PSYCHOLOGICAL METHOD AND SPIRITUAL POWER IN CROSS-CULTURAL PSYCHOTHERAPY

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Can a non-native psychotherapist conduct effective psychotherapy with a native client? This question has been asked by psychotherapists and native healers alike. It raises fundamental issues about both the conduct of therapy and the nature of healing. In terms of the former, issues of concern have included value differences between client and therapist, sociolinguistic differences in interactional styles and rules (interpretations of and inferences about nonverbal cues, speed and cadence of speech, gesture or lack of, backchanneling, response to physical distance, etc.), and the group and family orientation of non-Western populations and therapies versus the individualistic context of psychotherapy.

Researchers focusing on questions about the nature of healing (Torrey, 1970a, 1970b, 1972; Sue, 1977, 1981; Trimble, 1981a, 1981b, 1982) have challenged the use of individual therapy with Native Americans or other non-Western groups as being (1) disrespectful of a taboo against speaking about and concentrating on oneself, i.e., being in the spotlight, (2) solitary rather than organized within a group, (3) insight-oriented rather than action-oriented, (4) committed to using a culturally meaningless interpretive structure, e.g., individual trauma versus spirit phenomena. Therapists have offered some alternative models.

Attnaeve (1969a, 1969b, 1972, 1974; Belser & Attnaeve, 1978) proposed a therapy model for American Indians that draws upon the support of family networks. This model, she indicated, mirrors both the natural extended family network of Indian people and the indigenous healing methods which

typically involve family or group situations. Sue (1977, 1981) outlined a family intervention in which relatives were used to relieve acute marital crises for the couple. He shows how direct interventions through therapeutic insight or "assertiveness training" would have failed because of subtle cultural rules for who can speak to whom about what. A conflict in an Asian family between a daughter-in-law and her husband's parents could not be resolved in family therapy or by directing the daughter-in-law to confront her mother-in-law. The therapist had to involve the appropriate relative who could speak to such issues with the husband's parents.

Although these models may address some of the concerns described above, they do not answer all the questions. For example, beyond technique, what must a therapist and patient face for a "cure" to take place? Technique is only method, but it reveals the therapist's underlying assumptions about etiology and cure. This paper examines the issues that I, as a therapist working with Native Americans, learned to confront in both myself and my patients, and what I learned about the type of interaction in which my patients wished to engage with me. The paper also discusses how, when immersed in a Native American context, I learned from the indigenous healers, and how this changed my approach to therapy. What is proposed is that the failure or success of therapy — though affected by community context, interactional style, and cultural aspects of values — depends largely on the therapist's ability to reach the deepest levels of the native client's experience, including spirit phenomena.

Much of the recent literature has focused on alternatives to the therapeutic endeavor. As an alternative to individual therapy by Western or Indian therapists, many authors (Bergman, 1971, 1973a, 1973b, 1974; Torrey, 1970a, 1970b, 1972; Jilek & Jilek-Aail, 1971; Jilek-Aail & Jilek, 1978; Jilek, Jilek-Aail, Norman, & Galloway, 1978; Kiev, 1973, 1974, 1976; Trimble, 1982) have suggested that sophisticated indigenous methods for

treatment exist within the native community. These methods center on rituals performed by those popularly termed "medicine men." The implication of this literature is that Western therapy becomes unnecessary. The therapist should refer native clients to indigenous healers, develop with these healers the necessary relationships of mutual trust to be able to make such referrals, and feel comfortable that this provides very professional treatment.

Opposing this viewpoint is the literature of Devereux (1939, 1950, 1951, 1956a, 1956b, 1970, 1978, 1980) and Boyer (1962, 1964; Boyer, Klopfer, Brower, & Kawal, 1964) that conceives of the native healer as a psychotic or neurotic whose role has provided a social context to frame his illness. Boyer indicates that much of the medicine ceremonies he studied are performed by superb magicians who fool patients by basing their rituals on tricks of suggestion and persuasion. The implication of much of this research is that rituals must be considered as superstition to be supplanted by Western methods. Rather than referring clients to a charlatan, the therapist should perform the therapy or analysis and ignore healers, viewing them only as potential sources of resistance who offer the patient an escape into superstition.

The following case discussions illustrate issues of psychotherapy in a cross-cultural setting that offers the therapist the opportunity to collaborate with indigenous healers. In this collaboration, the psychotherapist neither becomes superstitious nor attempts to supplant the indigenous healer. Instead, parallel and open sessions provide opportunities for legitimate professional collaboration between psychotherapists and medicine men. The therapist must receive, understand, and speak to the material presented by the patient without resorting to reductionism, premature referral, resistance, or rationalization. Three case vignettes from my own psychoanalytically oriented practice with native people illustrate stages in the development of my concept about such a collaboration.[1]

The reservation I will discuss is that of a Northern Plains tribe that has lived in the area for generations. Eight to ten thousand Indian people live there. The tribal group were mystics and warriors of the plains who valued bravery and courage in war and sought visions through fasting and self-sacrifice. Although the tribe's placement on reservations led to laws prohibiting practice of their religious, and even their social, rituals, the tribe ensured the survival of these practices by taking them underground. The tribal people held healing rituals at night in the dark. They braved excommunication from the church. Men continued to spend four days and nights fasting in remote areas designated as power places. At these spots, power had been transmitted through visions. Today, these rituals are practiced openly, even with Christian priests attending and participating. Physicians, nurses, and mental health personnel attend healing rituals. Medicine men pray for patients in hospitals. University hospitals invite medicine men to perform their ceremonies.

