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SYDNEY G. MARGOLIN, MD
April 25, 1909 - December 3, 1985

In Appreciation of Sydney G. Margolin, MD

This fall edition of *American Indian and Alaska Native Mental Health Research* is dedicated to the memory of Sydney G. Margolin, MD. The articles contained herein celebrate Dr. Margolin's interest in American Indian people and their cultures, his passion for the Southwest, and his unique appreciation of sociocultural determinants of behavior.

The intent of these papers is to challenge ethnocentric biases and pose interesting questions. The importance of awareness of social and cultural differences in evaluation and treatment of American Indians is considered central to therapeutic working relationships and treatment outcome. At times the therapist may strategically facilitate the reappropriation and honoring of important aspects of an individual's unique religious and healing traditions. This can be useful for Indian and non-Indian patients alike.

I hope these articles serve to stimulate and provoke new avenues of thinking and questioning. Certainly Dr. Margolin might be best remembered in terms of his lust for the discovery of the misperceived and misunderstood.

Dr. Sydney Margolin was an interesting and complex person. Brilliant and aggressive, he expected a great deal of himself—and those around him. As a result, he represented many different things to different people. He was a man of contrasting moods, diverse interests, and paradoxical perspectives. His physical presence was commanding, his voice was hypnotically resonant, and his bearing was serious, intense, and professional.

Sydney's professional career work and accomplishments speak for themselves. His early work was deeply rooted in traditional psychoanalysis with an individual intrapsychic focus. Then, through the agency of psychoanalytic method and hypnotic techniques, he delved deep into psychosomatic medicine research, where his name became associated with concepts of physiologic regression in maladaptive response to stress and anaclitic therapy. Finally, through his work with American Indians and Hispanics, he opened the range of his interests and studies to include sociocultural determinants of behavior, and he speculated on methods of intervention.

In his clinical work with individual patients, Sydney had the uncanny ability to observe and understand things that others just noticed. Residents valued these "pearls" and sought his guidance in this regard. At the same time, he had the annoying habit, both with students and colleagues, of candidly saying exactly what he thought. This habit, combined with his reluctance to engage in some of the other social and fraternal dances of academia, sometimes lead to his being perceived as something of a maverick.

Dr. Margolin's custom of poking at the boundaries of convention and the accepted idiom were reflected in his work in other ways. He insisted that his students define their terms and refused to allow them retreat into the convenience of psychoanalytic jargon. He encouraged them to read original source materials and historic papers, believing that the phenomenologic case descriptions of pioneers in the field—Freud, Bleuler, Krapaelin, etc.—were fuller, richer, and more accurate than contemporary writers whom he suspected of trying to fit clinical data into preconceived diagnostic categories.

One of the essential themes in Sydney's life and work was the notion that the reality and life of patients and their problems were richer, more interesting, and more complex than could be encompassed or defined by any theoretical framework. Psychoanalysis provided merely the methods and tools for exploring the uncharted regions of human psychological experience and behavior.

Sydney felt strongly about keeping psychiatry and psychoanalysis firmly anchored in medical physiology; hence, his Human Behavior Laboratory. His laboratory was filled with polygraphs, videotape and sound equipment, and other sophisticated electronic gadgetry.

Sydney had an intense curiosity about unusual people and unique human problems. Individuals suffering stigmatism, various phobias, disturbing dissociative phenomena, and multiple personality were among those case studies that he had videotaped.

He was interested in the roots of healing processes and experience in the human psyche. He acknowledged historical kinship with priests and shamans of other cultures. He sought to appreciate the humanity beneath priests' vestments and shamans' masks. In this way, he honored the healing traditions of American Indians.

In his work with American Indians, Sydney was appreciated as "a man with a good heart." He seemed to present his best self—gracious, generous, and kind—in the honest, unpretentious environs of the reservation, away from the competitive complexities of the "civilized" academic community.

In and around the academic community, Sydney wore his professional demeanor most of the time, seldom letting go the more personal side of his nature. At home with his devoted wife, child psychiatrist/psychoanalyst, Gretel Hitchman, MD, he showed a more relaxed, personal side. Also, classical music and travel seemed to allow for the emergence of his more personal self.

Sadly, Sydney never completed the books he had expressed ambition to write. His proposed books on hypnosis, psychosomatic medicine, and ethnopsychiatry never materialized. Sydney's health failed him in the last years of his life.

The writers of the articles contained herein—Frank Tikalsky, PhD, Robert Putsch, MD, and John K. Nagel, MD—were all greatly influenced personally and professionally by Dr. Margolin. Others, including child psychiatrist, Bill Stennis, MD, of Santa Fe, New Mexico, and Elizabeth Kubler-Ross, MD, were among those encouraged and inspired by Sydney Margolin's influence. This edition of the *Journal of the National Center* is dedicated in gratitude to Sydney's memory and inspiration.

John K. Nagel, MD
Guest Editor



Sydney G. Margolin, MD, Professor Emeritus of Psychiatry, University of Colorado School of Medicine, Department of Psychiatry, died December 3, 1985 at his home after a prolonged siege with hepatitis and liver cancer. He was 76, having continued his active psychoanalytic practice until just a few months before his death. He was director of the medical school's Human Behavior Laboratory from 1955 to 1979. Prior to that he was Associate Psychiatrist in charge

of Inpatient Services and Psychiatric Liaison Service between 1946 and 1955. He acted as United States Armed Services Consultant Neuropsychiatrist to the Surgeon General in World War II and afterward from 1944 to 1955. He completed his undergraduate studies at Columbia University in 1929 and attended New York State University Medical School graduating MD in 1936. After medical school he did his internship and neurology residency at Mount Sinai Hospital in New York City from 1936 to 1940. He was honored as Abrahamson Research Fellow and Josiah Macy Foundation Research Fellow in 1941 and 1942. Dr. Margolin was well known for his contributions in the area of psychosomatic medicine. His interest and research in the psychophysiology of psychosomatic illnesses remained one of the central themes of his life's work. In Colorado he became fascinated with ethnopsychiatry through his work with Hispanic and American Indian populations. His passion for the Southwest was evident in his active support of the development of a Southwest Studies Center at Fort Lewis College in Durango, Colorado. He had a long-standing interest in natural history of psychoanalysis and its confluence of historical, sociological, and cultural conditions with Freud's destiny. Dr. Margolin and his wife, child psychoanalyst, Gretel Hitchman, MD, enjoyed many friends and acquaintances in both American and international psychoanalytic communities. Dr. Margolin's professional contributions include 50 years of teaching medical students as well as many papers and presentations which emerged from his vast clinical experience and research. What he stimulated and provoked in his students, residents, and fellows may stand as his most appreciated accomplishment.

I am glad to have been asked to add a few words to the Memorial Journal. I am grateful to Dr. Spero Manson for generating the idea of publishing articles written by friends and colleagues of Sydney. Drs. Nagel, Putsch, and Tikalsky were all close co-workers and they have contributed material that would have been of great interest to Sydney. I want to thank them deeply for their effort and time spent. Their contributions will enhance our memory of Sydney—researcher, teacher, and friend.

Gretel Hitchman Margolin, MD

GHOST ILLNESS: A CROSS-CULTURAL EXPERIENCE WITH THE EXPRESSION OF A NON-WESTERN TRADITION IN CLINICAL PRACTICE

ROBERT W. PUTSCH, III, MD

ABSTRACT. Ethnocentric beliefs and attributes of illness, etiology, and death are discussed in patients from three different cultures - Navajo, Salish, and Hmong. The cases illustrate the role of the dead in concerns and fears related to illness, depression and suicidal behavior. These issues are presented in the broader context of human experience with death and dying represented in the medical and anthropologic literature. Diagnostic and therapeutic approaches to special beliefs are illustrated.

