role adaptation: traditional curers under the impact of Western medicine[1]

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The functions of the curer's role in a tradition-directed society facing the challenge of a technologically more powerful medical system may be studied from many points of view. This paper will be confined to a consideration of certain theoretical aspects in the adaptation of the curer's role to changes accompanying acculturation threats and opportunities. Data are taken from a variety of studies by anthropologists and others. My objective is to place the changing role of the curer into substantive and theoretical perspective and to contribute to a model for the study of role adaptation under conditions of culture change.

anthropological treatment of the curer's role

Much attention has been given in ethnographic reports to the curer's status and role. Until recently, however, relatively few studies furnished detailed descriptions of the process of becoming a curer, of recruitment to the role, or the articulation of the curer's role with the social system (except, usually, the religious system). Among conspicuous exceptions we may cite Gillin's (1956) account of "the making of a witch doctor," Hallowell's (1939, 1942, 1955, 1963) many studies of sociocultural aspects of Ojibwa medicine, Handelman's (1967) account of "the development of a Washo shaman," Kluckhohn's (1944) classic study of Navaho witchcraft, Spiro's (1967) analysis of Burmese medical-religious beliefs and practitioners, Press' (1971) case-study analysis of the careers, practices, and variations among urban curanderos in Bogota, Colombia, and Turner's (1964) study of a Ndembu "doctor." Studies of the social control aspects of indigenous medical systems are now becoming available and these frequently relate the curer's role to the social structure, e.g., those in Kiev (1964) and Middleton (1967).

Scotch's (1963) review of "Medical Anthropology" contains a brief section on "ethnomedicine" citing twelve studies of which fewer than half are concerned with the role

To examine effects on the curer's role of the contest between indigenous and Western medical systems, the concept of role adaptation is proposed. Anthropological treatment of the curer's role and the role concept are described. Curing role adaptation in selected societies under acculturation is analyzed and a typology derived of the curer's role as adaptive, attenuated, or emergent. Alternative routes to role adaptation or extinction are explored. Role adaptation is considered as a conceptual tool and as it may relate to such associated notions as cultural broker, role analogue, and role ambiguity.

of the curer. Polgar's (1962) comprehensive review of studies in health and human behavior has a helpful section on social and cultural conditions under which people in preindustrial and industrial societies make a choice of medical personnel and is relevant to the subject of interest here. Caudill's (1953) earlier review also contains several relevant sections. Paul's (1955) well-known volume of "public reactions to health programs" contains only three cases that deal incidentally with the indigenous healer's role. Goodenough's (1963) book on applied anthropology and culture change contains but a handful of passing allusions to the healer's role, and it is scarcely mentioned in Foster's (1962, 1969) books in the same field.

Perhaps the closest approach to our concern with adaptation of the traditional healer's role in acculturation appears in the work of Alland (1970:155-178) on the medical system of the Abron of the Ivory Coast; reference to Alland's material appears later in the present study. Several studies in the compilations of Kiev (1964) and Middleton (1967) deal in part with the problem, though not within the context of the concept of role adaptation or role theory.

uses of the role concept in anthropology

Social science has been concerned with concepts of the self at least since the writings of James in 1890 and Cooley in 1902 and with the notion of role since Simmel in 1920 and Park and Burgess in 1921 (Biddle and Thomas 1966:4 passim). Moreover, social and legal philosophers have examined what are now termed role relationships and the nexuses of social relationships to social systems for well over two centuries, as Banton (1965:21-24) has shown. The major interest of anthropologists in the concept began with the still influential work of Linton (1936) and received further stimulus from the work of Parsons (1951) in sociology and Nadel (1957). However, original theoretical contributions by anthropologists, as contrasted with sociologists and psychologists, until recently have been sparse. For the most part anthropologists seemed content either to take the concept for granted, using it uncritically without attempting further refinement, or simply to ignore it. This becomes the more remarkable when one notes a rare statement of appreciation such as that by Southall (1959:17): "Role theory may be said to mark the highest level of generalization about social phenomena that has as yet become in any sense operational." Thus Manners and Kaplan's (1968) sourcebook in anthropological theory contains a single selection (Kaplan, "Personality and Social Structure") dealing in part with role as it relates to a Parsonian notion of personality, and Harris' (1968) monumental *The Rise of Anthropological Theory* scarcely mentions the concept in its 800 pages.

However, in the past decade some anthropologists have returned to the idea and have begun to rethink the concept of role as providing an important key to what Goodenough terms the "cultural organization of social relationships" (Barth 1963, 1966; Banton 1965; Benedict 1969; Coult 1964; Freilich 1964, 1968; Goodenough 1965; Keesing 1970; Southall 1959). Certain studies in political anthropology have focused on changing functions of chiefs and other political roles (e.g., Swartz, Turner, and Tuden 1966), and in economic anthropology on changing functions of entrepreneurs, traders, and other economic roles (e.g., Barth 1963, 1966; Belshaw 1955; Helm, Bohannan, and Sahlins 1965).

Among the more stimulating formulations, and most relevant to my notion of role adaptation, have been those explorations around the notion of the "cultural broker," beginning with the seminal paper by Wolf (1956) on the mediating functions of the

politician-broker role between local and national institutions in Mexico; Geertz's (1960) incisive analysis of the cultural broker role of the Javanese *kijaji* as Moslem religious teacher and nationalist politician; and the more recent work in Mesoamerica of Hunt (1968) and Press (1969) to which subsequent reference will be made. It will be seen that in some ways the more adaptive traditional curer roles incorporate important aspects of the cultural broker's role, though in some respects the curer's role departs from the broker model.

Press' (1971) very useful study of curers in an urban South American city calls attention not only to basic differences in the curing role in rural and peasant communities as contrasted with urban ones, but the fact that the culture and multiplex social organization of cities provide opportunities for a wide variety of curers to flourish. While in complete agreement with Press' major points, it must be asserted that many rural and peasant cultures contain a fair degree of variation in curing roles, though not nearly as broad as in urban cultures. Reference in this paper to *the* curing role refers only to specific instances in specific societies and makes no assumption about either stereotyped role models or lack of variation in role types.

I do not pretend that the works just cited fully represent the important recent work in anthropology on role, though they do provide, in my opinion, a sample of seriously critical and potentially fruitful writings. Many refinements of the concept in these papers are not utilized herein, in part because that task is beyond the scope of this essay, and in part because much of the data on the curing role with which I am familiar will not permit the kind of fine-grained analysis these conceptual refinements require (cf. especially Goodenough 1965 and Keesing 1970 for reasons).

conceptual and theoretical assumptions

The use of the role concept in social science has been primarily structural-functional (role performance, role-taking, role-modeling, role expectations, etc.), as recent comprehensive surveys clearly indicate (Biddle and Thomas 1966; Sarbin and Allen 1968). Processes of role change have been studied primarily as chronological modifications occurring, as in the socialization process, when the person assumes new roles as he reaches new age grades and therefore new social horizons. Research has also dealt with sex role changes due to status changes, as in the changing roles of women, or socialization into occupational roles in industrial organizations.

But in the case of role change in response to the stimulus of competing values and technology of another, economically more potent culture, this question has seldom been handled except in terms of conflict and strain, and these are seen as almost inevitably arising from culture contact. (Exceptions in economic and political anthropology were noted previously.) Indeed some writers seem to assume that a concomitant of acculturation will be personality disturbance, and by implication role conflict. It will be seen in the present essay that in the case of the curer the contact situation may be actually or potentially conflictual, but it may also possess possibilities for role adaptation insofar as elements of ideology and behavior patterns of the impinging culture are adopted to enhance therapeutic efficacy, and even to strengthen the curer's status in his own society. Some curers may resemble marginal men caught in an insoluble dilemma between the drag of the culture of orientation (what Belshaw [1955] calls the entrepreneur's "home group" culture) on the one hand, and the pull of the culture of reference—that of scientific Western medicine—on the other. But frequently the curer maintains his position strongly in his membership group while borrowing liberally from

Western medicine, without necessarily identifying with the reference group, in which realistically he accepts the fact that the doors to membership are closed, and without losing his psychological and social stability through fruitless floundering between the two cultures.