The medicine man is not trained formally in a school or by another medicine man. Training is accomplished in two ways. First, medicine men typically come from medicine families and, therefore, have been steeped in rituals and songs for years. Second, to become a medicine man, an individual must receive a vision, have this vision interpreted as valid by another medicine man, and practice in stages. These stages correspond to levels of power and delineate what rituals the medicine man can perform and what types of illness he can doctor. The vision includes instructions provided by the spirits. Called his "friends," the spirits typically speak to the healer through animals or deceased persons. Their messages will bring the words that tell the healer how to proceed, which words to speak to the patient to heal him or her, what medicine to use, and what to diagnose. The healer's practice is always "spiritual." No separation of the medical and spiritual function exists. Doctor and "priest" are one.

There are four types of rituals: the purification rite, healing rituals, vision quests, and the Sun Dance. The purification rite, colloquially called the "sweat lodge," is used as both a purgative in preparation for other rituals and as a place where the healer finds the diagnosis and discovers the medicine he needs to use during the healing ritual.

Healing rituals are all of nearly identical structure. Great variation exists, however, in what songs are used, what spirits manifest themselves, and what specific materials are used to constitute the sacred area in which the medicine man sits or stands. Most healing rituals are carried out at night in the dark and usually last from two to four hours. The patient's family and friends are important participants. The ritual is typically repeated for four nights. During the four days, the patient avoids all contact with persons other than family and may see the medicine man once a day to be given medicine.

Structurally the same as healing rituals are ceremonies performed for the purpose of giving thanks for help received in healing rituals. At times, this type of ceremony is also sponsored at anniversaries, birthdays, or on a monthly basis to request help and to give thanks. Such ceremonies constitute the majority of a medicine man's activities. They serve primarily a preventive function through providing ritual continuity for the group and establishing a lifestyle that maintains harmony within families, between families, and between the people's environment and their individual selves.

Another important ritual is the vision quest. A person participating in a vision quest fasts from food and water for four days and nights or less, depending on how long he or she has promised to fast. A medicine man directs the quest, picks the hill, holds ceremonies during the fast, and, after the vision quest, interprets the experience. Vision quests are carried out from June until September, and many people participate each year.

A further ritual of great significance is the Sun Dance, which is celebrated each summer. The purpose of the dance is to bring healing and strength to the people, to the entire nation. Persons participating in the Sun Dance have vowed to do so a year before. The participants fast and dance for four days. They dance in the sacred place in front of a cottonwood tree blessed for the occasion. At a certain time each day, the individuals can choose to have their breasts pierced, a piece of bone placed under their skin, and the bone attached to a rope and to the sacred tree. After this, the dancers move toward the tree and away from it, pulling on the rope and bone until it is ripped from the flesh. This intensely individual, yet communal, sacrifice reorients the whole people as the song says: "unshi malayo hecel lena oyate nipi ketlo (have mercy on me so that the people may live)."

All of these ceremonies are led by the medicine man. Certain medicine men do not lead the Sun Dance, but all practice the purification rite, healing rituals, and the guidance of persons on their vision quest. Finally, it must be pointed out that all of these ceremonies are frequent events. Every week and almost every night of the year, medicine men work, sometimes treating three to four patients within one healing ritual. In a study of the practice of six medicine men I conducted a few years ago, the low number of ceremonies per week was 2.4 and the high was 11 with a mean of 7.1 per week. As an example, one medicine man conducted 379 ceremonies over an eight-month period.

Within this context, I lived and worked as a psychologist for fifteen years, and saw numerous individuals in psychotherapy. Most of the therapy was brief and periodic. I would see a person for one or two months, then not see the person for six months before he or she would return for another series of sessions. Only during the last four years of my work there did I renew my interest in long-term, psychoanalytically oriented therapy. I began to see individuals once or twice a week over a

one to two-year period. We would break for two months in the summer and begin again in the fall. Some of the cases were psychotic; others were more situational, transient, or adjustment disorders.

My reorientation to psychoanalytically oriented therapy was inspired by contact with two kinds of healers: medicine men and French Lacanian analysts. Medicine men had made me sensitive to the importance of ritual, the power of words, the mystery of the unconscious, the complexity of the transference, and the long-term nature of treatment. I had seen people return to medicine men for years, becoming, in a sense, long-term patients. The medicine man's work reconstructed for these individuals a world that provided intelligibility to multiple levels of experience (including spiritual, psychological, and physical dimensions), as well as to the spirit world and the patient's historical and familial role in the community. The medicine men also helped patients find the courage to face and survive the unintelligible and unbearable.