It is twelve days since we buried you.
We feed you again, and give you new clothes.
This is all we will feed and clothe you.
Now go to the other side.
We will stay on our side.
Don't seek us and we won't seek you.
Don't yearn for your relatives.
don't call for us...
- A Lahu funerary prayer
(Lewis and Lewis, 1984, p. 192)

Go. Go straight ahead
Do not take anyone with you.
Do not look back.
When you reach your destination,
talk for us.
Tell them not to trouble us.
Or not to come here
and take anyone else away.
- A Cree funerary prayer
(Dusenberry, 1962, p.96)

AMERICAN INDIAN AND ALASKA NATIVE MENTAL HEALTH RESEARCH
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Writings on death and dying focus heavily on the problems experienced by dying individuals and those who care for them; the survivors of death in a family have received far less attention. Death and dying pose serious problems for surviving family members. Beliefs and practices regarding death and the dead have had a profound effect on the behaviors surrounding illness, and in many groups have led to traditions in which patients and/or family members may perceive a sickness as being connected in various ways to someone who has died (often a family member). This traditional stance regarding connections between the dead and the etiology of illness will be referred to as "ghost illness" in this paper.

Ghost illness appears to be a culture-bound syndrome. Spirits or "ghosts" may be viewed as being directly or indirectly linked to the etiology of an event, accident, or illness, and this may occur irrespective of biomedical etiologic views. Western languages lack formal terminology for ghost illness, and the parallel beliefs and behaviors are masked by and hidden within Western social fabric as well as the paradigms of Western psychiatry and medicine. In contrast, specific terminology for ghost illnesses not only exist in many non-Western cultures, but the terms co-exists with extensive and elaborate means of dealing with the problem.

The recurring theme that the dead may take someone with them is illustrated by the funerary prayers at the beginning of this paper. These two tribal groups expressed similar fears in prayers addressed to the dead.

Don't seek us and we won't seek you.
Don't yearn for your relatives.
don't call for us...
- A Lahu funerary prayer
(Lewis and Lewis, 1984, p. 192)

Tell them not to trouble us.
Or not to come here
and take anyone else away.
- A Cree funerary prayer
(Dusenberry, 1962, p. 96)

Since epidemiology informs us of a high rate of mortality during bereavement, these prayers and myths have a basis in fact. Additionally, there is real and symbolic evidence of an associated self-destructive impulse in the bereavement period. Thus it is that the psycholinguistic response of anxiety, dread, and fear of death in another is based on reality. We will observe the clinical significance of these themes in the three cases of "ghost illness" which follow. Each of the individuals to be presented had interacting somatic as well as psychosomatic components to their experience of illness, depression, and anxiety. In each instance, however, their views were directly tied to special, culture-bound beliefs and to the emergence of hallucinations and/or dreams of deceased relatives.

This paper reviews three patients who come from cultures which have well-documented views regarding illness caused by the dead. The patients are Navajo, Salish (a Northwest coastal group), and Hmong (a hill tribe in Laos, Thailand and China). Concern over burial, ghosts, and ghost sickness is well known in the Navajo (Haile, 1938; Levy, 1981). The religious/therapeutic expression of this concern is seen in multiple Navajo healing ceremonials that belong to the evil chasing or ghost way chant groups. Both the Salish (Ahern, 1973; Collins, 1980) and Hmong (Chindarsi, 1978) people have ancestral religious process, and both groups have ceremonial means to deal with ancestral interference and ambivalence. All three of the individuals to be discussed sought help from Western trained physicians for physical complaints. Following the cases, there is a discussion of the ghost illness tradition in the broad context of experience and beliefs relating to death and dying.

Case 1 - A Navajo Woman with Ghost Illness

<u>Date of Onset</u>	<u>Problem List</u>
May, 1977	1) Bilateral accessory breasts
1972	2) Infertility, 5 years duration, resolved 1977
July, 1977	3) Post-partum depression, family problems

This 27-year old Navajo woman was seen in an emergency room two months after the birth of her first child, a daughter. She complained of painless swelling in both axillae which had begun during the eighth month of her pregnancy. Earlier, her family physician had advised her that the swellings were caused by the enlargement of accessory breast tissue, and he had counseled her to avoid breast feeding in an attempt to prevent further enlargement. She had complied, but in spite of this precaution, the tissue failed to recede during the post-partum period.

Her pregnancy had ended a five-year problem with infertility. She was perplexed by the developments that followed delivery. "We waited so long...I should be happy, but I'm not...I've been having crying spells, and I get mad over anything." In addition, she had developed difficulty sleeping, had lost interest in her usual activities, and noted a markedly diminished libido. She had argued with her husband over minor issues, and on two separate occasions, she became angry and "took off in the car." "I found myself driving 80 to 90 mph, headed for the Navajo reservation...it really scared me, I was going 80 right through last night." Fright generated by this driving episode had precipitated a Sunday morning emergency room visit.

The patient presented two major concerns. One involved the lumps under her arms; although she acknowledged that these were accessory breast tissue and not cancer, the patient found herself worrying about "looking ugly" and about dying. Her second concern was of "losing her mind;" she explained this fear by referring to "not caring about anything" and to her "crazy driving." Additionally, she mentioned a brother who was a binge drinker, often threatened people (especially her mother), and was judged by the family to be uncontrollable and "out of his mind." "I'm afraid I'll get like that."

During the months following the birth of her first child, the patient had experienced repetitive disturbing dreams. She began dreaming about having an operation and had noted the sudden resurgence of an old, recurring dream of her deceased father. The dream of her father had a special meaning for her: "Whenever I dream him, it makes me feel like I'm going to do something crazy." She immediately gave "driving fast again" as an example of what she meant. While her original dreams about her father occurred prior to her marriage, the dreams had suddenly re-emerged, increasing in frequency during the post-partum period. Her father had died suddenly six years earlier under circumstances in which she was "with him the whole time." She had raised the issue of details surrounding her father's death after the interviewer made a comment about a possible Navajo interpretation of her dreams: "sometimes this kind of dream means that the dreamer thinks that something bad is going to happen, occasionally Navajos refer to dreams like that as *Ch'iidi dreams*. (*Ch'iidi* is a term that relates to ghost-related materials, places, dreams, or visitations. It has become the slang term for "crazy.")

The patient felt it was necessary to explain her concern in some detail. Six and one-half years previously, she had assisted in the delivery of her youngest brother at home; it was her mother's last pregnancy. The placenta had become stuck, and she had to take her mother to the nearest health clinic. She returned home alone in the truck to find that her father had suddenly become ill. "It turned out that he had a ruptured appendix. I went straight back to the clinic...they still had my mother, and they sent us to the hospital (a 175-mile trip by ambulance). Later the doctors said it had gone too far. He died when they tried to operate on him." When the patient subsequently developed nightmares about her father, her mother insisted that the patient needed a ceremonial to rid her of the malignant influence of the father's spirit. The patient's mother felt that the patient was somehow tied to the father's death. The patient had discussed the need for this ceremonial with her husband. "But," she stated, "he doesn't believe in it."