We define role adaptation as the process of attaining an operational sociopsychological steady-state by the occupant of a status or status set through sequences of "role bargains" or transactions among alternative role behaviors. In situations of rapid culture change, alternative behavior possibilities, expectations, rewards, and obligations will originate both within and without the indigenous social system. All individuals in any sociocultural system are confronted with "overdemanding" total role obligations (Goode 1960:485 passim) but must manage to equilibrate role relationships and role sets through continual bargaining and consensuses with other actors in the system, and consequently reduce role strain. Therefore, the instance of the traditional curer's role under potential stress from the demands and temptations of the competing medical system represents an extension of Goode's theory of role strain (cf. also Banton 1965: Chs. 2, 3).

I make the following assumptions: (1) The curer's place in his society originally was relatively secure until threatened by the pressures of culture change. His personality may or may not have been in phase with the behavioral norms of his own sociocultural system, but his status was traditional and prescribed, though not invariably ascribed.

(2) Prior to contact, in addition to ameliorating the effects of illness and disease, the curer's activities were oriented toward enhancing and/or reinforcing his social position. Although role prescriptions were traditional, he would still have to rationalize nonsuccess, and ordinarily he would have to compete with other curers in the number and profundity of his achievements. Admittedly the factor of competition among curers is not emphasized in most anthropological accounts, though many data suggest it. For example, Lévi-Strauss (1963:167-185) describes the acquisition of curing power by a Kwakiutl skeptic who then engages in competitive exhibitions with other shamans. Press (1971) emphasizes competition among curers in Bogota. I hypothesize that the curer's status was at least as competitive as any other highly valued position in a given society.

(3) Nevertheless, a measure of security was present in that role performance expectations were shared with other members of the society, and competition originated primarily from within the group and presented a relatively known range of possibilities. To some extent competing performances could be gauged, anticipated, and controlled. Sources of role strain probably were fewer than in the post-contact period, and possibilities for successful interpersonal transactions in the interest of reduction of role strain and achievement of role adaptation probably were greater (Goode 1960:491).

(4) The curing role could be a full- or part-time one, but prestige in one role tended to be linked to prestige in others, so that status in any tended to reinforce the power of all (Goode 1960:491-493). This follows from the notions of role sets, status sets, and status sequences (Merton 1957).

Analysis of role adaptation of curers in selected societies undergoing acculturation has suggested a model of adaptation possibilities in which the data may be grouped into three categories: adaptive, attenuated, and emergent curing roles. We now proceed to examine the data in these terms.

adaptive curing roles

Erasmus (1952) found in Quito, Ecuador, as has been discovered by many other investigators, that those illnesses thought to be supernaturally caused were referred to

indigenous practitioners, those that had a mundane origin and were thought to respond to common remedies were treated at home, and certain others of nonsupernatural origin such as tuberculosis and appendicitis were referred to the modern physician, "folk" practitioners agreeing that the latter referral was appropriate. Usually the victim of illness first tried home remedies, then a folk curer, and only when these two possibilities failed did he consult the physician. As Erasmus (1952:417) shows, a division of role responsibility has been arranged tacitly between the traditional curer and the physician:

It would appear that the folk look up to the doctor for his ability to cure serious illnessess for which their own remedies are less likely to be efficacious, independently of whether or not they understand or believe in his explanation of causes. Their acceptance of the doctor rests primarily upon empirical observation and experience.

In the village of Sherapur in North India, Gould (1957) differentiated between what he called "village medicine" and "doctor medicine." He conceptualized these as two systems of treatment in constant interaction. Village medicine was used primarily to treat "chronic nonincapacitating dysfunctions" ("conditions manifesting drawn-out periods of suffering, sometimes cyclical in character, usually not fatal ... and only partially debilitating, enabling the sufferer to maintain a semblance of his daily routine" [Gould 1957:508]). Doctor medicine was solicited mainly for "critical incapacitating dysfunctions" ("ailments ... involving sudden and often violent onset, and rather complete debilitation with reference to some aspects of the individual's routine" [1957:508]). The people tended to make choices on the basis of what Gould terms "folk pragmatism." Choice of scientific over folk medicine was related directly to "(a) economic well-being, (b) formal education, and (c) occupational and spatial mobility" (1957:515). Since there is a wide range of chronic nonincapacitating dysfunctions for which modern medicine can prescribe no specific, and since many critical incapacitating dysfunctions may respond to different remedies, including the therapy of time, it seemed probable that native medicine would continue to thrive in a structure complementary to scientific medicine.

Nurge's (1958) study of an agricultural fishing village in eastern Leyte, Philippine Islands, differs somewhat in its conclusions from Erasmus and Gould, since "the relationship between a treatment and its effect is usually far from obvious, is often obscure, and at best is amazingly complex" (Nurge 1958:1170). She felt that neither Erasmus nor Gould could be certain that disease entities that they defined in Western scientific terminology were clearly apprehended by their subjects. As she stated the case for this Filipino village, "the individual does not grapple with a disease, but with a discomfort or malaise which he may describe as being itchy, disturbing, or painful. It is not measles or bronchitis or tuberculosis but an unhappiness and a dis-ease which the patient brings to specialists and which the curer or physician defines for the patient" (Nurge 1958:1169-1170). She believes with Hsu (1952) that

Magic and "real knowledge" are often intertwined, may be indistinguishable, and ... the individual oscillates between the two and resorts to both quite indiscriminately .... Such practice is not confined to primitives or to peoples of underdeveloped areas, but is part of the way of life of societies everywhere, although the proportions of magic and science in a given society vary (Nurge 1958:1169).

Nurge describes the functions of five types of indigenous curers, and, like Gould and Erasmus, sees them functioning in a cultural system in effective interaction with modern medicine.

After additional fieldwork Gould (1965) elaborated on his earlier work by recasting his findings within the cognitive structure and world view of the indigenous culture. That

people in Sherapur made pragmatic choices did not mean that they had achieved an understanding, let alone acceptance, of scientific medicine, but simply that they had availed themselves selectively of its technology. He appears to approach the view of his critic, Nurge, when he says, "the acceptance of scientific medicines . . . resulted in no material changes in basic folk cognitive structure. These experiences were filtered through the screen of this cognitive system and converted into meanings which did no violence to it" (Gould 1965:204).

The implications of Gould's findings for the role of the traditional curer coping with the competition of Western medicine are that

> The more modern medicine becomes entrenched in, say, the domain of the critical incapacitating dysfunctions, the more indigenous practitioners stabilize their control over the treatment of chronic nonincapacitating dysfunctions. The latter even adopt the paraphernalia of modern medicine in order to intensify their psychological impact on their patients. . . . The routinized impersonality now so intrinsically a component of the modern professional role probably intensifies and helps promote the consolidation of this defensive reaction (1965:207-208).

Gould has made a significant contribution to the study of comparative medical systems by indicating the need to differentiate the technical from the scientific since they do not necessarily coexist.[2] Thus, also, the traditional healer is seen not merely as passive receptor of modern science and technology,[3] but as incorporating technocultural agent and as creator of new technocultural syntheses. The curing role is not only changed, but resynthesized.