The Lacanian analysts who influenced me were from Paris and visited us at our home on the reservation. Over a period of four years they became acquainted with the medicine men, approaching them, not in the fashion of anthropologists studying and observing their ways, but as professionals interacting with other professionals. The French analysts were able to accept and resonate with the native explanatory structure without defining it as primitive or reducing it to a set of Western psychoanalytic concepts. For example, in their work, the two analysts, similar to medicine men, used an approach in which transmission across generations through naming and assigning roles within the community is an important consideration in analysis. They analyze their patient's names to reveal who they were to and in their family and community. Names provided the symbolic link for the person to their social history. This insight has been the traditional practice of many native groups and is ritualized by the giving of names to establish

identity and responsibility. They also learned from the medicine men rather than only seeking to corroborate their own theories. They learned to speak directly, simply, and clearly. They learned to be strong and bold in therapy. They learned about spiritual power and its roots, about their own responsibility because of their "calling." They learned that "curing" is not "their" power, but the work of two or more and that one should not and cannot protect the patient from himself. The patient's freedom and will must not be jeopardized by analysis.

During our discussions of my practice, my French colleagues pointed out that all my patients were native, and all could have taken their issues to the medicine man. However, all brought them to me, asking me for assistance. With this, my patients demanded that we face their issues in the framework of psychotherapy. The question then was whether I, as a therapist, could have the courage and skill to meet and not run from this challenge. A second and corollary issue was the question of how I would deal with material that had a strong cultural overlay and that I had considered most properly the domain of the medicine man. I needed to understand how I, as a Western therapist, might relate to the medicine man and the cultural world of my patients. The following three brief case vignettes highlight what I learned about doing therapy with persons of a different cultural background.

STAGE ONE: ESCAPE FROM TRANSFERENCE THROUGH A NAIVE, CULTURAL-SPECIFIC THEORY

The case involved a year and a half of intense analytic therapy, occurring twice a week with a young adult Indian male. Referred originally by an employer and relatives, Kili (Bold One) was acutely paranoid. Conspiracy to kill him existed everywhere. He was followed by planes, cars, radar, and indi-

viduals from a variety of ethnic groups. He owned guns to defend himself. They were his best friends. He never abandoned them. He had to stay in his apartment where he could see all approaches from the windows to ensure that no one could kill him. Therapy proceeded with revelation after revelation of incredible experiences that had already happened or were soon going to happen to him. A monster lurked in the hills surrounding the city in which he lived. The monster grew and became both a personal tormentor and protector.

I listened, speechless. I felt defeated and overwhelmed. Interpretations that tried to identify resemblances to early childhood figures, or reflective feeling statements, were met with either disdain or simply no comment. "Of course I'm terrified. Wouldn't you be?" he said. Nothing I said could be correct. I felt like the dedicated physician with the reluctant patient (Searles 1977, 1979). I would try and try, only to feel defeated; then try again, only to exasperate the patient by my bungling. Infuriated, he would resolve more strongly to defeat me. I stuck with him in a silence which grew from his own speechlessness at his material, rather than my therapeutic foresight and planned intervention.

He moved back and forth between delusion and everyday life. Toward the end of the tenth month, the patient began to describe the home of the monster. The monster was a boa constrictor of mammoth proportions. The snake hounded Kili because he was the person who had let him out of a cage during a circus at a park. The snake was vengeful and enraged because he had lost his master. Kili felt guilty, yet pleased because he knew where the snake lived. This enraged the snake more because he knew only Kili could betray his whereabouts.

One day Kili confronted me. Wouldn't I come with him and confront the monster? He would bring him out of the hideout by calling his name. Simultaneously he spoke of being able to mobilize power, to move from place to place through body de-

composition and recomposition (as in "Star Trek"). He began to say he possessed spiritual power: "Perhaps I am a medicine man. Spirits don't scare me. I meet them. They are familiar to me."

At this point I had to make a subtle distinction. Was this material about spirits and recomposition cultural or idiosyncratic? Normal or psychotic? Two thoughts struck me about this. First, to leave one's body or even have one's body taken away by the spirits was plausible within a native perspective. Medicine men said this happened to them. It was not associated with madness, but with punishment or a journey to the spirit world. But, secondly, such spirit travel would always take place either in a ceremony, or in a vision quest, with a guide.

Kili's lack of fear of spirits bordered on a lack of respect for them. I knew idiosyncratic flirtation with spirits was dangerous and not advocated by medicine men. As a result, I considered his belief about being a power person to be delusional. I felt uncomfortable dealing with spirit phenomena. I am a psychologist, not a priest or healer. "I have no power," I concluded. "Perhaps this delusion does involve the work of spirits. So," I thought, "if this involves spirit phenomena, why don't I suggest he see a medicine man? That is the medicine man's business."

At the next session, I suggested this to him. His response was that his relatives did not believe in medicine men, but maybe he would go. However, more importantly, would I go with him to meet the monster? No, I didn't think so. We should talk about the monster as controllable here in the session. I again spoke about the medicine man. He again resisted.

During the next three sessions, I "taught" Kili about the process of going to a medicine man. There exists a very carefully prescribed method of requesting help from a medicine man. Persons seeking assistance must use a sacred ritual pipe,

present it to the healer with a specific clockwise movement, allow him to smoke the pipe while they tell their problems, and await instructions as to what they should do.