There were other problems. The patient had experienced irritability, decreased interest in daily activities, and inability to relate well to her husband since the birth of their child. Additionally, she noted that references to her as "La India" by her husband's Spanish speaking family were now very upsetting. "Why do they call me The Indian? They know my name, why don't they use it?" In the past, the patient and her husband had experienced difficulties when they entered the environment of each other's homes. For this reason, they were purposely living away from both families, and had been supportive of each other when at either in-law's home. Until her husband's brief layoff at work, they had been doing well.

The patient and her husband had participated in Navajo ceremonials on numerous occasions. Her family and friends had occasionally stated that it "wasn't right" for the husband to help Navajo ceremonials. She was convinced that her successful pregnancy was the direct result of treatment by a female ceremonialist on the reservation a few months before becoming pregnant. On her husband's side, she had agreed to the christening of her daughter via the Catholic church. Her husband's

family had used traditional healers and had an awareness of the special folk knowledge of Curanderismo. The husband's aunt, for instance, was regarded as a *bruja* (witch) by the rest of the family, and a number of family problems had been ascribed to her malevolence.

An Approach to Treatment

The therapy, outlined below, was designed to simultaneously account for both the traditional views of the illness and the biomedical problems the patient was experiencing.

1) Arrangements were made for a cosmetic surgery evaluation, and the patient was advised to wait a sufficient period to be certain that the effect of her pregnancy on her breasts was maximally resolved.

2) Diagnostic measures were undertaken to ensure that there was no other endocrinologic problems contributing to the prolonged post-partum depression. (This included an evaluation for post-partum hypothyroidism.)

3) Lengthy discussions were undertaken regarding the couple's disparate beliefs and backgrounds. Each spouse had made prior concessions to the other's backgrounds; however, their beliefs and ethnic differences had become an issue during this period of stress. The patient viewed her problem from a distinctly Navajo point of view. At one point, she explained her behavior by directly stating that her father "was making me do these things, he's the one who makes me do it." In fact, this view was shared by her mother, who had discussed the need for a ceremonial repeatedly, by mail and over the phone. The patient was not a Christian, and after the birth of their daughter had participated in a Catholic christening without "really believing it." Her husband and his family had been unhappy over her failure to participate fully in Catholicism, but they were pleased by her participation in the christening. The difference between believing in things and respecting them was reviewed. The patient's husband eventually agreed that it was necessary to respect his wife's views and to deal with the dreams "in a Navajo way."

4) The couple decided to attack the problem of the dreams first. Their first decision to have a ceremonial done dovetailed with the need for the patient to await any spontaneous regression of the massively developed accessory breast tissue and her husband's layoff. (He was off work at the time, and the ceremony would require a week-long trip to the reservation.)

Discussion

This case is a classic example of the ghost illness process. The individual views the experience both as an assault and as a means of explaining the death wish and associated behavior. To the patient, the dreams were concrete evidence that she was going to die (actually, be killed). This was the reason for her quick association between reckless driving and the dream (literally, "he is making me do it"). She

was not assuming responsibility for the actions at any level; the problem was one of intrusion of an external force. The patient's view is in concert with that described by Kaplan and Johnson (1974).

In ghost sickness, the patient is a victim of the malevolence of others...we have speculated that, since in fact there is no ghost, the symptoms derive from the patient's own beliefs and attitudes. The social definition of the illness is that of an evil attack on the good. In the curing process, the community ranges itself on the side of the victim and musters its strength for his support. (p. 219)

According to Western theory, the ghost of the father was a projection of a death wish growing out of the patient's frustration with her accessory breasts, fear of surgery, post-partum depression, and anger at her husband. While the Western explanation psychologizes about the ghost experience, the Navajo explanation concretizes it. The ghost is real, an essential part of the etiology of the problem.

The patient had explained her fears about "going crazy" via discussion of her brother's behavior. Part of her perception of craziness had to do with being "out of control" and part had to do with "thinking about dying." Both were attributes that the family had ascribed to her brother at one time or another. At one point, her family blamed his drinking on marital discord and witchcraft. Although they had sought therapeutic help for him through traditional means (the traditional Navajo pollen way) and through the Native American Church, the brother's drinking had persisted. The family felt that her brother had no control over his behavior, and his behavior, like her own, had become destructive.

Historically, there was little room for "natural death" among the Navajo. Everyone was thought to die as the result of some malevolence, and the reference (except for death in old age which is sought for) was to being "killed." Psycholinguistically, the culture has given very little attention to the existence of death as a natural and inevitable event; one gets "killed," and the evidence for this recurs with such regularity among the Navajo that it helps to underscore the patient's views of the events described above. As a result, self-destructive behavior is not logically seen as self-destructive. The Navajo often view self-destructive behavior as the fault of someone else, or as the result of "being driven to it." The patient's view was not idiosyncratic. There was evidence of family agreement on this point; "He (the father) is driving you to it."

Her mother's response included the suggestion that she would assist the patient by arranging for a ceremonial, and a request that the patient return home to live and to help out. The patient reacted to these suggestions with ambiguity. She did not like either the pressure to return home or the uneasiness associated with not complying. Keep in mind that this mother suggested that the patient had some connection with the father's death. This suggestion may have sounded unusual to the reader. However, establishing blame for a death is not an uncommon circumstance among the Navajo. The mother's accusatory suggestion that a connection existed between the daughter's actions and the father's death is interesting from the point

of view of family dynamics. The author has observed the same accusation after the death of a parent in other clinical situations. The effect on the child is profound and frequently ties the child in a highly ambivalent fashion to the surviving parent.

The ceremonial provided a solution to the dream and established a compromise with the mother. Having made the decision to undertake the ceremonial, the couple verbalized a series of plans to handle their remaining difficulties. By Western psychologizing standards, the dreams and the patient's interpretation of them were clearly projections of her anxiety and depression. Her own view differed, the threat seemed all to real. Toward the end of an interview, the question was asked again with a slightly different approach: "What does your mother say is causing these troubles?" There was no hesitation; "She says my father is making me do it." Her mother had not focused on the patient's marital problems, financial troubles, being isolated in a mountain town, or the new baby. The patient's decision to focus on the ceremonial becomes all the more clear and reasonable when seen in this context. This initial step appeared to be necessary in order to remove the threat and to re-establish her role as an active mother and wife.

Case 2 - A Salish Woman with Ghost Illness

<u>Date of Onset</u>	<u>Problem List</u>
Summer/Fall 1976	1) Rheumatoid arthritis
Longstanding	2) Diabetes mellitus, insulin dependent
Longstanding	3) Obesity
1976	4) Positive tuberculin, treated with isoniazid (INH)
	a) Hepatitis related to INH therapy
Summer, 1976	5) Depression
Longstanding	6) Asymptomatic diverticulosis

This middle-aged woman was referred for the evaluation of diffuse arthritic complaints. Two and one-half months prior to her hospitalization, she had developed recurrent problems with early morning stiffness and aching of the proximal interphalangeal joints of her hands. She became progressively unable to care for herself during the six-week period immediately preceding hospitalization. She required assistance dressing, eating, and bathing. Two weeks prior to her admission, she became almost entirely dependent upon the help of others. Physical examination in a referring clinic did not explain the severity of her illness. Her laboratory evaluation had been negative. At the time of her admission to the hospital, she was a remarkably disabled woman; walked with a shuffle, shoulders forward, stooped over, and with her arms folded across her chest. Her evaluation in the hospital supported the referring clinic's view; there was a disparity between her laboratory evaluation and physical examination on the one hand, and her severely incapacitated state on the other.

