member who usually comes with the client. which should lead to symptom relief (in his theory), but at times (for various reasons that he can list) does not. In such a case, he might claim partial or complete cure even in the absence of symptom change: although he will either predict such a change for the future or explain that another problem has been encountered which also must be "cured". Practitioners of shamanistic and other temple-based healing in Taiwan are usually quite clever at explaining therapeutic failure in such a way as not to imply that their god's healing powers have been inadequate. Chinese-style doctors use the pulse both to diagnose illness
and evaluate if the patient has returned to a harmonious state of bodily functioning. They sometimes will tell patients who feel entirely better that they are still ill, since the underlying problem has not been completely treated. I have seen Chinese-style doctors tell patients that even though their symptoms have not "yet" improved, their pulse indicates treatment has been effective. Of course, this very same process occurs all the time in Western medicine, when the physician attributes cure or improvement to measured changes in blood electrolytes and other chemical values in the absence of clinical signs of improvement. For patients these discrepant practitioner assessments may present significant problems that cause them to leave treatment or fail to comply, but many seem to accept these views as part of the medical mystique, the medical expert's special understanding of the problem and its treatment.

On the other hand, for the shaman, symptom relief in the absence of complete ritual treatment to expel an evil spirit, or for the Chinese doctor, symptom relief in the absence of a return to harmonious balance of yin/yang, hot/cold, or the five body spheres (wu-shuang), is not a cure, no matter what the patient says. But these niceties may be explained only to the researcher, because for most indigenous practitioners resolution of the chief psychosocial issues which comprise the illness experience is more important than these theoretical fine points.

Treatment, for most practitioners, seems to be directed at two aspects of a given health problem: the disease and the illness. This distinction is as appropriate to make in the case of the shaman who treats both the invading ghost (disease) and the symptoms and psychosocial problems (illness) produced by the disease, as it is in the case of the Western doctor who treats both the biochemical derangement in diabetes (disease) and the symptoms and psychosocial problems which comprise the clinical picture of diabetes as an illness. Seen from this perspective either or both may be successfully treated. Problems in clinical care seem to arise when the practitioner is concerned only with curing the disease, and the patient is searching for treatment of his illness. Indigenous folk practitioners in Taiwan seem to be generally more sensitive than Western-style doctors about treating illness, especially the personal and social problems it gives rise to. From the perspective of the modern medical profession in Taiwan, indigenous healers are viewed as dangerous because they cannot define the disease in scientific terms and fail to treat it, which could have potentially disastrous results for patients.

From the patient perspective, however, disease and illness are usually not distinguished. Most of the time patients are concerned principally with symptom relief and treatment of psychosocial problems produced by the stress of illness. But for many patients that is not enough; they require explanations of their health problems which are personally and socially meaningful, and that usually requires the practitioner to explain about the disease as well as the illness. Indigenous practitioners (especially sacred folk practitioners) in Taiwan seem to be remarkably skilled at judging when to talk about the disease and emphasize its treatment, and when to talk in terms of, and direct treatment principally at, the illness. Western-style doctors both in Taiwan and Boston seem to have considerable difficulty in doing this. Part of the problem may be that indigenous practitioners seem to be better at eliciting patient views, the rub of which often concern this very issue, whereas Western-style doctors perform this clinical task quite poorly, when they do it at all. Furthermore, the indigenous practitioner's view of the disease is usually more in line with patient beliefs than is the Western medical concept of disease.

For the researcher this is a special problem. Which definition does he use for disease (indigenous or biomedical), which for illness, and when he evaluates cure is it cure of the disease (and which view of the disease) or the illness, or both? Most anthropological writing is unclear on this point; so is most of the medical and psychiatric literature.