The next time Kili and I were to meet, we went to a medicine man. My patient arranged the ceremony. I instructed him in how to prepare for the ritual, picked him up, and took him to the diagnostic purification rite. We sat side-by-side in the sweat bath as the healer told Kili that the medicine man's friends (spirit allies) said that nothing bad was seen, that my patient needed a healing ceremony, and that he should do it immediately. After the ritual, Kili prepared for the ceremony to be held the next night in total darkness as the medicine man, his helpers, friends, and singers held a *lowanpi*.

I sat next to Kili during the ceremony. At one point, the young man spoke of his problems. Tearfully, he talked of fear, suffering, and needing help. Earlier, he had told the medicine man his problems in more specificity. Kili finished. A ritual song was sung. The spirit friends spoke to the healer. The song stopped and the healer told the young man that there was nothing seriously wrong with him. In fact, he said that his spirits said that what the young man saw or spoke about didn't exist. He could not move from place to place through decomposition and recomposition. The only name for the monster was his own, and he could speak to it and not be afraid. No planes followed him. He would be given medicine to help him sleep and clear his mind. He was instructed to return each day for three more days to receive the medicine. He would then feel good.

When we left the patient was frantic. "Drive fast because enemies are in the trees," he said. "The ceremony was worthless," he concluded. "You must return tomorrow," I said. He returned, took the medicine, and spoke no more of his body transformations. During our sessions, he now spoke of a person who was after him, but would not kill him or be killed by him. In fact, the person was now ineffectual. When

he named this person, it had my mother's maiden name, which Kili would have had no way of knowing. Two weeks later, he terminated and never returned to therapy. He did not live an easy, symptom-free life, but began to work, married a woman with whom he had lived, and had a family.

The case illustrates two faults in therapy. First, I used the medicine man to avoid confronting the madness I was asked, as a therapist, to meet and speak to. I used the medicine man as a convenient way to prevent or escape the point of the psychotic transference (Searles, 1977, 1979). In addition, I used the medicine man to compensate for my own lack of will to bring into speech the names of the beasts, monsters, and limitless fantasy. Fortunately, the medicine man could speak in this manner, and the ceremony could provide the context from which health could emerge.

This case illustrates the first stage in my evolution, aspects of which I call the "naive cultural-specific theory." According to this theory, when specific cultural material, or material relating to an altered state arises, it should not be defined in Western terms. This theory implies a stark duality between Western dynamic or analytic theory and non-Western healing rituals. Spirits are either to be viewed as projections that must be analyzed, interpreted, and discussed analytically; or, if acknowledged as existent, to be referred to a medicine man. As a psychologist, I dealt with projections — not with spirits. However, because I did not believe that spirits were only projections, and because I could not deal with them in therapy in any other way, I was left with a convenient "out" — referral to the medicine man.

Later, however, as I analyzed my sessions with Kili, I realized that I had betrayed my patient. He had brought his beasts to me. His use of my mother's name ("out of the blue," so to speak) showed that, although I had escaped the psychotic transference, the patient had looked to our relationship as a place in which to kill the fantasy. Viewed within this context,

my resorting to the cultural-specific theory was a failure of will and skill. Intrigued by, but fearful of, the material, I had been unable to speak to the patient of what the medicine man spoke — they are from you, not other. It should have been me who said, "These things come from you." Since I did go to the ceremonies with Kili, however, my actions expressed that I concurred with and acknowledged the truth spoken by the medicine man.

STAGE TWO: CONSOLIDATION OF WILL

I saw another young man in therapy twice a week for nine months. At the time he entered therapy, Ishnala (Alone) was involved with a medicine man as an "apprentice." The patient felt that he could deal with his "hang-ups" in therapy, and his possible calling to become a medicine man in ceremony. After a vision quest, he had had visions interpreted by the medicine man who pointed to the possibility of Ishnala being selected to serve in the medicine role.

Soon after therapy began, the patient brought material to me that seemed culturally specific. Dreams had archetypal woodland and plant symbols: ravens, eagles, beavers, coyotes, bears, all of whom gave him messages. They spoke to him about his girlfriend, relatives, women. They told him to resist the flesh, abstain, and give everything to the adopted family with whom he was living. Coyotes came to him and accused his girlfriend of something that he could not understand. Their words were too fast and, therefore, unintelligible. The medicine man was clear and specific about the meaning of these words. "Your girl friend sleeps with another man." Ishnala was devastated. Betrayal again. Abandoned by parents, placed in boarding schools, and shuttled from foster home to foster home, he knew betrayal. The anticipation and fear of it pervaded his interpersonal relations. "Why me?"

He became deeply depressed, suicidal, immobile, and he wept openly in the sessions. He felt ashamed to be weeping before a man, but what was he to do since life seemed so dreary?

Material in the sessions focused on his questions of how he was to interpret what the medicine man told him; what he should and should not believe. I had told him in the beginning that I was not going to comment on cultural material that he brought me from the medicine man. However, by this time I felt uncomfortable with my cultural dichotomy. I had to deal with cultural material in some way; how, I did not know. Although no spirit presences were coming into the patient's life or the sessions, he spoke more and more about his apprenticeship. I made no comment except, "You sound ambivalent." "What does that mean?" he asked. "It's like two opposite desires juxtaposed: trust and mistrust, to proceed or to retreat." "What's this juxtaposed?" he asked. "It's two things side-by-side," I said. "Oh, yeah, that's a good word," he finished. The session ended. I decided to speak to the medicine man.