The patient's history was unusual. She dated the onset of her illness to a specific date in the preceding fall, the morning after she experienced a visit by her deceased father. "I felt a bump against the bed and I thought, 'I wonder what my husband is doing on that side of the bed.' I felt the bump again, I opened my eyes and my father was standing there. He had on his tie, and looked the same as when we buried him..." The patient insisted that she was awake at the time, and stated that her father spoke and made her the special gift of a Salish spirit song.

A later part of the interview included an account of an associated episode which she felt may have contributed to her illness. She stated that her arthritis may have been caused by her failure to be properly "brushed off" after participating in a healing ceremony. This incident had occurred about three months prior to her admission, and the ceremony was being done for an individual who had multiple arthritic complaints. The patient hypothesized that the spirit that was causing the arthritic individual's illness had "come off" and somehow had been transferred to herself. (Brushing off healers and participants in healing practices is a common practice used by Salish groups. It is aimed at preventing dangerous spirits from sticking to others during and after the healing process.)

The patient had acted on the basis of her Salish beliefs and disparate Salish interpretations of her sickness. She had sought the assistance of different healers from a number of different Salish groups. Multiple attempts at dealing with her problems had been unsuccessful. At one point, she was treated during a service in the Indian Shaker Church. "They saw the spirit, and took it off me." However, the healer in charge of the service noted that the "whole church seemed to be rocking and upset," and because "he felt the spirit was too powerful, he put it back on me the next morning—I'm telling you that I never felt so bad as I did when that man put that thing back on me." At least two other medicine men had attempted to deal with her, and the therapy had failed. Subsequently, one of the medicine men suggested that she needed to see a Western physician because the illness was not responding. In an attempt to put the spiritual aspect of her illness into perspective, the patient described earlier illnesses of similar nature. "I've lost my soul a number of times." As an example, she reported becoming ill after the death of her father 18 months earlier. During his funeral she had an impulse to "jump in his grave," and two weeks later was "still feeling real bad." She was treated by a medicine man who "told me that I had lost my soul in the graveyard...that it had been standing out there in the rain and cold all that time." His therapy involved retrieving her soul. She then described a second episode of a "spirit sickness" and in doing so revealed a longer history of arthritic complaints. Six years earlier she had developed pains in her arms, shoulders, and neck for a period of three or four weeks following an episode in which she had inadvertently unearthed some snakes while clearing an area for a new home. "The spirits from those snakes wrapped around my arms and shoulder, and the medicine man had to take them off before I got better."

An Approach to Treatment

According to Salish tradition, dreams of the dead may portend illness or even death, or might indicate that the spirit has laid claim on the dreamer. The following suggestion was made to the patient: "Your story gives me the idea that you have been thinking of someone's death." She immediately replied, "I told my mother that if these symptoms don't clear by spring, I'd go with my father's spirit." The Salish ancestral religion demands respect and recognition of the dead by gifts and prayers (Amoss, 1978; Collins, 1980; Jilek, 1974). In circumstances in which someone believes that they are being made ill by a spirit, there is a perceived threat of soul loss, or even death.

In the 1950's, the Lummi...(Salish)...would still attribute chronic illness during Winter time to possession by a spirit demanding the patient to sing it song as a new dancer; all owners of spirit songs were assumed to become possessed in Winter and to suffer an illness treatable only by singing and dancing. (Jilek, 1974, p. 34)

Although the patient had already been a dancer, she was convinced of the need to "bring out" her father's song. Additionally, according to the Salish tradition, a spirit might bother one of the living because the spirit lacks something. A frequent interpretation is that the living have something that belongs to the dead, or that some goods are needed by the dead. This can be objectified and returned to the dead by way of a ceremonial burning. The patient denied that she might have something that belonged to her father. However, after initiation of discussions about her beliefs and concerns, she improved remarkably, became more mobile and active, and began to care for herself.

In addition, the patient and her mother had been discussing the need to have a memorial service for the father. The service was to be held near the second anniversary of his death, the period when the deceased father's spirit would cease wandering and become less of a threat to the living. The patient feared dying in the period before the anniversary of this death. Her interviews involved discussion of the memorial, family members' opinion about it, disagreements between herself and her siblings, and the relationships between the surviving family members. Eventually, she was given direct encouragement to complete the ceremonial. She then announced her plans to undertake the singing of her father's song, and to complete his memorial service. Prior to her discharge she asked if I would see her mother who, she said, had the same trouble. Her mother was hallucinating her father "all the time," and refused to believe that he was really gone.

During the months following discharge from the hospital, the patient's rheumatoid arthritis worsened, and the evolution of the arthritic changes revealed typical physical findings with the additional supportive laboratory evidence. Six weeks later, at a follow-up appointment, she had marked progression, with swelling of the synovium over the metacarpophalangeal joints becoming quite noticeable, increased weakness of her grip, etc. In contrast, her mental status had improved remarkably.

She had made a commitment to return to work. She was taking care of herself and her mother. Her appearance and activities suggested a remarkable reversal in her anxiety and morbid ideation.

Discussion

A number of issues seemed clear: (a) Choosing between competing, traditional explanations of her illness, the patient had interpreted the onset of her symptoms as a sign that she had been singled out by her father's spirit and that she, or someone else was threatened with imminent death. (b) The patient's problems with unresolved grief were shared with her mother, and both women came to the conclusion that someone was going to die. The daughter initially had feared her own death, and later both women came to the conclusion that it was an ill grandchild who was threatened. (c) Both were filled with anxiety, and had severe bereavement problems. (d) The daughter's grief reaction was likely exacerbated by the emergence of her rheumatoid arthritis.

The mother's denial of her husband's death made her reluctant to participate in the memorial service. The service would be an irrevocable sign and recognition that many decades of marriage had come to an end, and that her husband was indeed gone. The therapeutic suggestions were specifically designed to meet the circumstances. The patient was encouraged to sing her father's spirit song, to give something up, and to help with the ceremonial process. The mother was encouraged to participate in the memorial service. The service was successfully held two months later, and the patient participated with vigor in spite of severe problems with active rheumatoid arthritis.

Case 3 - A Hmong Refugee with Ghost Illness

<u>Date of Onset</u>	<u>Problem List</u>
September 1976	1) Headaches, sleep disorder
Longstanding	2) Amebiasis, hookworm
10/31/77	3) Miscarriage
1975	4) Refugee, monolingual

The patient is a 19-year old, monolingual Hmong woman. She was born in the north central highlands of Laos, schooled for a short period of time in a Catholic school, and fled Laos after her parents were killed. She immigrated to the United States from a Thai refugee camp when she was 17 years old and married a young Hmong refugee shortly after arriving in the United States. The two had met in Thailand.

The month following her immigration to the United States, she developed severe headaches which occurred one to three times per week, and occasionally lasted 24 to 48 hours. The headaches were predominantly left-sided, and were associated with nausea and occasional vomiting. She had often awakened with a headache, but

she had not experienced an aura, or visual symptoms. Neither aspirin nor prescribed medication had provided any relief. Her headaches seemed to respond only to sleep. She denied a past medical history of trauma, seizures, or other neurologic symptoms. She did recall a pattern of infrequent headaches dating from her early teens, headaches that occurred during times of stress.

Her recent efforts to sleep off the headaches had often caused her to stay home and miss her English classes. She had been seen acutely at least eight times in emergency rooms and clinics over a 15-month period. The physicians involved had recorded a variety of impressions of her problem: migraine, cluster headaches, and on "tension, acclimatization, and adjustment problems." Extensive neurologic evaluations had been unrevealing, and empirical therapy for tension headaches, migraine, and (later) cluster headaches had been unsuccessful.