Many detailed descriptions are available of the role of Navaho singers, diagnosticians, and herbalists, as well as of the reactions of the Navaho to modern medical practice (Leighton and Leighton 1945). More recently in the work of Adair (1963) and others we are beginning to learn of the adaptation of traditional Navaho curers to contemporary scientific medicine. Rosenthal and Siegel (1959:148) pointed out that they have "often tried, unsuccessfully, to make new magical songs for the white man's tuberculosis, measles, influenza, and syphilis." Adair and the Leightons indicate that most Navaho still trust traditional curers even while selectively utilizing "white medicine," and occasionally they were permitted to hold a sing in a hospital or clinic, usually after Western medical treatment had been given (see also Kluckhohn and Leighton 1962). Adair (1963) reports that in the Many Farms community there were fifty-five curers or singers "among our clinic population—one for every two and one-half camps, or one for every forty-one people." Adair points out that Navaho curers respect White doctors, acknowledge their superiority in some areas, and cannot understand why their respect is not reciprocated. Diagnosticians (hand tremblers) are still usually the first professionals to be consulted and they in turn advise "their patients to go to the clinic in certain circumstances, rather than to the medicine men" (1963:246). After extensive interviewing and psychological testing of thirty Navaho informants, Adair (1963:248) concludes:

> There was general agreement . . . that both types of medicine were essential for Navaho health needs, and that it was best to follow the advice of the hand trembler. There are 73 diagnosticians in the area, more than one to every two camps. . . . This large number of diagnosticians reflects the important role they play in the Navaho society, as decision-makers between alternate means of curing.

Adair points out that patients with injuries or suffering from acute, sudden disease attacks "are readily brought to the clinic," while those suffering from illnesses developing more slowly and less well-defined are assumed to have broken a taboo and usually are treated by the singer, a finding reminiscent of those of Erasmus and Gould.

The revitalization movement of Handsome Lake among the early nineteenth century Iroquois (Wallace 1956a, 1961a, 1961b, 1961c, 1966) seemed to be an effort to reinvigorate remnants of the indigenous culture by blending into it elements of the Quaker variant of Christian religion and by creating a new ideal personality type that would be rewarding through becoming the diametric opposite in most respects of the existing, somewhat anomic modal personality. This process required what Wallace (1956b) describes as "the association of rapid personality change with 'paranoid' cultural creativity" in the case of the leader-curer, and involved profound and dramatic behavioral transformations. Its effect on the Iroquois medical system, insofar as emotional disorder was concerned, transformed the aboriginal "cathartic" system of preventive and curative psychotherapy of the previous 200 or more years into a "control" system (Wallace 1958, 1959). The role of the religious leader-curer was that of a modified control agent, in which the major task was to repress traditional Dionysian-like, often violent types of activities and ceremonies which formerly had been expressed to appease dreams and "wishes of the soul" (Wallace 1958), and to create a type of modal personality and culture that would both preserve national cultural integrity and terminate internal and external conflict and frustration. The people did not wholly relinquish the old ethics and ceremonies but reworked them into a new synthesis in the Code of Handsome Lake. The role of curer was thus transformed and resynthesized.

Among the highly acculturated Cherokee Indians of the southeastern United States, Fogelson (1961) has found a strong persistence of traditional medical beliefs and practices compounded with many Christian elements, and the role of the conjurer-curer still surprisingly viable. The Cherokee syllabary, originally an instrument of progressive change in the early nineteenth century, has functioned as a conserving force, since it affords the conjurer a means of transcribing sacred formulas formerly transmitted orally through a priestly hierarchy. One result, strengthened by geographic isolation until comparatively recently, has been for an increase in secretiveness and interconjurer rivalry, and a rigidifying and freezing of practices and beliefs current in the early 1800s. As elsewhere, some functions and related artifacts have changed in modern times, with hunting, fishing, and agricultural magic fading out, but divination, sorcery, and curing by the conjurer persisting and being used simultaneously with scientific medicine by modern Cherokee. "The impact of Western medicine on Cherokee theory and practice can be seen to involve partial assimilation, the accentuation of differences where the two theories are irreconcilable, and an overall feeling that the two systems are complementary, rather than fundamentally contradictory" (Fogelson 1961:222).

A study of the medical system of a Philippine town (Lieban 1960, 1962) illustrates again the role of the curer as control agent and the process of cultural and role adaptation and resynthesis. Illnesses of supernatural origin remain in the province of the local curers, and while physicians may be consulted for illnesses of more earthly etiology, it is felt that treatment by them of supernaturally caused maladies actually may exacerbate them. What we may term the medical mythology is altered, so that the traditional chameleon-like, dangerous, illness-producing spirits called *ingkantos* that may be unpredictably invisible or exist in any organic or nonorganic form, including that of humans, have assumed new powers and functions.

To the people of the barrios, ingkantos appear to represent, *inter alia*, glittering and inaccessible wealth and power beyond the local community. The individual who sees and interacts with an ingkanto can, through fantasy, bring temptation within reach, or succumb to it. However, such experiences are considered hazardous and often are thought to lead to illness or death. This

pattern of thought and behavior associated with beliefs about ingkantos and their influences appears to support social equilibrium in the community by dramatizing and reinforcing the idea that it is dangerous to covet alluring, but basically unattainable, wealth and power outside the barrios. In this way, the value of accepting the limitations of barrio life and one's part in it is emphasized. Furthermore, if someone has a relationship with a dazzling ingkanto and becomes ill, it is the manambal [indigenous healer], a symbol of barrio service and self-sufficiency, who restores the victim to health and reality (Lieban 1962:309).

The local healer had always acted as an agent to control overly lusty appetites. To this traditional function is now added that of controlling the expression of newly acquired tastes as well. The healer represents the leveling pressures of the community so that "part of an individual's wealth is siphoned off to kinsmen and neighbors. ... In this perspective illness attributed to *ingkantos* can be seen as helping to reconcile the individual to social reality by demonstrating that it is a mistake to overindulge personal desires" (1962:311). The healer frequently functions in a dual role as sorcerer and must be capable of the kind of cognitive adjustment that will smoothly incorporate both roles.

> The contrastive roles of sorcerer and healer may be assimilated by scheduling each for the appropriate situation, whether that be service for health or service for "justice" [the rationalization underlying vengeance sorcery]. Even in situations where role contradictions are most sharply focused—when X, the healer, treats someone whose illness the same X, as sorcerer, was responsible for—the apparent discrepancy in behavior can be explained by resorting in turn to relevant values of the roles involved (Lieban 1960:132).

This presents an interesting example of role adaptation of the curer, since he must operate in at least two different roles and clusters of ideas and behaviors that are cognitively dissonant (Rosenthal and Siegel 1959; Banton 1965:Ch. 7). He must adapt the apparently contradictory indigenous roles of healer and sorcerer while preserving and extending his status as healer and control agent in his contest with modern medicine.

In the southern Caribbean islands of Trinidad and Grenada, Mischel (1959) found that healing functions of the Shango cult curer operated within the context of a tendency for people to "affiliate themselves with several different religious organizations [and] many of them visit both the bush healer and the legitimate [sic] doctor in times of illness" (Mischel 1959:407). The Shango cult is itself "an amalgam of old Yoruba beliefs and New World Roman Catholicism" (1959:408), and cult leader-healers derive their powers directly from the gods, but resort to medications and advice derived in part from older cult members and in part from such sources as Napoleon's *Book of Fate*, prayer books, the Bible, and the *Home Physician's Guide*. Scientifically trained physicians and clinics are over-burdened, refer patients in "severe mental stress" to mental hospitals, and tend to treat only physical complaints. By contrast, the cult healer will treat any type of ailment using differential diagnosis and therapy; where he fails after several attempts he will "often refer his patient to an older or generally more prestigeful leader" (1959:411), and where ills appear for which he recognizes that the cult treatment has no cure, fractured limbs for example, he will refer the patient to a physician.