I did this out of a desire to clarify our juxtaposed roles and to discover what kind of collaboration was possible — and also out of curiosity. I had never worked with this medicine man on a case. However, he had always been the one most interested in the idea of collaborating with psycho-healers.

One day, the medicine man came to my office on other business. I took the opportunity to talk with him about our mutual client. He seemed a bit surprised by the fact that I was seeing someone he was seeing. He said little. I had not expected any immediate response or discussion on such a serious issue. We parted with my question of how to work together, side-by-side, unanswered. Two days later, the medicine man returned. "Psychic power and spiritual power — that is the difference," he began. "You work with the psychic power and help the psychic world, i.e., telepathy. You may have a personal sense, but it comes from within your psyche. I work with the spirit

world on spiritual issues," he said. "The psychic power lets people deal with the problems that have to do with their minds. I deal with spirits; what they want to tell people, what they can say to us and want from us. You deal with the power of the mind — man alone figuring out what to do and what others want." We parted, agreeing that I would stick with psychic power, and he with spiritual power.

At the next session, my patient said this would be our last meeting. I asked why. He said therapy confused his work with the medicine man. "What do you mean?" I asked. "Well, I don't think the medicine man approves of this therapy business," he responded. "That's not what he told me," I said. I explained the distinction between therapy as related to psychic power and apprenticeship as related to spiritual power. He told me he would let me know at the next session whether he would continue or not.

The session arrived, and he said he would continue — that in fact I was right, and that no conflict arose. Session after session brought more and more questions that seemed to overlap what he brought to the medicine man and what he brought to me. The psychic/spirit distinction seemed conceptually clear; nevertheless, he seemed to bring psyche and spirits to both of us.

One day he called me to say he had to see me immediately. It would only take a minute. I agreed to a brief appointment. He arrived, and immediately related a dream filled with symbols of a cultural nature. In the dream, a black-tailed deer spoke both to him and to me while we stood together, endangered by a storm. The animal told us how to escape the perils that awaited us. "Please don't drive in storms because you might be hurt," he said. I said, "Only if I am with you, it sounds like. Maybe you are afraid that your presence will kill me. But then again, if we listen to the spirits, we'll escape, eh?" "Well, stay home," he replied. I said, "I will be care-

ful. Thank you for your warning. I'll see you tomorrow for our regular session."

The next day arrived, and he said he would take a break from his work with the medicine man. He wanted to concentrate on our work. I said, "That's your choice." I wanted to leave his relationship with the medicine man for them to work out. I talked with him about what he now expected from me. "Maybe we don't have to juxtapose," he said. "Maybe, but we have juxtaposed many desires," I said and added, "They are your obsessions and choices." "Okay, we'll go forward," he said.

During the next months, he was alternately optimistic and pessimistic. He recapitulated a tragic history of abandonment, foster care, life in residential centers, lost friends, experiences of racism, affairs, marriage, and substance and alcohol abuse: a long series of failures in intimacy (to use Sullivan's word), resulting in pervasive loneliness. The therapy also became lonely and desolate. The markers of this process were tears, missed sessions, and a deep sense of ennui. Drugs, alcohol, and thoughts of death returned.

Finally, in the spring, he related some long and intensely emotional dreams. Although noncultural symbols were present, he began to speak of his former relationship with the medicine man. He said that it might be time to return to the rituals. I told him I thought he had to speak more about these dreams in the present sessions, even though they were complicated dreams. "I am not able to speak to you in a ritual ceremony," I said, "What needs to be said must be said here and now." He came back to the dream associations related to lost persons and unfinished business. He told me the names of people with whom he had unfinished business, and he related the things he needed to tell them. He decided to return to Seattle, from where he had arrived months before, and find these people and "finish this business." He did not go to the medicine man. We interrupted our sessions for my summer

vacation, and when I returned in August, I found a note: "I went back to find my friends and family like you said. I am going to stay. Thank you."

The stage illustrated by this vignette represents an evolution in my development as a therapist from Stage One to State Two, which I will call "the consolidation of will." In this stage, I was willing to trust my instincts about what the healer called "psychic power" and speak to it. The transference developed; the low points of possible neurotic or psychotic transference were not resisted on my part. I was willing to let Ishnala speak what he wanted and to find something to hold on to. The collaboration with the medicine man took up one session. We spoke of the two realms (psychological and spiritual), and he told me I was to be responsible for the former. After this, I could not return to him to ask what realm I was in at any given point; to do so would have meant asking him to do my job. I had to accept the place in which the patient and I were and work from there. I could not look to the medicine man to save us nor could I try to be a medicine man. I had to deal with my patient's material in the here and now and with the tools of analysis.