In October, 1977, the patient had a miscarriage. Her headache pattern had persisted throughout her two months of pregnancy, and thereafter. She was re-evaluated for headaches in January of 1978 and part of the inquiry focused on her sleep patterns and dreams. She reported severely disturbed sleep and recurrent nightmares in which she saw her deceased parents: "She sees her mother and father...sometimes her father's face comes towards her...it comes right at her." She would awaken screaming and her husband reported that she often made references to death at these times: "Sometimes, she wakes up saying she's going to die." Referring to the dream and the father's image, the husband said, "She thinks he's going to take her with him...." She had been experiencing a similar dream pattern since the onset of the symptomatology. Severe headache episodes were always preceded by the dreams.

An Approach to Treatment

The nature of the dream was discussed in some detail. The patient's reaction to the dream—specifically, that her father was "coming after her...going to take her with him"—represents a universal interpretive option regarding such dreams. It is important to recognize that the patient's problems with her dreaming were not idiosyncratic. A night-long Hmong funerary prayer known as Sersai makes a direct reference to both illnesses caused by ghosts and the relationship between death and dreams. A translation of part of the prayer as used for a family that had lost their father is as follows:

"If you do not want to remain healthy and prosperous it does not matter, but if you want to you must give charity to your father by giving him three joss sticks, and three amounts of paper money... For years and years there has been no sickness. This year the sickness came this way and then come to this house... This year sickness came to the roof and came to the bedroom. The first time it came to the roof and later it came to our bodies. He did not want to die but *SI YONG* the ghost used *CHIJIER* to touch his heart. If he touches anybody with *CHIJIER*, that person must die..." (*CHIJIER* is a kind of illness which the Hmong believe belongs to *SI YONG*, the ghost.)

The old man had a nightmare last night. He dreamed that he trod on the ghost flower. He dreamed that he rode the ghost horse. He dreamed that he stepped in the grave...The old man did not want to die but the ghost up in the sky world blew the pipe. They blew it in the sky world and blew it along the way, and then blew it at the house of the old and then the soul of the old man went with the ghost and he died... (Chindarsi, 1978, p. 150)

Once again we find the theme of the dead calling for, or returning for the living. It had significant meaning for this patient. Interviews with the patient and her husband evolved as follows:

1. To begin with, the couple was encouraged to discuss the religious practices and beliefs of their parents and grandparents. This was a natural extension of an earlier discussion of details regarding the patient's origins, early experience, family members, etc. The parents on both sides had practiced ancestral worship and the discussion focused on what they "would have thought" about the dreams. The couple's response was clear: the dream meant that the wife was threatened. The couple insisted that they were not aware of a solution.

2. To the patient, the dreams represented a direct threat that within the context of Hmong beliefs, the spirit(s) needed to be neutralized (via gifts, prayers, by showing respect, and the like). For these reasons, a separate discussion was then undertaken; it focused on generalities regarding the ancestral aspects of celebrations and ceremonial meals, or gifts. The couple was given an example of a family who had prepared meals and gifts, and offered prayers to their ancestors during a time of trouble. It was not pointed out that these practices were often viewed as helpful to the participants, and that in the face of need, similar offerings and prayers could be undertaken any time of the year.

3. The couple protested, "We've heard about those things, but we don't believe them." "We're Catholic, we both went to Catholic school, and we don't know about those things..." (Their combined exposure to Catholicism had been less than 20 months.) In a concrete sense, being Catholic implied immunity to the patient's interpretations of the dreams and was viewed as an effort to avoid unpleasant, threatening explanations of the dreams. Additionally, their statements about their Catholic backgrounds were viewed as attempts to avoid being labeled as different. The discussion then focused on the difference between knowing about things and believing them. They both knew about the beliefs and the point was made that the wife's interpretations of the dreams were very similar to those she attributed to her parents and her grandmother.

4. The patient and her husband were encouraged to discuss the matter further with the family members and with some older Hmong people that they respected and trusted.

Diagnosis and Treatment in the Community

Initially, the couple approached an older brother of the patient. His initial reaction was similar to their own: he stated that "as a Catholic," he did not know enough to make a decision. All three decided to discuss the matter with an uncle, and thus

began to involve the entire family. Within 48 hours, a number of relatives and other Hmong refugees gathered, a meal was prepared along with gifts and prayers for the deceased relatives. A diagnosis had emerged: the family had decided that the patient's problems were due to failure to seek parental permission for her marriage. Since the husband's parents were also deceased and he had no relatives in the United States, the wife's family and other members of the Hmong community assumed primary responsibility for preparing the meal.

The patient and her husband were seen in a follow-up visit. They were delighted with the outcome; she had become cheerful, animated, and involved. She remained headache-free for a six-month period after the meal. After six months had passed, she developed a problem with anxiety associated with a second pregnancy. However, neither the dreams nor the headaches recurred. The patient did report a dream two weeks after the meal. She dreamed that she was visited by the deceased mother of her husband. The older woman made a sign of respect to the patient and voiced approval of both the patient and her marriage.

Discussion

A number of questions have been raised about this case. Does this illness have a unified etiology? Was there more to it than the dreams and associated meanings? Why insist on the term ghost illness? The patient had experienced multiple traumatic events and complicated changes, which included the experience of war, the killing of her parents, flight from Laos, refugee camps, immigration, marriage in the absence of family support, and an early miscarriage. The patient was isolated from the community at large by language, lack of knowledge of the society, and the like. Certainly these were all valid features of her problem, and they existed in the face of what appeared to be prior underlying problems with tension and occasional headaches whenever she was under pressure (evidenced by the problems she experienced in younger years). According to Western psychology, the sum of her difficulties could be viewed as creating high levels of anxiety and depression. A Western solution would focus on helping her explore and work out those difficulties. However, Hmong tradition lacks a similar formulation of this sort of problem; there is no Hmong term for anxiety or depression.

Therapeutically, the decision was made to separate out the concrete fears associated with the dream interpretation—literally, the perceived threat of death. The ceremonial therapy was aimed at the dreams. The more complex issues of the young woman's character and personality structure, and of her status as a monolingual parentless refugee and a newlywed with a recent miscarriage would remain. The patient's dream-related fears and associated ideation about dying may return, but they are likely to do so only in response to a new set of circumstances. Should ghost dreams recur, the meaning of her reaction to them will be partially dependent upon her circumstance at the time. In this case, the term "ghost illness" describes the traditional view of the cause and potential effect of the dreams. Discussion of

Southeast Asian traditions about the dead provided a specific means of communicating about the illness and associated fears. It also established a basis for a partial solution within the context of the beliefs involved.

The meal provided by relatives and the Hmong community neutralized the patient's dreams and dread. By participating, she dealt with her own and her husband's identity in a new, threatening, and difficult place. The therapeutic activity was undertaken with the full knowledge and support of a group and can be viewed as displacing a series of fears and concerns onto a process that had powerful meanings to the patient. In addition, the therapeutic process directly diminished her sense of isolation. The process mobilized the concern and acceptance of a small Hmong community. As in many other therapeutic actions, the patient was forced to make a decision regarding her beliefs—but that is not unusual.

The therapeutic role of the physician was undertaken without a detailed knowledge of Hmong beliefs; that is, without detailed knowledge of terminology, practices, and the like. As is evident from the history, the patient and extended family managed to fill in many of the gaps regarding a solution to the problem.

Ghost Illness and Human Experience and Beliefs

In order to place the previous three cases and the mythology of the ghost illness tradition in a broader perspective of human experience, this paper will next discuss the prevalence of the ghost illness phenomena. It will be linked to: (a) the epidemiology of human experience with death in family members, (b) the impulse to die during bereavement, and (c) beliefs regarding hallucinations, dreams, and recurrent thoughts of the dead.