In Trinidad the physician feels modern medical facilities are available, dismisses the Shango healer as pagan, and will not refer patients to him. But in Grenada, with inadequate medical facilities, the physician frequently refers psychic or psychosomatic disorders to a cult curer. From the viewpoint of the people, the modern physician is perceived as a person of a different social class and culture whose financial and social prestige and technical abilities are recognized, but not his scientific knowledge. The "bush" healer is seen as a trustworthy sharer of one's own culture, with a direct tie to the spirit world, and a broad range of curing powers. The patient may be a passive participant in the curing process, and does not have to try to recover as is required of the European

or American sick role (Parsons 1951; Parsons and Fox 1958). Especially in the case of lower-class Negroes whose channels of social advancement are blocked, the sick role becomes a source of social recognition, and "the longer the illness, the broader the symptoms, the more the patient may gain in the way of attention and unquestioning acceptance of his limitations with respect to work and other duties" (Mischel 1959:417). The indigenous curer thus serves, in contrast to the Philippine case, not so much to dampen newly acquired appetites as to assuage them in acceptable and unpunishing ways. And he assumes the major responsibility in the therapeutic relationship.

In Southern Ghana, despite some utilization of Western medicine and hospitals, indigenous healers are handling the bulk of ailments, physical and mental, in all social classes, and a differentiation cannot be made between literate and illiterate (presumably more and less acculturated) patients, either in kinds of medical problems or frequency of use of native curers. These inferences derive from a study by Jahoda (1961) and are strengthened because of the care with which he investigated sociocultural background factors of the clientele, as well as the nature of presenting symptoms and complaints. More men than women seem to consult and utilize services of indigenous healers, probably because the brunt of acculturative pressures is felt most poignantly in the demands placed on male role performance, and channels of social mobility and role enhancement are more open to men than to women. While complaints of a group of mental hospital patients contained a frequent overlay of "magical" problems such as "accidental contact with dangerous 'juju,' " most emotional problems centered around interpersonal conflicts at home and at work that seem directly related to the acculturative impact on role requirements.

Jahoda's study of 315 adult cases that were handled by his five healer informants reveals that 54 percent dealt with physical complaints of which more than half were concerned with venereal disease and gynecological problems, 12 percent were classified as "mental," 18 percent as "job, love, and marriage," and 16 percent as "protection and ritual."[4] It could be speculated that a large proportion of the latter two categories would be looked upon as emotional disturbance by Western-trained psychiatrists. The majority of cases under "job, love and marriage" concern problems connected with social and occupational mobility.[5]

In addition to traditional healers, a new type has emerged "involving the adoption of some of the external trappings of the Western medical man and pharmacist" (Jahoda 1961:254), who dispenses herbal remedies in an affectively neutral manner and tends not to become as closely involved with the patient as the traditional healer. Furthermore, a number of healing churches have sprung up that cater to, and recruit on the basis of, a broad range of illnesses summarized by Jahoda as "barrenness, sickness, difficulties in life, worry caused by witches" (Jahoda 1961:255), and which approach the role of the traditional healer in the intensity and closeness of the therapist-patient relationship.

It is not clear whether these healing churches are to be placed in the same category as the shrines studied by Field (1960), but if we can assume that they are, then these instrumentalities are handling most illnesses in rural Ghana. A total of twenty-nine shrines were included in Field's study in the Ashanti area of Ghana alone, and these did not represent the total. The shrine priests are licensed by the government as "private practitioners of native medicine." On the basis of government registration records, Field estimated "at least ten thousand native practitioners in Ghana, *excluding* the Northern Territories" (Field 1960:91n), and these healing agencies are "seething with vitality whereas all the ancient supernatural sanctions are moribund . . ." (1960:87).[6]

Among the Fanti of Southern Nigeria, Christensen (1959) found that healer-priests still played a crucial and viable role, though many role modifications were taking place under the impact of European religion, education, and economics, with consequent weakening of indigenous religion, kinship, and family structure. Christensen feels that acculturation has resulted in a steep increase in anxiety, though not necessarily mental illness, among the Fanti, the individual and group being torn between the new and the old.

> There has been an increasing emphasis on aids and nostrums to meet the needs of the modern world. Traditional charms to aid the traveler are now used by drivers and passengers on lorries; one priest claimed that he provided a charm to make people invisible to the police; a medicine formerly used to "tie the tongue" of an opponent in a dispute heard in the traditional manner before a chief is sometimes used by the plaintiff or defendant in adjudication before the government court; students request assistance to develop acumen or pass an examination; and one deity was reported to be particularly efficacious in causing the football teams from other towns to stumble when playing the home team (Christensen 1959:272).

Christensen also includes similar changes in the economic, political, and technological spheres with respect to priestly medical functions. And among the Fanti, as among the Ashanti, new shrine cults have arisen with healing as a major function.

Alland's (1970) investigation of the Abron medical system and its several curing roles compared their fate *vis-à-vis* Western medical practitioners. Major Abron curing roles are those of the nonprofessional curer, essentially a lay herbalist and user of charms; the *kparese*, a priest with powerful magico-religious curing functions, who operates both as diviner-diagnostician who may refer a diagnosed patient to a specialist, and as healer; the *sise*, a secular curer, employing magical and empirical techniques, standing "halfway between the nonprofessional curer and the kparese" (Alland 1970:167), working in symbiotic complementarity with the *kparese* since the *sise* is not trained in divining and depends upon the *kparese* for referrals; and the *sogo*, a Moslem sorcerer who is sometimes used and usually feared. Facing this indigenous array of healers stand the Western trained physician, few in number, not always accessible; the *médecin africain*, Africans with a two-year special course in medicine at the University of Dakar, more numerous and more accessible; the nurse, frequently accessible but with very limited training and competence; and the missionary doctor. To the Abron, the *médecin africain*, the physician, and the nurse are all classed as "doctor" which "further dilutes the doctor role in the eyes of his Abron patient" (1970:178). The more analogous and viable indigenous roles are those of the *sise* and *kparese*, the former because his approach to medicine is similar to the Western approach, the latter because he is, as the missionary doctor, priest, and curer rolled into one. Thus the *kparese* actually may use the *médecin africain* and Western physician for referrals, but he feels understandably threatened by the missionary, "a conflict," says Alland, "the missionary welcomes." The Abron will use Western practitioners if available, but do not hesitate to use their own practitioners, and, for magically-caused or prolonged illnesses, prefer them.

In the face of incessant pressures of immigration and social-cultural change, the healing role of the Yemenite Jewish *mori* persists, though in a somewhat narrowed orbit (Hes 1964). For centuries he functioned as "a teacher, a judge, a religious leader, a ritual slaughterer, and a healer" (1964:364) but as the Jews of Yemen slowly and resistantly adapted to life in Israel, with a curtailing of the traditionally authoritarian father's role (and expansion of the social importance of wives and children), as schools displaced his role as teacher, courts took over his function as judge, and physicians and clinics his role as healer, he adapted to these losses, while maintaining his traditional roles as healer of

supernaturally-caused disease, especially mental illness, and as counselor in times of emotional stress and social uncertainty. Indeed in these roles he has maintained his community status and not only older Yemenites but even acculturated, educated younger ones continue to use him to help cure emotional stress, or resort to him when the ministrations of medical psychiatry have failed. As Hes (1964:382) states it, "Although stripped of many of his traditional functions, the mori in Israel still provides an important source of psychotherapeutic help for persons suffering from emotional problems and troubles in living. This kind of help is adapted specifically to the needs of his fellow men and could not be easily supplied in more effective ways from any other source." Surrounded by ways of life they do not fully prefer and economic and social discrimination, the Yemenite Jews cling to their traditional beliefs, and only the *mori* understands them and knows how to negotiate the believer back to health within their terms.

attenuated curing roles

As the powerful scientific medical and economic system spreads its influence, the curer may choose to continue in his traditional role and ignore the attrition in clientele due to competitive services. This implies, in effect, his voluntary acceptance of diminished prestige because he now yields his influence to more powerful competitors that threaten to render his own role completely obsolete. The social position of a Tuscarora curer with whom I lived was in part anchored to the fact that he was a clan chief and member of the tribal council (Landy 1958) and in part to the fact that he still prepared his remedies and performed his treatments, not only for many Indians, but for middle- and lower-class Whites from Niagara Falls and Buffalo. He charged modest amounts for his potions and services and did not depend upon them for a living (his wife owned a small store on the reservation) but he had resigned himself to only a moderate amount of prestige, no special powers beyond those of diagnosis and prescription, and to the reality of the state health clinic on the reservation and the physicians and hospitals in the city. He expressed deep discouragement over his inability to interest a younger man to train as his successor and predicted that the traditional role of curer would terminate with his death.