As I have noted elsewhere [26], most traditional forms of healing include two closely interrelated functions: providing effective control of the disease and illness manifestations, and personal and social meaning for the experience of being ill in a particular cultural setting. Evaluations of healing (by either patient or practitioner) may involve both or only one of these functions. For patients both are usually essential. For traditional practitioners the available evidence suggests that both are also usually taken into account. More and more, however, modern medical care seems to view only the former as the proper task of clinical care and disregards the latter. This certainly seems true of Taiwan, and also reflects research and clinical experiences in Boston. As Horton [27] shows, scientific medicine is structured to provide technical information, but not personally and socially meaningful explanations. Modern clinical practice, however, which Horton does not consider separately from medicine as a science, involves translations between scientific and popular common sense rationalities. There is much to suggest that the professional clinician still can provide (though he usually fails to do so) explanations which are meaningful to patients and their families [28]. Or at least differently, clinical rationality like popular rationality deals in personal and social meaning as well as technical information. What is at issue perhaps is clarifying the role of personally and socially meaningful explanations in treatment, so that modern health professionals recognize it as an important index patients and their families use to evaluate therapeutic efficacy. The alternative, of course, is to remove this from the clinical tasks performed by the doctor, and make it a special task for another type of health worker or assistant (nurse, secretary, health auxiliary, etc.). In my view, while this may be an experiment worth trying, it would radically alter the doctor's image, turning the healer into an engineer or technician in his own eyes and those of his patients, and consequently produce a situation even worse than the one it seeks to remedy. It would exonerate a clinician from treating the psychosocial aspects of disease: causal and symptomatic. One of the chief contributions of behavioral and social science to clinical care should be to better conceptualize this explanatory function of clinical practice so that it may be taught and practiced. Comparative cross-cultural studies provide an exceptionally good
essentially cured, but that (as the god was testing him as part of a final trial before he was cured at the time of our first follow-up visit. In fact, when his symptoms reappeared and his treatment became more active, he felt that he was effectively evaluated. Mr. Chen's rapid recovery from his acute anxiety reaction (though this also may have been part of the waxing and waning course of his illness) suggests a realization that Mr. Chen was suffering from a chronic illness or constitutional tendency which had to be kept in check by continued treatment. The tâng-ki's advice that he must return to the shrine regularly is a sign of his recognition of the need for chronic care. Mr. Chen himself seems to adopt this view at the time of our second follow-up visit, when he explains to us how evening visits to the shrine are able to relieve anxiety building up over the course of the day.

But a major discrepancy remains. Mr. Chen and the tâng-ki are convinced his disorder has been cured. I am not convinced, and suspect that treatment may not have altered the chronic course of his sickness, as it is defined by my psychiatric explanatory model. Is Mr. Chen cured? The tâng-ki and Mr. Chen say yes. I am tempted to say no. The question again turns on what is meant by cure. Mr. Chen's symptoms have gone away, his chronic anxiety seems to be controlled, and he has received and incorporated a personally and socially meaningful explanation of his illness. By the definition of healing I gave above, he is cured. In this sense, it does not matter if cure has been brought about by the shrine, or a non-specific placebo effect, or the natural course of the illness. Put differently, Mr. Chen seems to have been successfully treated, but not his disease. My prediction is that his symptoms will recur. But I also would predict that they will go away again, as in the past, but perhaps more rapidly than in the past while he is treated at the tâng-ki's shrine. The acute illness will continue to recur (and remit) as long as the underlying disease exists. But to demand evidence in support of the successful treatment of the disease may be quite unfair, because even with appropriate professional psychiatric care (tranquilizers and psychotherapy) it is unlikely the disease would entirely disappear either.

This viewpoint leads me into treacherous ground. Anxiety neurosis is not an entity but an explanatory model. Within the medical explanatory model I employ, it makes sense to talk of healing from the perspective of certain explanatory models. From the theory of the health care system which I have advanced, healing is not so much a result of the healer's efforts as a condition of experiencing illness and care within the cultural context of the health care system. The health care system provides psychosocial and cultural treatment for the illness by naming and ordering the experience of illness, providing meaning for that experience, and treating the personal, family, and social problems which comprise the illness. Thus, it heals, even if it is unable to effectively treat the disease. In Mr. Chen's case, we see this very thing happening.
Let us offer a provisional and seemingly paradoxical conclusion: Mr. Chen's disease is not cured; Mr. Chen's illness is cured; and Mr. Chen's health care system, not the shaman and not his shrine, is responsible for that cure, i.e. Mr. Chen's illness is healed by the cultural construction of clinical reality. In that sense, the shaman and his shrine cannot do anything but heal Mr. Chen's illness and the illnesses of others like him, who are willing to participate in the cultural reality of the shrine and accept its explanatory models, and whose personal and social problems are effectively dealt with there. The same holds for patients who actively and fully participate in the cultural reality of any form of clinical practice (indigenous or modern) in which their illness is treated by: (1) the provision of personal and social meaning for the illness experience; and (2) the clinical resolution of personal and social problems constituting illness as a human experience. It is striking to realize, however, that this kind of cultural healing is least likely to occur in the health care institutions of professional medicine, whose clinical reality is so constructed as to discourage this most traditional type of healing of illness from happening, at the same time as it strives to maximize the effective treatment of disease.