Ghost illness is well known in many North American Indian groups. For instance, the Mohave have had a rich terminology for the problem that includes real ghost illness, ghost contamination, ghost alien diseases, and fore-ordained ghost disease (Devereau, 1969). By Mohave definition, illness may erupt from dreaming of dead family members, by direct contamination with the dead, by violation of funeral practice, by witchcraft killings, by contact with twins, and so on. The Mohave have attached ghost-related causes to a wide variety of somatic illnesses. (One must recall that the mind/body separation that exists in Western biomedical paradigms does not exist for many members of groups like the Mohave. The same applies to a large number of human groups, perhaps the majority.)

Similar beliefs are wide spread among American Indian groups, although there may be wide variation in specific rules and mythology. For example, there is anthropologic literature describing concern over interference by the dead in diverse groups such as the Sioux (Powers, 1986), Comanche (Jones, 1972), Tewa (Ortiz, 1969), Eskimo (Spencer, 1969), and Salish-speaking people (Amoss, 1978; Jilek, 1974). An active ancestral religion exists for the Salish tribes in the Northwest, forms the basis for current practices in their "Smoke House" tradition, and has been incorporated in syncretic fashion into their newer Indian Shaker religion. The dead are appeased by gifts and prayers, help may be sought from the dead, and lost or

stolen souls can be located. These practices have the capacity to help the living receive strength, power, and aid from the dead. They are also designed to protect believers from potential malevolence on the part of the dead.

Experience with the dead is broadly represented in the anthropologic literature. The dead may play a role in the religion, healing practices, and beliefs of Chinese (Ahern, 1973), Pacific Indian groups (Johnson, 1981; Sharp, 1982; Lazar, 1985), the Thai (Tambiah, 1980), African peoples (Bohannon, 1960) and in India (Kakar, 1982). One can find ceremonial means of dealing with alien spirits, ancestors, and animistic representatives of human spirits. The purposes of these ceremonial processes range from obtaining direct assistance, blessing, or protection from the dead, to obtaining advice on how to deal with or drive off a malignant spirit. Interestingly, ghosts have either served the needs of the living or harmed them in a uniquely human fashion. Illness, or even conflict between individuals, may be attributed to malevolent spirits (Shore, 1978). The view "that death is an end of consciousness and of the person's involvement with the world of the living" has been described as a Western "ethnocentric assumption," which is contrasted with the view of "some Melanesian people...(who)...assume that a ghost has consciousness, that it is aware of the effects of its death on its survivors and on mundane events, and that it is capable of contacting those who are still living" (Counts, 1984, p. 101-102).

Human Experience with Death in Family Members

The epidemiologic basis for reactions to a death and dying are brought into sharp focus by a number of striking studies of mortality among the immediate survivors of a death in the family. In 1969, Rees (1967) reported on the mortality of bereavement among 903 close relatives (widows and family members) in Wales. Over 12% of widowed individuals died within one year of losing a spouse. Widowers died at the rate of 19% and widows at the rate of 8.5%. Overall, these rates represented a seven-fold increase in death when the bereaved group were compared with a matched control group from the same community. There was additional evidence that the remainder of the family was also at increased risk (primarily siblings and children).

In another study of 4,486 widowers in England (Young & Wallis, 1963), mortality was found to exceed that of a control group by 40% in the first six months of bereavement. Helzing and Szklo (1982), suggested that only male widows were at increased risk, and found that broad statistical analysis of a widowed group of 4,302 persons failed to support increased risk during the period of bereavement. In contrast to this finding, Karrio, Koskenvuo, and Rita (1987), did a prospective study of 95,647 widowed persons in Finland, and found striking increases in risk during the first year of widowhood. Additionally, high mortality rates among the widowed were clearly demonstrated in statistics based on all deaths in the United States between 1949 and 1951. Kraus and Lilienfeld (1959), demonstrated that death rates for widowed individuals ranged from 4 times greater to more than 10 times the rates in married individuals of the same age. Remarkably, this study showed that widowed individuals are at increased risk from a wide variety of diseases. These

included tuberculosis, vascular lesions of the central nervous system, heart disease, arteriosclerotic disease, hypertension with heart disease, as well as accidents and suicide.

An excess mortality rate extends beyond the first year of loss, and the figures begin to provide a real basis for the widespread human dread of the death of another human. Mythology, religion, and popular ideas regarding death focus on the notion that one death may follow another. These myths and beliefs codify actual human experience. Assuming that similar patterns have held over the centuries, actual survivor experience of increased risk has provided a direct basis for the dread of death of another. The survivors sense the threat, which at times is coupled with their own impulse to die.

The Impulse to Die During Bereavement

The impulse to die at the time of another's death is symbolically and concretely represented by the Hindu practice of Suttee, in which a widow would throw herself on the funeral pyre of her husband. Whether one views Suttee as an individual impulse or a sociocultural expectation secondary to the pressure of others, the outcome is the same. If the act of Suttee is solely secondary to group pressures, customs, and enforceable expectations, then the widow becomes a scapegoat for the group.

The suicide impulse of bereavement provides an additional tie between the dead and survivors of the experience. Referring again to the study by Kraus and Lilienfeld (1959), they proposed three hypotheses to explain the high frequency of death among the surviving widowed individuals. The first two hypotheses deal with the notion that marriage mates may select individuals with comparable high-risk illness and inabilities, or may be mutually exposed to environmental or infectious factors which lead to early death. The third hypothesis deals with the issues of "grief, the new worries and responsibilities, alterations in the diet, work regime...frequently reduced economic condition," and the like.

Human emotions are strongly tied to experience within the family and community. In cross-cultural clinical settings, one may find patients who have had direct experience with preparations for burial, sewing clothing from the deceased, choosing burial goods, digging the grave, burial of the dead, and even the washing of ancestral bones for reburial (Ahern, 1973; Collins, 1980). In this regard, death in many societies and families provokes a level of direct personal involvement that may not be true for Westernized people. There is nothing to suggest that the practice of burying one's own dead is necessarily good or bad for the survivors. The point is that different practices and beliefs dictate different perceptions of death as a reality. In addition, some individuals and groups have a higher frequency of experience with death in immediate family members. Our experience with American Indian patients, for instance, shows a remarkable incidence of direct and frequently recent experience with death. The experiences necessarily mold the individuals' reactions and thoughts when threatened by illness or adverse life events.

Hallucinations and Dreams of the Dead

Patients may report or experience dreams or hallucinations of the dead during a state of physiologic and/or psychologic disruption. The emergence of troubles from a variety of sources may provoke concern over death. This is especially true in patients with disrupted family process, anxiety states, or depression. The process may also arise with any circumstance that gives rise to aggressive and/or destructive impulses, even impulses towards self-destruction.

Dreams of the dead may be associated with a variety of reactions on the part of the dreamer, although the patient may not explain the event by the kind of formulas used by modern psychology. It is important to recall that the dreams are often viewed as real events, real in the sense that the ghost or the spirit is real. The commonly-shared belief that dreams portend trouble leads to a sense of dread on the part of the dreamer or the dreamer's family. Dreams of the dead are associated with a high frequency of sleep disruption and may provide direct evidence of anxiety and/or depressive patterns. For these reasons, it is essential to obtain sleep histories and dream patterns from patients who cultures have historic involvement with ancestral beliefs. The clinician should recognize that such dreams of death or the dead may be equivalent to seeing the dead in a waking state. Four points must be made in this regard.