Among the Anang, an Ibibio group of southeastern Nigeria (Messenger 1959), traffic is heavy among native healers in patent medicines and other forms of treatment, but an increasing number of persons are visiting physicians and hospitals where, paradoxically, treatment is less expensive than among indigenous curers. Anang women, attracted by efficient obstetrical services, preceded men in changing their medical allegiance. Here the traditional curer would seem not to have been able effectively to adapt his role, and perhaps the most prevalent form of therapy is the sale of commercial remedies.

Bantu curers in South Africa of a variety of types, all of whom are called *izinyanga*, were studied in Durban and Johannesburg by Bloom (1964) and compared with lay Africans of varying degrees of literacy and urbanization. As in the West Indies, they refer difficult cases to presumably more qualified Bantu specialists, and as in many places, they handle a broad range of diseases, with special competence in the treatment of emotional and hysterical states. They were found to rely more heavily than most laymen on "traditional, hereditarian, magical explanations," and to serve as "a conservative force in African society and therefore as repositories of traditional beliefs" (Bloom 1964:66, 94). Bloom goes on to say, "The *izinyanga* respond to the pressures of urbanization largely by

clinging to their traditional beliefs but also, paradoxically, by trying to incorporate into these certain elements derived from urban experience" (1964:69). Apartheid only seems to whet the appetites of the Bantu for Western ways and this author feels that as soon as racial restrictions are removed there will be "a complete assimilation of modern ideas and a withering away of traditional beliefs that are no longer functionally significant" (1964:94), and, one would conclude, consequent obsolescence of the traditional curer's role. Role adaptation here seems to have decreasing support because of rapidly changing beliefs among the laity and the curer's role is subject to much strain, uncertainty, and attenuation.

One type of parallel, but dependent, coexistence was the case of the Negro midwife in parts of the rural southern United States who took over many of the obstetrical accoutrements of the modern town physician, utilized his sponsorhip as protection against the threat of dislicensing by public health agents, and for a long time enhanced and preserved her place in the indigenous social system (Mongeau, Smith, and Maney 1961). Her role after several decades, however, became weakened and decayed as recruiting into the apprenticeship system failed because younger female relatives acquired formal education and entered other occupations, as the older White town physicians who functioned as protectors and sanctioning agents died out, as contemporary physicians sought not to change but outlaw midwifery, and as hospitals and clinics grew in influence.

Still another type of marginal coexistence is the kind of parallel but competitive role of the subprofessional nurse or *tsukisoi* in Japan, a combination domestic and mother-figure who ministers to, and sleeps in with, the mental patient (Caudill 1961). Caudill sees the *tsukisoi* role as directly reflective of the mother's function in the Japanese family and social structure, as in conflict with the nurse and psychiatrist, though her role is legitimated by both professionals, as therapeutic but also possibly maltherapeutic, and probably slated for drastic change.

emergent curing roles

While some curers have adapted their roles successfully to the demands of acculturation and others have become so battered as to be attenuated and in danger of extinction, the contact situation may stimulate new, emergent roles. This happened among the Manus, a technologically primitive people of New Guinea when first observed by Mead (1930), with no special curing roles who treated most injuries and illnesses by family members within the household but referred some to the "doctor boys" appointed by the administration of the Australian Trust Territory. By the time of Mead's (1961) restudy doctor boys were being used as agents of control by the central government, and the efforts of the charismatic, Western-oriented leader, Paliau, to encourage the use of modern medicine by setting up his own hospitals and "screening" presenting symptoms were interpreted by physicians and government officials as hiding patients and therefore "subversive" (Mead (1961:264-265). Nevertheless, some individuals had apparently become part-time local practitioners

who collect huge fees for using counter-magic. . . . The tendency to blame disease, whenever it is intractable, on a source wholly external to the society, and to reserve tractable and curable diseases for confession, reform, and medicine, may well grow. These attributions of sorcery to work boys from other areas are justified on the grounds that other peoples may not have "thrown everything away yet," and by the statements of the inability to help made by European physicians and employers who send hopeless cases home to their villages to die (1961:286).

Thus, in a sociocultural system in which apparently there had been no traditional curing specialists, the impact of Western medicine in fact seemed to give rise to them. In this formerly preindustrial but rapidly acculturating society, medical system and curing role thus resemble only in part solutions reached in other spheres of culture. A new synthesis both of sociocultural system and of curing role begins to appear, with Western medicine fertilizing, rather than starving, the emerging practitioner's role.

Another new medical role, emerging side-by-side with both the still strong traditional curing roles on the one hand, and those of the scientific medical system on the other, is that the Navaho health worker or health visitor (Adair 1960; Adair and Deuschle 1957; Deuschle and Adair 1960; McDermott et al. 1960). This role was created by the Cornell University health project as a way of contacting isolated Navaho and mediating, linguistically and medically, between them and the clinic. The role seems to have fallen mainly to Navaho who were more or less marginal to local groups, either because of formal education and high aspiration levels, or because they had been away in White society and were out of touch with the native culture. Unfortunately we are not told whether the role was ever filled by indigenous curers, but it proved strategic in securing increased acceptance of modern medicine by the people.

A healer may invent or discover a revolutionary new medical method that places him in a potently competitive position *vis-à-vis* modern medicine. In McCorkle's (1961) brief study of chiropractic we learn that the method was discovered by one D. D. Palmer in rural Iowa in 1895. Palmer, "a sometime general storekeeper and magnetic healer," cured the hearing impairment of a man by snapping a displaced vertebra back into place. He extended this curing technique to others with great success, and thereby evolved a single-cause disease theory that all ailments are due to obstructions between the brain and body organs, the spine being the principal transmission tract. As McCorkle (1961:22) describes it,

> Healing is by manual "adjustment" of the spine, supplemented by massage, and by advice as to diet and rest, the latter defined as proper amounts of sleep, not as taking to one's bed. *All* medicines are denounced as "drugs" and therapy may involve "withdrawal" from "drugs" formerly used by the patient. Surgery and preventive medicine are rejected as violations of the sanctity of the human body. Appeals, delivered verbally and through pamphlets written to relate chiropractic theory to specific diseases and ailments, are to the "common sense" of the mechanically minded Midwestern patient.

The widespread and continued success of this emergent indigenous healer appears to be due to the precision with which he fitted his theory and practice into the existing social structure and value system. Especially in the Midwestern family-type farm, the major relevant characteristics are: extensive mechanization, frequent injuries, and "aches and pains" (perhaps related to working in all kinds of weather), work as a primary value, pragmatic world view (a thing is good if it works), deep belief in "the good work of God and in the sanctity of the human body," the healing power of the laying on of hands, and belief in natural remedies. The role of the chiropractor, therefore, has been not simply competitive, but parallel in its development and spread to modern medicine. McCorkle does not describe the prestige and power of these healers in their communities but it is likely they are rewarded with both trust and wealth.