CONCLUSION: WHY INDIGENOUS PRACTITIONERS SUCCESSFULLY HEAL.

Based upon the material we have presented, we draw the perhaps startling conclusion that in most cases indigenous practitioners must heal. Why? As we have seen, indigenous practitioners primarily treat three types of disorders: (1) acute, self-limited (naturally remitting) diseases; (2) non-life threatening, chronic diseases in which management of the illness is a larger component of clinical management than biomedical treatment of the disease; and (3) secondary somatic manifestation (somatization) of minor psychological disorders and interpersonal problems. The treatment of disease plays a salient role in the care of these disorders. The indigenous practitioner usually (but not always) is exceptionally well poised to maximize psychosocial and cultural treatment of the illness. Contrariwise, he may not be competent to effectively control severe, acute diseases. In the sample of twelve cases, only the two cases of severe, acute somatic and psychological diseases led to negative evaluations of treatment by patients and families. From our standpoint, the case of the patient with progressively worsening congestive heart failure is another example of ineffective indigenous treatment, despite the patient's positive evaluation of the treatment. The cases of infants with infectious diseases being treated by both indigenous and modern professional practitioners suggest that families in Taiwan are quite sensitive to this issue. They go to Western-style doctors for the control of potentially life-threatening diseases, diseases which Western medicine is particularly effective in treating; and to tâng-kis for personally and culturally meaningful treatment of illnesses. They do not go to Western-style doctors for the treatment of "fright", which is a cultural illness, but to practitioners poised to apply the culturally sanctioned treatment for this illness.

What we have said is not meant to imply that indigenous therapy is entirely ineffective against all severe, acute, and life-threatening chronic diseases. In fact, it may exert placebo effect or directly effect such diseases. For example, in the case of Mr. Chen, the therapeutic milieu of the tâng-kis' shrine may have provided him with effective psychotherapy not only for the treatment of his illness, but perhaps also for his underlying disease. We now know that all forms of psychotherapy seem to work for a wide range of mental disorders [30]. The universal therapeutic components of psychotherapy [31] seem to be present in both modern and traditional forms [32]. Thus, there is much in favor of the argument that indigenous forms of psychotherapy may effectively treat certain psychological (and perhaps also psychophysiological) diseases. Moreover, recent research on the physiological effects of meditation, behavior therapies, biofeedback, and placebos suggests a number of different ways by which indigenous therapies may effect biologically-based diseases. In that the epidemiological web causing and sustaining physiological diseases not infrequently includes major psychosocial factors, indigenous healing may at times work to effect such diseases by altering those factors. Thus, to the extent indigenous practitioners provide culturally legitimated treatment of illness, they must heal.

The equally startling corollary of this argument is that in most cases modern professional clinical care must fail to heal. Why? Because most of primary general medical practice is made up of the same types of disorders found in indigenous practice [33]. Thus, the majority of cases require successful treatment of illness for there to be therapeutic efficacy. But the physician is trained to systematically ignore illness. This represents a profound distortion of clinical work which is built into the training of physicians. It pays off on the application of biomedical technology to the control of disease, a less common but crucial clinical function, while it founders on the psychosocial and cultural treatment of illness, which is so much more common clinically and frequently. Failure to heal illness is not articulated in the health professional's system of evaluating the efficacy of healing, but it is articulated in patient non-compliance and dissatisfaction, use of alternative health care facilities, poor and inadequate care, and medical-legal suits.