First, the patient may describe a waking experience as a dream and attribute it to a non-waking state. This is often done to avoid the sequelae of appearing to be unbalanced, insane, or even dangerous. (Anyone who reports seeing the dead in a waking state is likely to be avoided by others and may be regarded as unusual, dangerous, or even psychotic. This is a universal phenomena except in those groups that have formally sanctioned the activity by making it an expectation).

Second, the patients often project their own dread of hallucination (or dream) to the listener and may withhold or alter the description of the experience. This is often explained in terms of "not wanting to put a burden on someone else."

Third, many societies, especially those that have not developed or depended upon a written language, have paid extensive attention to dreaming, and to the important implication dreams hold for the living. Individuals from these societies must be dealt with in a fashion that takes their dreaming patterns into accounts, especially as their dreams may help to explain their own explanations of disrupted health or life patterns.

Fourth, patients from backgrounds that include extensive magical-religious beliefs and/or lack a written language, may sense that dreams are causative. That is, they may believe that speaking about dreams may literally cause trouble.

In 1971, Rees reported on the "hallucinations of widowhood." He interviewed 293 widowed individuals in a Welsh community and inquired about visual, tactile, or auditory hallucinations of the dead. He included those experiences he termed "illusions (sense of presence)" of the dead spouse. Of the 293 people interviewed, he reported that 137 (49.7%) had post-bereavement hallucinations. Many of these hallucinations lasted for years; at the time of interview, 106 people (36.1%) still had hallucinations. It is important to recognize that Rees did not include experiences

reported to have occurred at night, or on retiring in the evening; for the purposes of his study, Rees regarded all these instances as dreams, not hallucination. In addition, he did not count instances in which individuals reported an experience and then rationalized about it, for example, saying they had seen the deceased in "their mind's eye."

In Rees' study, the incidence of post-bereavement hallucinations increased with the duration of marriage, tended to disappear with time, were relatively common occurrences, and generally remained a secret which the survivor had not previously revealed to a professional. The information remained a "folk" issue. Although 33% of the women, and 12% of the men had disclosed their experiences to others, none had reported them to a physician, and only one person out of 137 had spoken with a member of the clergy regarding the experience. Rees felt that most of his patients were helped by the experiences and that the hallucinations served a useful purpose.

Rees felt he lacked evidence that religious beliefs played a role in the frequency of these experiences. The majority of his subjects were Christians of either Anglican or Welsh Methodist denominations, and 49% denied a religious affiliation. Rees' findings are not unique to individuals of Celtic descent. In 1958, Marris reported interviews with 72 widows in Southeastern London and found that 50% had experienced hallucinations or illusions of the dead spouse. Additionally, in 1969, Yamamoto and colleagues reported interviews with 20 widows in Tokyo and found that 90% of them reported feeling the presence of the dead spouse.

Note that none of the cited reports involved investigation of situations in which the hallucinations or dreams appeared to be playing a role in the individual's state of health. They do, however, establish the existence of human experience with hallucinatory phenomena after bereavement. The first case in this paper illustrated a relationship between ghost dreams and suicidal ideation. Similar dreams, ruminations and hallucination of the dead have been reported to the author in suicidal American Indian patients, survivors of suicide in Alaska Native families, and by unsuccessful suicides. For all of these reasons, assessments of mental status in American Indian patients should take interactions with the dead (dreams, ruminations, and hallucinations) into careful account.

To the Western mind, waking hallucinations of the dead, seeing, hearing, talking to, being touched by, or sensing the presence of the dead, are considered projections of the living individual who reports the experience. It is important to recognize that this Western tradition is not shared on a universal basis. Patient views and reactions to experiences with the dead must be assessed with great care, since either the individual's explanation or explanations provided by his culture may be in discord with a view based on Western psychology. In clinical settings, these experiences most often involve deceased relatives or friends, and less frequently someone whose identity is not clear.

Summary

There is no cross-cultural normal or abnormal set to which one can refer when dreams and hallucinations of the dead occur. One must judge hallucinations and dreams of the dead in the context of an individual's life history and circumstances. Patients may present these experiences as being protective, comforting, or threatening. Clinical findings parallel Spiro's (1953) description of the multiple human attributes of ghosts. Presentations which indicate pathology or difficulties for the patient are highly varied.

It is not necessary for a dream or hallucination to fill the patient with dread. For example, a professed sense of comfort and ease regarding auditory hallucinatory experiences with a deceased son were presented by an Irish woman. She refused to change her residence because she feared she would lose contact with him. She stated that if she moved, her son would no longer be able to find and communicate with her. Her family felt that the experiences represented her excuse for refusing to deal with the need to change residences. An Eskimo patient reported that hunting dreams involving his deceased brother indicated that a good hunting season lay before him. He was simultaneously excited and anxious to report this knowledge. In my view, the dreams represented evidence of the patient's return to a positive outlook after a long illness and successful surgery. Prior to surgery he had experienced dreams of the dead which had filled him with dread (Putsch, in press). Terminally ill patients may report comforting dreams of the dead in preparation for their own demise.

The tradition of ghost illness reminds us that the interpretation of illness is dependent upon belief systems. Any illness can provoke concerns over loss and death, and may result in the patient having an interaction with the dead. When patients with special beliefs interface with Western medicine, failure to take their beliefs and concerns into account may lead to an inability to either understand or resolve a significant clinical problem. Accommodation to disparate beliefs often requires that solutions fit the context of the patient's beliefs system and simultaneously deal with both the Western and non-Western traditions.

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THE FEARS OF NAVAJO CHILDREN: ADAPTATION OR PATHOLOGY?

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ABSTRACT. Past and current literature concerning the fears of children generally and Navajo children specifically is examined in the perspective of current research and in-depth interviews. The position is taken that high fear frequencies in Navajo children may not be *prima facie* evidence of pathology, but rather evidence of a cultural pattern that has important adaptive value.

The Anglo-Saxon heritage, which venerates fearlessness, supports the traditional clinical view that predisposes us to regard fears as generally undesirable behavior and potentially pathological. This view stands in sharp contrast to the view of fear held by the Navajo. The Navajo view was described by Kluckhohn and Leighton (1956): "When one first studies Navajo belief and practice, he thinks more than once that the Eskimo's description of their religion—'we do not believe, we fear'—would be appropriate for the Navajo as well."

At times the clinical view is no doubt correct. However, if certain behaviors such as fear are often concomitants of serious personality disturbance, this correlational fact does not establish the criteria for determining when fears should be regarded as pathological symptoms, neurotic traits, or *prima facie* evidence that something has gone awry psychologically. Furthermore, it is possible that what appears to be psychologically maladaptive may in fact have important adjustment advantages within the context of a given culture. What role does culture play in establishing the milieu that gives existential meaning to such fears?

The Western Clinical Approach

A review of the Western psychological literature dealing with fears and phobias reveals that they have ordinarily either been examined in light of a variety of learning models, such as operant and classical conditioning, or viewed psychoanalytically, as representing ego processes such as anxiety and defense. But—and this is the important point—in all these studies, high fear frequencies are considered, *a priori*, as a sign of pathology, and what is determined to be a rational or an irrational fear is established on the basis of clinical criteria and without consideration of cultural variables.

An implicit assumption in the clinical approach has been that if we somehow determine the statistical mean of the fears extant, then significant statistical deviation from that mean represents pathology. A corollary assumption holds that the fewer the fears, the healthier the personality. The bias is clearly in favor of fearlessness.