It is important to realize that this stage is still culture-specific, but represents an evolution from the state of naivete which allowed me previously to escape difficult moments in the therapy through referral. However, spirit phenomena were still off-limits in my work with Ishnala. In Stage One, the therapist uses a medicine man to escape difficult moments in therapy and, in essence, loses will and betrays the patient. In Stage Two, the therapist accepts cultural material in the session and applies the analytic method to it. In this situation, the choice of using the medicine man is entirely the patient's but is open to analysis. The client is encouraged to bring whatever

ern tools (in this case analytic ones) to face the client's material. The central focus is on acknowledging that the client wants to bring the material to therapy. Often, when the client brings the issue of the medicine man to the session, he or she asks the therapist directly, "Will, or can you, deal with what I am on the verge of speaking?;" that is, with his experience of spirit phenomena.

STAGE THREE: ACCEPTING THE SPIRITS

Gnaya (Fooler) is an adult male whom I saw in therapy twice a week for about six months. A strong and athletic man, he prided himself on his self-reliance and physical abilities. Gnaya had been raised by Christian grandparents, his aunt and uncle, and his mother. Since his nuclear family had been unstable, he had been cared for within the extended family.

After the first six months of therapy, he left the area for a few months and reentered therapy upon his return. The initial six months of our work were dominated by issues concerning a woman with whom he was having an intense relationship. Although not married to this woman, he spent much of his time with her. He became easily terrified at the thought of losing her. If she was not home when he arrived, he often became frantic, running through the city trying to find her. In situations like this, he thought of killing himself if she did not return. Upon her return, he usually became either silent or very gracious, even waiting on her. He never said a strong word against her, trying to avoid conflict as much as possible. Periodically, however, he lost complete control when the phone rang for her or she made a mistake with money for shopping. Although he did not beat her, he feared he might kill her in his rages, and she also was afraid this might happen.

In the first six months, therapy had done little for him in coming to terms with this relationship. He had gained some

relief from his rages through dealing with memories of being in the Korean War; he had recalled the carnage he had witnessed there and the killing he had done. He had shot a woman he believed to have been a North Korean.

During this phase, issues in the transference focused on me as the sympathetic physician who saw the wounded warrior, saved him, and finally received his trust after a period of intense distrust and wariness. The warrior image contrasted sharply with his other self-image which came from his deeply Christian upbringing. However, he also recalled that some members of his family had been medicine men and warriors. What difference this piece of family history made, he didn't know, but he always wanted to find the grave of his great-grandfather and mark it properly. Perhaps the ancestor was buried near a river. Gnaya's memories of hunting or warfare in Korea frequently included images of rivers.

The first part of the therapy ended when we became hopelessly trapped in endless discourse about his woman friend. When I tried subtly to encourage him to speak to her about his feelings, he seemed to become disappointed in me and in therapy. He left the area and moved to another city.

After he had reentered therapy, he no longer spoke about the woman. Now he wanted to talk about warfare, hunting, graves, and presences. The presences sat across from him at home, but he did not look at them. They were at the foot of his bed and in his office. He knew he could not look at them. He said that perhaps he should go to a medicine man and talk to him about a ceremony. Maybe the medicine man could tell him what to do. I said, "Who is this spirit?" He didn't know, but he felt it was ancestral and related to his father's people. He also thought it had to do with some recent deaths in his family. These were tragic deaths which had occurred suddenly and shockingly, as do many deaths on the reservation. "What do the spirits want from you?" I asked. He thought they must want to say something to him or to let him say something.

"Do you think perhaps they want to speak to you about the frequency of accidental and violent deaths that occur on the reservation?" I asked. He wondered about that; but then again, he thought, maybe he was just being overwhelmed by his grief at the loss of his relatives and was unconnected to the community situation. I said this could be so, but the spirit presence seemed to have much to do with the state of his people today. He said yes, that was for sure. Then he told me that he and others his age had recently talked extensively about death being so omnipresent and powerful in the Indian community. They had to hunt this, I said. Then I asked him, "Aren't you a hunter?" "Yes," he said. The session ended.

The next session began with the statement, "My spirit friends have left. The whole week, since our session, they are gone." The presences never reappeared. He never again mentioned going to a medicine man. The sessions continued for a few months, after which he disappeared with no advance notice.

What is important in this case is that I, as a therapist who believes spirits exist and further believes that spirits manifest themselves to impart important messages, had to bring this into therapy. I could not luxuriate in referral or ignore the need to speak to this reality. If the patient wanted to bring spirits into the session, I had to discern when they were present in the phenomenal world and when these presences were called for by the desire of my client and the wish of the spirit world. I could not relate to spirits as if they were exclusively a fantasy or hallucination emanating from intrapsychic experience. Gnaya pushed me to ask which of the two worlds — spirit or psychic — was present in the sessions. If it was the spirit world he was bringing to therapy, I could not explain it away with analytic interpretations. Instead, I had to acknowledge the spirit and search for a name for it. Once named, or even left unnamed but acknowledged, the power of the spirit was dissipated. I had to say to Gnaya, "I believe you." I had to admit

to myself that the spirits existed, that their presence was real. If I explained them away, they never went away. If I attempted to analyze them, they continued to speak. They had to be acknowledged and addressed in order to be dissipated.