Finally, we may see an instance of an emergent curing role that involves aspects and functions of several preceding roles, that of the Puerto Rican spiritist medium. Rogler and Hollingshead (1963) found widespread belief in spiritism and utilization of mediums in all urban social strata, being most pervasive in the lower class, and rationalized in scientific terms in the upper class. For the former, especially, beset by "the intimate trials, strife,

and personal turmoil that enmesh the members of a socially and economically deprived stratum . . . its function is to discharge the tensions and anxieties generated in other areas of social life" (Rogler and Hollingshead 1961:654). These investigators believe that most lower-class schizophrenics will receive group therapy from a spiritist medium before, during, after, or instead of seeing a psychiatrist, and they see this emergent curing role in competition with modern medicine as having many assets.

> In addition to the presumed advantages of group psychotherapy as practiced in clinical settings, spiritualist sessions are coterminous with the values, beliefs, aspirations, and problems of the participants. No discontinuity in social contacts is required for participation. Little social distance separates the afflicted person from the medium, but, in contrast, visiting a psychiatrist involves bringing persons together who are separated by a vast social gulf. The others in the session are often neighbors, and so the spiritualist and her followers form a primary group where problems are discussed in a convivial setting, classified, interpreted, and rendered understandable within a belief system that is accepted even by those who profess not to believe in it. . . . Participation in a spiritualist group serves to structure, define, and render behavior institutionally meaningful that is otherwise perceived as aberrant (1963:657-658).

These authors claim that the spiritist also serves a protective function since going to a clinic or psychiatrist places the person in the category of *loco*, which is stigmatized and highly feared, while anyone may visit the medium regardless of the severity of his affliction (see also Landy 1965:42-44 passim; Seda Bonilla 1969).

interpretation and discussion

We have considered the role of the indigenous curer confronting the demands and possibilities of his own often rapidly changing society on the one hand, and those of the intrusive Western medical system on the other. Studies have been examined in many parts of the world in which Western beliefs, practices, and technology in medicine, as in most life-spheres, are impinging with ever-increasing velocity upon preindustrial societies. Used as a conceptual framework was Goode's theory of role strain from which I have derived the concept of role adaptation in order to consider the special instance of the curing role under acculturation and change. If the studies selected for analysis are partially representative of the world range of acculturation situations in which the traditional curing role is being critically confronted in some fashion, and I believe they may be, then we have presented a crude nonrandom sample of acculturative contexts and types of curing role adaptations.

In any society the process of healing involves to some degree what Freidson (1959, 1960, 1961, 1970) has conceptualized as the interaction of the lay referral system with the professional medical system. Freidson postulates that the process by which a case for curing reaches beyond the stage of home treatment involves a concentric series of decision-making diagnoses by the patient himself, by family members, friends, and then, in ever-widening circles of referral, various types of lay, religious, and medical agents. Even in New York City where Freidson's studies took place, the process could be short-circuited at the door of an indigenous ethnic curer before reaching a physician or clinic. Only at that point did the lay system come into contact with the professional medical system. The indigenous medical role may carry as much and at times more, power, prestige, and responsibility as the medical role in Western society (Sigerist 1951:161-180). Therefore the label of "professional" should not be confined to scientifically-trained personnel, though obviously the ideology, technology, and recruitment of personnel of scientific medicine are different in many respects from that of nonscientific medicine. In culture contact and change, then, the formulations of

Freidson can be extended to include two potentially contesting medical systems in contact with each other and with the indigenous lay referral system.

We have seen that the indigenous medical system frequently contains its own professional referral system, as in the instance of the Ecuadorian urban folk curer, the Bantu *izinyanga*, the Abron *kparese*, the Navaho hand trembler, or the West Indian Shango religious curers, and that sometimes the indigenous professional referral system maintains a degree of cooperative interaction with the scientific professional referral system, and sometimes it does not, as in the relatively independent activities of the Yemenite *mori*, the Japanese *tsukisoi*, and the curers in the Leyte fishing village. Such factors as numbers, cost, and location of Western medical services, as well as ability to recognize and tolerate the indigenous medical system, undoubtedly set the limits and conditions permitting such cooperative interaction. Primarily it is the local curer who borrows elements from Western medicine rather than vice versa, although many "primitive" botanicals have been incorporated or synthesized.

In his role adaptations to culture change, the traditional healer not only incorporates, but elaborates, Western elements. Furthermore, resynthesis flows in the other direction when customary ceremonies and fetishes become used for new functions, especially to relieve some of the tensions and anxieties of acculturative pressures, as in West Africa, for example, the Fanti, Anang Ibibio, and Ashanti.

The indigenous curing role may exist in complementarity to the scientific medical system in a variety of ways, from almost complete isolation to almost total interaction. In endeavoring to strengthen his role relationships, the traditional curer may make grudging or happy accommodations to as many Western medical elements as he feels he must. Generally this means, as in most instances cited herein, that he becomes, or remains, an advocate of conservative beliefs, and if change is sharply accelerated, may find himself perhaps fatally lagging his lay fellows. When this occurs, his role adaptations have become ineffective since the basis for his prescribed role relationships is broken, and it is likely that his role is slated for oblivion, as in the instance of the Tuscarora curer. Furthermore, even if a dependent relationship is worked out under the protection of the scientific medical system, as the Southern rural Negro midwife had evolved under the town physician, when the external supports are removed (the dying out of the older physicians as patrons, the attack of public health and medical authorities) and the internal means of recruitment to the role dry up (young women preferring other careers), the role soon crumbles away.

Another possibility is that at the bidding of the donor culture (Manus doctor boys, Navaho health workers) a new medical or quasi-medical role is created, usually in order to bring about change and acceptance more quickly and efficiently, though, as among the Manus, new indigenous healers also may arise. Still another possibility is that a new role is created, due to the ingenuity of native practitioners or laymen (Midwest U.S. chiropractor, Puerto Rican spiritist, many varieties in urban Bogota), which operates completely independently of, and offers vigorous competition to, the scientific medical system. I do not know whether the point has been investigated, except by Adair (1960), but it is likely that such powerful, emergent curing professions contain many practitioners who utilize this occupational channel to circumvent blocked mobility, and that some of these individuals possess capabilities that, given education and training, might equip them for entering the scientific medical system.

Although he may be a change agent and innovator, the effect of any of the role adaptations we have cited nevertheless places the traditional curer in the position of a

cultural conservative. Not only is he a conserver of old ways, but his social control functions in a situation of culture change seem largely to be those of assuaging or holding the lid on rising aspirations and containing the discontent of his people, as the Filipino *barrio* and Shango curers. This may not be his intent, but it appears to be a consequent of his role imperatives. Hunt (1968) has made a strong case for the basically conservative role functions of the cultural broker in Mexico.

> We attempt to document the following propositions: (a) the mestizos in the rural areas of Oaxaca form an important group of cultural brokers [Hunt uses the Spanish term *agentes* as a preferred equivalent] ; (b) these brokers act mainly as promoters of the status quo, that is, they are conservatives and do not induce change in the indigenous segment [the Indian culture] ; and (c) the functions of these mestizo brokers are not so much to maintain open interaction among the [cultural] segments as to preserve cultural distance (Hunt 1968:600; translation mine).