That many primary care physicians do, in fact, heal most of the time is a function of their clinical skills in treating illness as well as disease, by which they overcome the profound limitations and distortions of modern health care. What is needed in modern health care systems, in both developing and developed societies, is systematic recognition and treatment of psychosocial and cultural features of illness. That calls for a fundamental reconceptualization of clinical care and the restructuring of clinical practice. For, if appropriately trained, the modern health professional (not necessarily a physician) can effectively and systematically treat both disease and illness. Whereas, in many instances, indigenous healers can neither systematically nor effectively diagnose and treat disease (biomedically defined). For reasons I do not have the space to elaborate on here, this research suggests that most indigenous practitioners (especially sacred practitioners) cannot be trained to systematically recog-
nize, refer, or treat disease. They cannot be incorporated into modern health care organizations. (In the PRC, tâng-kis have not been made into barefoot doctors, but have been discouraged or prevented from practicing.) However, certain kinds of indigenous practitioners, such as Chinese-style doctors in Taiwan (and the PRC), and chiropractors and lay psychotherapists in the U.S., may be suited for integration into modern health care.

This leads me to argue for the creation of a clinical social science which would be involved in research, teaching, and the actual practice of clinical care. Clinical social scientists (anthropologists or sociologists) or social science-trained clinicians (psychiatrists or physicians) would translate and apply relevant behavioral and social science concepts through practical clinical strategies to real patient care problems and the training of clinicians. (They would, for example, translate and negotiate between discrepancies in professional and popular evaluations of clinical care.) In that way, medical education and modern health care would reintroduce the treatment of illness as a central clinical task, but one which is based upon a social scientific foundation for clinical science just as the treatment of disease requires a biomedical foundation for clinical science.

REFERENCES
11. Field research in Taiwan was made possible by grants from the following sources: Foundations' Fund for Research in Psychiatry; Social Science Research Council: Harvard Yenching Institute, and the Dupont-Warren and Milton Funds. Harvard University. Research was conducted from January to September, 1975, while I was Visiting Lecturer, Department of Neurology and Psychiatry, National Taiwan University Hospital. Miss Sung is still carrying out some of the research. Preliminary reports of our research findings are found in Kleinman (1975b, 1975c); findings from the comparative cross-cultural study of practitioner-patient relationships are still being analyzed; Kleinman A. Cross-cultural studies of illness and health care: a preliminary report. Bull. Chin. Soc. Neurol. Psychiat. 1, 14, 1975b; Kleinman A. Medical and psychiatric anthropology and the study of traditional medicine in modern Chinese culture. J. Inst. Ethnology: Academia Sin. 39, 107, 1975c.
14. Ibid.
19. I am indebted to Dr. Nancy Waxler for pointing this out to me, first, in her own work in Sri Lanka (Ceylon), and then as a cross-cultural generalization.
20. A full description of this tâng-kì and his cult is found in Wang C. A folk doctor and his cult on Keelung St., in Taipei. Unpublished B.A. thesis. Department of Anthropology, National Taiwan University, 1971. (In Chinese.)
23. Approximately 17% of Taiwan's 16 million population are Chinese who speak the Hakka dialect and are identified as a distinct subgroup: the Hakka (K'echia-chien, "guest people"). The Hakka are ethnic Chinese who
once lived in northern China and who long ago migrated from there to the south, primarily Kwangtung province. From there many migrated to Taiwan. They are considered to be one of the most culturally traditional Chinese groups with a strong ethnic identity. They tend to be endogamous and reside in their own communities. Taiwan has several large areas that are predominantly Hakka, but in Taipei and other large urban communities there now is considerable intermarriage with Taiwan's predominantly Hokkien-speaking population. However, in the past these two groups frequently fought each other; and even now bitter feelings remain. Many of my Hokkien-speaking informants hold the following ethnic stereotype of the Hakka: more achievement-oriented, more intellectual, more filled with their own sense of importance, more close-knit, more concerned with cleanliness, and more traditional in beliefs and customs than the Hokkien population. These views are portrayed in negative terms with resentment for what are seen as the "strengths" of Hakka culture. Of interest, many Hokkien people have an impression (one I share) that Hakka are overrepresented in the medical profession (Western and Chinese).

24. The shrine's tâng-kí, an extremely shrewd person, assigned me this same tutelary god, "Monkey", making sure that my research assistant and I were aware of this epithet.
25. Miss Sung recently made a two year follow-up of Mr. Chen which found him to be asymptomatic and doing just as well as at 7 months. He has become an important and much respected member of the cult.
30. Luborsky L. et al. Comparative studies of psychotherapy: is it true that "everyone has won and all must have prizes?" Arch gen. Psychiat. 32, 995, 1975.