I was confused about how to explain the sudden dissipation of the spirits. I wondered, "Does my patient experience relief simply from speaking about spirits?" I had to reject this explanation because simple ventilation or emotional catharsis had not worked before when I had maintained silence, and Gnaya had spoken of these presences. Perhaps my use of good Rogerian reflective listening to provide unconditional positive regard and acceptance had helped him to accept his fears and caused the presences to disappear. No, previously that had not provided any relief either. In fact, the spirits stayed around and grew in number, in spite of the patient knowing how fearful they felt or experiencing how overwhelming his grief was. Rather, it seemed that the presences had disappeared because I had made an effort to accept not just Gnaya's belief in spirits but to come to a personal acceptance of the real presence and influence of these spirits in his life. I had attempted to learn to admit this presence into therapy without resistance.

There are links between madness, the social world, and the spirit world. In Gnaya's case, the individual experience of spirits pointed to a pervasive social situation of disharmony that I could not ignore. In other words, individual grief and trauma corresponded to a disruption in the social context that needed words to become present. The individual spirit experience pointed to this need. Once Gnaya acknowledged the social situation and its link to the tragedies he had been experiencing, he was touching the world toward which the spirits had wanted to push him. To challenge and confront this world in his search for answers was now his task — his hunt. When Gnaya could acknowledge that he was a hunter, the spirits could leave. Thus, in mysterious ways, the spirit presence

pointed to a disharmony in the social world, challenging the individual to act.

The world is harmoniously organized. Human beings act as humans, animals as animals. Life is based upon the notion of mutual respect between the individual and his or her environment. Once people violate the rules of their "cultural" life as human beings, for example, by lying, committing incest, or speaking to relatives to whom they shouldn't speak (in the case of Northern Plains Indians, mothers-in-law); or when they mistreat the earth and its plant and animal life, a rupture takes place. The individual or group which caused the disharmony must acknowledge and repair it. If this cannot be achieved, the tear becomes greater and greater and passes from generation to generation as an open wound in need of attention. As each generation participates in the pathology, it becomes more and more likely that spirits will appear. Partially, they appear as madness appears. Spirits and madness arè both there to try to explain to people their disrupted social system, to challenge them to discover the messages that can reveal the rip, and to urge them to repair it. Viewed from this perspective, the symptoms of unintelligible spirits or social disruption must be seen as the individual's or the group's desperate attempts to formulate the words that lead to reestablishing a social frame for the community or family. As illustrated in the above vignettes, I was ignorant about how to deal with this.

In order to learn, I spoke with elders or medicine men who worked with such phenomena. I talked with them about cases to provide examples of what kind of material comes into therapy and to find out what could be done in the context of therapy. My trainers taught me that medicine men do not expect common people to be confronted with spirits for capricious or meaningless reasons. They indicated that spirits are there to request some action. The spirit experience says something about the individual in relationship to his or her community. Was a ritual of grieving not accomplished? Was the group in

jeopardy because of disharmony and unrepaired rifts in family relationships?

In addition, my teachers explained to me that common people are not expected to meet and interpret spirit phenomena in everyday life, nor are they supposed to deal with these experiences by themselves. Ritual is the proper place for spirit phenomena. The medicine man is the proper person. Too often, current literature has encouraged the romantic notion that spirit encounters can free a person or provide mystical experience. For the medicine man, solitary spirit experiences by common people are dangerous. The person needs a guide and a moral or spiritual frame if such experiences are not to tear him or her apart.

My case discussions with healers in the private setting of their homes or in a circle with two or three close associates helped me to dissolve the psychic/spiritual distinction. I came to understand that the patient can bring either reality to the therapist. The medicine men did not tell me that what I do is the same as what they do, only in a different setting. Rather, they said that I must speak strong words. They said that Western therapy had light words, and that these words did not speak to signification (to use Lacan's term), but skirted or avoided it. Therapists must develop strong words. The Lakota word for light is "kapajala," which has many connotations, including the lack of strength in one's speech.

What the medicine men wanted to point out to me was that the words I used in therapy had to speak directly to the larger context of the patient, to what I call the "big history." Whereas an individual's "little history" refers to his or her idiosyncratic or idiopathic history within the family context. The big history, though also idiosyncratic, includes the global context, the generational history of the person and the community, and the spiritual and transcendental world.

Within this larger context, the frightening search for signification has to be pursued as a hunt. The hunter must be clever,

ruthless, patient, and always ready for the moment when he or she needs to leap forth to speak what is necessary. Gaining insight has never been the issue. The issue is finding the words that say simply and directly that things are a specific way and not another. The question is, "where do these words come from?" I believe that the answer can be found in the words of the old medicine man, Lame Deer, "In the beginning was the sound, and the sound *was*." "Explain to the people," he said, "that the meaning of words is in their sounds." Uncannily similar to the structural interpretation by Lacan or Freud, what Lame Deer is saying is that a healer must learn the structure of sound to discover meaning. Meaning emerges from the restructuring of sounds into words that resonate with the patient's big and little history. For Gnaya, the word was "hunt." The importance of reconstructing sounds, rather than searching for interpretive content, is reflected in what Lame Deer has told us, "Learn to listen and see so you can speak the heavy, direct, big sounds."

The three cases presented in this paper illustrate three stages in my development of a theory according to which therapy can and must consider spirit phenomena and other culture-specific material of a transpersonal nature without reductionism. In addition, the cases provide insight into my personal development in relation to the spirit world. The vignettes illustrate how therapists may fail to consider spirit phenomena not only because of their theoretical assumptions about what can and cannot exist but also because of their resistance to psychotic or neurotic transference.