In a sense, the curer, even more than such cultural brokers as teachers, entrepeneurs, and politicians, has a crucial stake in the maintenance of the indigenous culture, for the more closely it begins to approximate the donor culture, the more vulnerable his role becomes. Adaptation for role preservation consists in selecting only those changes that will preserve his role while at the same time minimally disturbing his already intruded culture. A possible exception might be the case of the leader-curer Handsome Lake in the revitalization of nineteenth century Iroquois culture. Even here, however, he was interested not so much in changing his culture to approximate White, Christian, capitalist culture as in remaking it in an image that would allow a greater probability of survival against the thrusts of White society while at the same time strengthening those components which had become frayed under acculturative pressures, and returning to his people a sense of pride and ethnic identity (Wallace 1966:31-33, 211-213 passim, 1961b).

On the psychological level it may be assumed that if role adaptation to cultural stress is to be achieved, it must be accompanied by cognitive change or by what Wallace (1956a, 1956b, 1956c, 1957, 1961a, 1961b, 1961c, 1966) terms "mazeway resynthesis." Depending upon the pace of culture change, the curer may have to undergo continual adaptation, not only socially in seeking constant realignment of interpersonal relationships, but psychologically in assimilating or redirecting the ever-increasing flow of new ideas, values, and technology, in learning rewarding paths in the changing external maze, and in repressing some paths in his internal mazeway while adding on others. His personality inventory would include a tolerance of cognitive dissonance, a capacity to "compartmentalize" (Goode 1960) dissonant values and role requirements. In applying his theory to the case of the individual facing a suddenly catastrophic change in his environment following such disasters as tornadoes, floods, fire, or bombardment, Wallace (1957:26) says

> There is first of all a considerable reluctance ("drag") to changing the old way, because of its symbolic satisfying value. As the old way, however, leads to less and less reward, and as frustrations and disappointments accumulate, there are set in motion various regressive tendencies, which conflict with the established way and are inappropriate to the existing maze. The individual can act to reduce his discomfort by several means: by learning a new way to derive satisfaction from the maze; by encapsulating the regressive strivings in a fantasy system; and by reifying to himself his current way and maze, regarding a major portion of it as dead, and selecting (from either traditional or foreign regions, or both) part of the existing mazeway as vital, meanwhile mourning the abandoned (or abandoning) portion.

The traditional curer who achieves a viable role adaptation not only retains the indigenous community as his major membership group but also retains it as his basic reference group, as in the examples of the curers of Sherapur and the Cherokee conjurer-curer. It is from the culture of his membership group that he draws his sanction as healer, and from the maintenance of its values and practices that he retains the

legitimation of his role. We may speak of the scientific medical system as representing only his secondary reference culture, since his identification with its values is partial and he draws upon its practices only insofar as his clientele may demand them or he may safely select those that augment his therapeutic repertory without diminishing his charisma. He may even enhance his diagnostic capabilities by utilizing the scientific system for referral of those cases he clearly recognizes to be beyond his capabilities. Insofar as such cases may be identifiably terminal, the apparent failure of the modern medical system to alter the course of death actually may enhance his position in the local community while discrediting his competitor.

The curer's status does become attenuated, however, when the expectations of his community are such that the technology, if not the values, of scientific medicine is perceived by them as so clearly superior that they distinctly prefer it to their own, as the Anang women who prefer scientific obstetrics, or the Tuscarora who increasingly use the state clinic. Role strain and role conflict follow, and the curer's status may become so hopelessly compromised that role adaptation is impossible of fulfillment and the status of curer becomes marginal and headed for extinction. Since only viable or partly viable curing roles are most readily perceived by the anthropologist, we do not, unfortunately, have very much or very useful data on circumstances under which the role becomes marginal or obsolete, and this process is little understood. I suggest the following alternatives (and others could be hypothesized as well):

(1) The curer accepts a marginal status, though perhaps maintaining some recognition and gratification through hostile means, such as sorcery.

(2) The curer attempts to denigrate scientific medicine by associating it with an oppressor group. If this occurs in a period of rising nationalism, his efforts may succeed since his medicine may not seem as potent as scientific medicine, but it will be associated with "good" values and the other with "bad" ones.

(3) The curer surrenders or radically modifies his status and attempts to capture a substitute status, perhaps even as an adjunct to the Western physician or clinic. This has occurred with mutual benefit in Western Nigeria where native healers may be called in as adjunctive therapists in difficult cases of psychoneuroses (Lambo 1956; Leighton, Lambo, et al. 1963).

(4) The curer becomes unable, or unwilling, to adapt to a marginal role and his sufferings from status deprivation may drive him not only to alienation from his traditional role but from the society which has rejected that role. The result may be behavioral deviance, including the possibility of neurosis or psychosis, or even self-exile as he in turn rejects the society. At least in part these alternatives, and others as well, could be cast into the framework of alternative modes of deviance suggested by Merton (1957) in his essay on "Social Structure and Anomie," though I suspect the model would have to be modified.

As for the new emergent curing or quasi-medical roles, it may be predicted that they also are likely to be thrust into competitive stress and strain with their analogues within the Western medical system, especially such paramedical roles as those of nurse, attendant, medical technician, etc. Structural strains certainly seem characteristic of all paramedical roles in Western medical systems. In urban settings where population size and heterogeneity encourage many variations in role performance and technique, curers may compete with each other (Press 1971).

A well-established general principle of sociocultural change is that those values and practices will be most easily transferred which are most consonant with the ideology and

behavioral standards of the host culture. Proceeding from this premise, Alland (1970:157 passim) hypothesizes that those impinging new roles for which "analogue roles" exist in the host culture will be most easily accepted. His example, to which we earlier alluded, was that of the missionary doctor and his analogue, the Abron *kparese*.

> The process of change is influenced not only by the relationship between new elements and existing theories and the reward value of certain behavior, but also by similarities and differences between role systems in donor and receptor populations. When analogous roles exist in two different behavioral systems, change need only involve a shift in the content of existing roles. When no such analogues exist, change may require the adoption of an entirely new role or set of roles. What I am suggesting is that anlogue roles act as templets for behavior and have the effect of facilitating and directing change (Alland 1970:157-158).

The *kparese* was most threatened by the missionary doctor's role and seemed most vulnerable to displacement precisely because his role was pervasive, encompassing "the entire religious life of the Abron" and not only the medical system, so that the missionary is predicted by Alland to "have much greater success [than the secular physician] in the long run in the introduction of Western medical practice in Abron culture" (1970:178). Although the *sise* (secular curer) provides an analogue to the secular physician's role, his role is likely to be retained since it is semantically classed with that of the doctor, *médicin africain,* and nurse as "doctor" (see earlier discussion), and many critical substances considered essential in curing are not obtainable in the Western medical system. However, Alland does not suggest that the *kparese*'s role is slated for complete obsolescence and one could wonder what might happen to a *kparese* who adopted Christianity and parts of the Western physician's technical and pharmacological repertory. Perhaps it should also be assumed that those roles that provide no, or a negative, analogue to the Western medical roles stand the greatest chance of survival and are least in need of change in the interest of adaptation, for example, that of the Moslem sorcerer.

Press (1969) suggests in the instance of the cultural broker role of a teacher in Yucatan that his role-set is strengthened as it embodies larger numbers of mutually dependent roles from both cultures, thus rendering his "total configuration" "the more ambiguous" (1964:214). Press seems to be saying that in such a case role viability, and by implication role adaptability, are strengthened by the incumbent taking on visible, essential, and needed roles or role characteristics, of both the host and the contacted culture. He suggests that "As the bicultural passes from one behavioral complex or role-set to another ... it is possible that he is clearly identified at one time or place, and viewed ambiguously at another" (1969:216) and that this very ambiguity increases role adaptability. This, insofar as the indigenous curer attempts to innovate, adopting elements of Western medicine, he increases the ambiguity of his role but also the possibility of its adaptation to the acculturation situation. Indeed he could increase what is already fundamentally ambiguous in his traditional role, since it has been recognized that the medical role in Western medicine (Davis 1960; Parsons 1951), and, I assume, in non-Western medicine, is fraught with ambiguity precisely because the healer in any society deals with "real" uncertainty in scientific and clinical knowledge, with the uses to which uncertainty is put by the healer and his patient, and by the fact that such uncertainty derives from the basic ambiguities inherent in all serious phenomena that threaten life, such as disease and illness.

Associated with the uncertainty and ambiguity of the phenomena with which the curer deals are the factors of unpredictability and uncontrollability. As Aberle (1966:221 passim) has shown

it is through the unpredictable and uncontrollable that man most experiences power, whether in the world of nature or of man, that he endows with power that which or those who help him cope with the helplessness that results from these experiences, and . . . due consideration of amounts and kinds of unpredictability and uncontrollability may help to order a variety of beliefs and acts relating to supernatural power.

The curer's role is endowed with power precisely because it stands at the interstices of religion, magic, and the social system. As Aberle (1966:228-229) further states:

Magic is a technique used to try to achieve empirical ends when empirical techniques provide inadequate prediction and control; religion is action that deals with the inevitable, unpredictable, and uncontrollable gap between the normative and the existential order; charismatic figures are unpredictable, do things other people cannot do, and force decisions in spite of lack of information; divinatory techniques use the unpredictable to predict the unpredictable.

As the course of disease becomes more controllable (prevention, public health measures), more predictable (medical intervention with miracle drugs, scientific surgery) and less uncertain, the curer's role faces its greatest challenge. Its survival, of course, is heavily dependent in the acculturation situation on the ability of its incumbents to increment their power through adoption of what might, in indigenous terms, seem to be Western "magic." But he soon learns that most serious diseases may still be essentially unpredictable and uncontrollable, and in this basic uncertainty lies the probability of successful role adaptation. For he should come to know that uncertainty is often no less for his scientific competitors than for himself.

There are many relevant questions that could not be handled in this paper. Thus, it is apparent that the ultimate usefulness of the notion of role adaptation will depend upon the clarity with which future investigators may be able to define the social and cultural conditions under which role adaptation will succeed or fail. The relationship of this concept to new ways of conceptualizing the notion of role, for example in the work of Goodenough (1965) and Keesing (1970) should be examined. I am aware, for example, of the point that both of these scholars make regarding the social identity component of role, and the fact that, because a role is operative mainly in terms of the various alters with which a particular ego interacts, it is misleading to speak of *the* curing role, or even *a* curing role. A curer necessarily enacts his role differently with each class of alters (men, women, children, nurses, other curers, chiefs, etc.). Another important factor completely ignored here is that of the "impression management" aspects of role, since, as Goffman (1959) has shown, this is basic to defining and understanding the way in which roles are in fact effectively negotiated.

The relationship of role adaptation to the notion of cultural broker also needs further exploration. Most, though not all, instances of cultural brokers, especially in Mexico (Wolf 1956; Hunt 1968; Press 1969), are those of bicultural Mestizos, who in a basic sense stand outside the indigenous (in this case, Indian) culture, while the curer is indigenous to his cultural system. Furthermore, especially for shamans and other religious curers (some are mainly empirical lay practitioners), there is a strong element of a calling and of religiosity in the curing role which is of course completely absent from those teachers, entrepreneurs, and politicians who frequently are the focus of analyses in terms of the cultural broker concept. It is also clear that field studies in depth of role adaptation of the curer confronting the Western medical system need to be undertaken to a much greater extent than they have been heretofore.

In his essay on role Southall (1959:17) has said: "What is required is a type of theoretical formulation applicable to the analysis of highly heterogenous situations, influenced alike by the ubiquitous international exchange economy and by the presence

of persons from markedly contrasting social matrices, Western and industrial on the one hand, nonliterate, peasant and 'folk' on the other." I propose role adaptation as one such formulation. As I have attempted to use it here, I believe it permits the possibility of more fully understanding the changing role of the traditional curer in the confrontation between the "markedly contrasting social matrices" mentioned by Southall. I suggest also it may be applied usefully as well to other changing roles in traditional societies moving toward industrialization and what many, perhaps ethnocentrically, have called "modernization."

notes

[1] A quite different version of this paper was presented to the Society for Applied Anthropology, San Juan, Puerto Rico in 1964. The present one is the last of many redrafts since that time. Oral presentation of an early draft benefited greatly from comments of my former colleagues at the University of Pittsburgh, especially Leonard Kasdan (now Michigan State University), Edward A. Kennard, George Peter Murdock, Arthur Tuden, Alexander Spoehr, and Otto von Mering (now University of Florida), and a sociological colleague, Paul N. Geisel (now University of Texas, Dallas). I am also grateful to Golamreza Fazel (University of Massachusetts, Boston) and to Robert Hunt (Brandeis University) for calling my attention to the citations by Barth and Belshaw (Fazel) and by Banton and Keesing (Hunt). Responsibility herein is entirely mine.

[2] For example, in such complex preindustrial societies as those of ancient India and China, huge areas of culture were highly technological, as the superbly developed Indian surgery and the Chinese irrigation systems, but they rested upon a substructure of essentially empiricist and spiritual beliefs regarding the nature of man and the universe.

[3] Polgar (1963:411-412) has suggested this crucial fact from another point of view when he defines four fallacies of Western health personnel in contacts with non-Western societies. One is "the fallacy of the empty vessels," that is, the assumption that new values and technology are to be poured into the "empty" receptacles of the cultural receivers, oblivious to "the fact that clients already have established health customs."

[4] I made these extrapolations by converting percentages in Table 1 of Jahoda (1961:248) back into whole numbers and taking means of the rows.

[5] Scotch's (1963:49) review of this study includes a misinterpretation of Jahoda's conclusions when he says, "These findings contrast strongly with the expectations of experts in the area of mental health who maintain that rapid culture change is a fertile area in the pathogenesis of psychopathology (e.g., Leighton)." Jahoda does not question this assumption and indeed his data would lead to the conclusion that Ghanaians under acculturative stress experience psychic disturbances severe enough to be diagnosed as mental illness in Western terms, though we have no evidence from any study that these are more, less, or the same in quantity and distribution as before the contact situation. Scotch's (1963:49) point that "The traditional healers, as well as the healing churches, function to prevent occurrence of serious breakdowns, and thus keep the mental hospitals, which Jahoda also studied, from being overwhelmed by a flood of cases," indicates that Field's (1960) inference of a heavy rate of mental illness in Ghana *may* be correct, but see note 6.

[6] Bohannan (1961) has praised Field's study as "far and away the best book on mental illness among Africans." While in many respects this may be true by comparison with previous studies, I find myself, with a few exceptions, in agreement with most of the criticisms of Field's work voiced by Opler (1963), and I hope that the book will not be accepted uncritically by anthropologists. The case histories and description of healing shrines on the whole are excellent, but the book suffers from the absence of a summary chapter so that the findings are not brought together, and from a vagueness on Field's part in identifying the sources of many of her findings and assertions, and from the frequent admixture of unsubstantiated generalizations and evaluative statements regarding Africans and Europeans. The following is not untypical:

> In our own society there has always been a proportion of good-for-nothings—tramps, work-shy, slum-makers, poachers and (abroad) beachcombers and "poor whites," unemotionally resisting all redemptive efforts or, if they accept it, always shambling back to their old ways. It is now recognized that most of them are either mentally defective or schizophrenic. In the East (I do not know the East) I suppose their counterparts become beggars. In West Africa they stay with their kinsmen, drink palm-wine and trap "bush-meat" (Field 1960:447).

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