From the three cases I presented, it can be inferred that if an Indian patient seeks help from a medicine man to find relief from symptoms or deal with the spirit world while in therapy, the therapist may have failed to allow the analytical process to enter critical transferential moments. The resistance, therefore, must be viewed not as being that of the patient, but that of the analyst or therapist. We therapists need to pray for

courage for ourselves, rather than praying that our clients may be courageous.

Therapists referring patients to medicine men after having developed a therapy relationship risk allowing their decisions to be governed by their own resistance to becoming more deeply involved with the client. In my experience, such referrals frequently involve issues of abandonment and betrayal by the therapist — a loss of will by the therapist. The patient comes to me, a Western white therapist. He or she chose my medium; therefore, I must speak to and hear the person. To refer the client to the medicine man may be only providing a convenient escape for the therapist, who needs to examine closely his motives for referral.

These conclusions do not imply that collaboration between medicine men and psychotherapists should be avoided. Such a collaborative relationship can be a source of significant consultation. Collaboration can take place through case discussions in which the therapist presents his or her work, but does not seek to delve into the medicine man's mind in a quasi-anthropological fashion. When professional collaboration occurs, it must originate from the mutual respect of the therapist and the medicine man in their search for knowledge about how to treat the mental illness best. In contrast to this kind of collaboration, Western psychologists and psychiatrists traditionally have stood at two opposite poles in their cross-cultural interactions with Indian people. They seem to have said either "We have twentieth-century tools that can solve your problems and therefore, do not need collaboration," or, "You have the necessary ritual tools and are better off alone, and, therefore, collaboration is unnecessary."

Joe Trimble (1981), an Oglala psychologist, writes in an article on prevention that an old Salish man told him he felt that Indian people of his tribe did not have the *words* to prevent needless death and tragedy; that the words had been there, but today have either disappeared or lost their effectiveness. New

words, new methods for all of us are needed. I believe that the collaboration of therapists and medicine men who represent two parallel systems of treating madness could benefit mankind. If we do not trivialize each other, but instead develop appropriate contexts to speak to each other, we could make breakthroughs in understanding madness. Neither system is sufficient in itself. Therapists in cross-cultural therapy with native people will confront spirit phenomena. Their choices seem to be either to explain the experiences as always pathological, overlook them as "normal within the culture," drug the client, or seek the idiosyncratic, social, or spiritual meaning of these phenomena.

In conclusion, I must point out that none of the cases discussed in this paper represents a "cure," especially if cure is defined as "relief." None of these therapies ended on a note of permanent relief. All were filled with therapeutic mistakes. However, in each case occurred specific events that indicated progress. Each person moved forward in his or her life, continuing to struggle on a level of greater differentiation.

The cases helped me to clarify the role of Western therapy in a Native American context. I learned that therapy of an analytic nature can meet and deal adequately with cultural and spirit material. I discovered that collaboration with medicine men can lead psychotherapists to understand the potential power and range of Western analytic methods, as well as protect them from thinking in terms of psychotherapeutic imperialism or trying to act like medicine men. I believe that if Western analysis is to deal with the depth of material often brought by native clients, it will have to understand and accept the spirit realm and spiritual phenomena. My own experience is that if one accepts these phenomena as real, then the spirit phenomena can enter the therapeutic frame on their own terms. This then allows the analyst to use psychoanalysis, or, as Freud called it, "the speaking cure," to deal with them. The Lacanian perspective provided me with a conceptual

structure as well as a structure for practice. It allowed me to use "tools" consistent with my training and culture in ways that were resonant with and symmetrical to what I had learned from the medicine man. Thus, I could develop a notion of therapy as an endeavor capable of creating a modern ritual evolving from close and intimate contact between Western therapists and native healers. Possibly, such an understanding may not only have benefited one therapist and the three patients presented in this paper, but may as well express the potential for creating a truly "Native American," psychoanalytically-oriented, therapy.

NOTES

1. In over seventeen years of practice among native people, my therapy has gradually become more psychoanalytically oriented. Though my training had strongly focused on psychoanalysis, I had become more involved in issues of community and social change. My practice of therapy had become short-term and problem-focused, and not oriented toward the establishment of long-term relationships. However, I discovered often that after short-term therapy, my patients were not finished, and they returned. After beginning again, deeper relationships usually developed and stronger unconscious material surfaced. Therefore, I began to see individuals in multiple sessions, realizing that there would be a break, after which they would return, and we would start again. Stylistically, I attempted to use knowledge gained from discussions with Lacanian analysts. I focused more on the history of the family and its transmission through the giving of names, and their meaning and role in the family and community. I listened more closely to the sounds of words and the sounds between words to reconstruct the language of the unconscious and reach for signification. I attempted to stay with the clients, examining my own resistances rather than looking primarily at their resistance, especially when confronted with a desire to refer or discontinue on their part or mine. Since words became very important in my practice, I did some of my work in the language of those clients who spoke a Native American tongue. Although we generally did not conduct entire sessions in the native language, we did seek the tribal words to describe important experiences.

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