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Anthropological Views of Fear

The anthropological literature, on the other hand, has predicated its research on a relativistic position which emphasizes the vital role played by culture in determining the fear frequencies of given groups of people. In this research, culture is also regarded as determining the various meanings of fears. This literature, in effect, argues that fears and taboos may represent "a sociology of danger" (Steiner, 1956). That is, they prescribe behaviors which are appropriate in potentially dangerous contexts. Thus, fear derives its meaning from the perceptual view of members of a given culture.

One of the most provocative, early anthropological studies challenging ethnocentric Anglo-Saxon views of fear was R.L. Fortune's (1932) studies of the Dobuan people. Fortune's work portrays a culture in which fear is the all-pervasive theme. Darkness, food grown by others, the possession of property: almost everything is the occasion for fear. Every woman believes her husband a sorcerer and every husband believes his wife a witch. For a Dobuan not to be riddled with fear is culturally atypical, or if you will, abnormal.

A later study by Evans-Pritchard (1937) described similar patterns of apprehension in the Azande, and Kluckhohn and Leighton (1956) examined the pervasive belief in witchcraft among the Navajo. Such anthropological studies of cultures with particularly high fear levels should perhaps have given clinicians reason to question their use of exclusively psychological models in interpreting fears. Furthermore, there was early empirical evidence indicating cultural patterns in the fears of children which apparently has not been incorporated into our clinical thinking.

In a cross-cultural psychological study using the Emotional Response Test, Havighurst and Neugarten (1955) noted that Midwestern children cited "objective danger" more frequently than children from the American Southwest. The study also found that Southwestern children were inclined to attribute two sources of their fears: the supernatural and objective reality. Certainly here was empirical evidence, slight though it was, of cultural patterning; however, for better than 25 years there are no indications in the literature of further attempts to empirically and cross-culturally examine the issue. In fact, those familiar with Navajo ethnography wondered why Havighurst and Neugarten did not find more dramatic differences.

A Study of Fear in Navajo Children

In a recent study comparing third grade Navajo children with third grade Anglo children, Tikalsky and Wallace (in press) used the Louisville Fear Survey for Children (LFSC) and employed factor analytic and chi-square techniques. They determined that Navajo children had higher fear frequencies on 49 out of 60 items on the LFSC. There were also factor analytic suggestions that the structure of Navajo fears differed from Anglo fears. In reviewing the pronounced differences in fear frequencies found in this as opposed to the Havighurst and Neugarten (1955) study, one must speculate on the reasons for such discrepancies. A unique feature of the Tikalsky-Wallace study is that it utilized a Navajo interviewer (as opposed

to an Anglo interviewer) and focused on children with relatively traditional backgrounds. Perhaps certain fears are acknowledged only when one is being interviewed by a person who shares your culture.

In wake of the factor analytic study of Navajo fear responses on the Louisville Fear Survey for Children, a series of in-depth interviews were conducted with the Navajo parents of one of the subjects. The parents reported relatively high fear responses for their third-grade daughter (31 out of 60 items). The purposes of these interviews, which involved the assistance of a Navajo interpreter, were to determine parental attitudes toward their daughter's fear responses, and to gain insight into the parent's views of fear as well.

It should be emphasized that the parents interviewed represent traditional Navajo backgrounds. Both parents speak Navajo, and preferred to speak Navajo at home. While relatively fluent in English, they were by no means facile. The parents live with their daughter in a hogan located in a relatively isolated part of the reservation near hogans of six other families who comprise their extended family. Neither parent graduated from high school.

Neither parent demonstrated concern about the fears which they attributed to their daughter. When asked to account for the multiple fears they checked on the LFSC, they observed proudly, "She is a good child and wants to do things right." Questioned about how they would feel if the number of fears were diminished, they specifically indicated that this was a matter of little importance unless "something of importance was forgotten." They then went on to affirm that nothing was wrong with their daughter and proudly produced her report card which, in fact, indicated excellent school progress.

They also noted that not to know what to fear is to be vulnerable to great difficulty at the worst and—at a minimum—to disturb the harmony that is so important to the Navajo.

Several questions were raised with the parents to gain a clinical impression of the child's emotional status. No signs of gross pathology were found; however, many indications of a variety of fears were noted.

Were the Navajo parents engaging in denial? Or should we consider cultural variables when attempting to understand the fears of children of Navajo and other cultures? Should an attempt be made to discover what pragmatic, cultural function a child's fear may serve?

Implications for Clinicians

Kluckhohn (1944) argues that Navajo witchcraft (which encompasses many fear patterns) has an important adaptive function for the Navajo. He also understood that the Navajo believe that witchcraft is a means of achieving power as well as maintaining harmony. Any student of Navajo culture understands the importance of power and harmony for traditional Navajo people.

Bulow (1953) in a study of Navajo taboos argues that "taboos are prescriptions of proper behavior in dangerous or potentially dangerous situations." In a position very similar to Kluckhohn's, Bulow argues for the important adaptive value of fear for the Navajo. Thus, there is an obvious need for the clinician to comprehend the whole of Navajo culture if fear behavior patterns are to be understood.

How deeply rooted are these patterns? Chisholm (1983) suggests that adaptations made by the Navajo several hundred years ago could have etiological/genetic effects today!

In my work as a psychologist on the Navajo reservation, I have learned that clinical decisions are often reached without consideration of ethnographic perspective. Such decisions can be seriously awry due to the ethnocentric biases of the clinician.

Both current and past anthropological and psychological studies offer support to Linton's (1945) admonition:

Until the psychologist knows what the norms of behavior imposed by a particular society are and can discount them as indicators of personality, he will be unable to penetrate behind the facade of social conformity and cultural uniformity to reach the authentic individual.

It very well may be that attempts to eliminate some fears of Navajo children is an attempt to deprive them of a mechanism that has adaptive value. Further study is obviously necessary.

Summary

Traditional views of fear may not be appropriate when attempting to understand the fears of Navajo children. A review of the literature, a recent cross-culture study and in-depth interviews with Navajo informants reveals ethnocentric bias both in traditional psychological approaches to the study of fear, and in clinical decisions determining when fear responses are to be considered abnormal.

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UNRESOLVED GRIEF AND MOURNING IN NAVAJO WOMEN

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ABSTRACT. Grief and mourning are normal psychological processes in response to loss. They are the means whereby individuals psychologically let go and free themselves from the bonds of attachment to others. Although characteristic stages and phases of this process can be discerned, there is considerable cultural patterning and shaping of this experience. Case examples are given of Navajo women who experience spontaneous dreams and hallucinations of lost loved ones as an expression of their unresolved grief and mourning.

Introduction

In the history and tradition of Western medicine and psychiatry, grief and mourning have been used to describe the psychological process normally experienced by individuals who suffer an emotionally significant loss. It is understood that typically these processes are most completely manifested under circumstances where an individual has experienced the loss by death of an emotionally important person such as a close friend or relative.

Freud (1915/1955) in his paper entitled "Mourning and Melancholia" wrote:

Mourning is regularly the reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one such as one's country, liberty, an ideal, and so on. In some people the same influences produce melancholia instead of mourning and we consequently suspect them of a pathological disposition. It is also well worth notice that although mourning involves grave departures from the normal attitude to life, it never occurs to us to regard it as a pathological condition and to refer it to medical treatment. We rely on its being overcome after a certain lapse of time, and we look upon any interference with it as useless or even harmful. (pp. 243-244)

Later in that paper Freud describes the work of grief and mourning as consisting of the emotionally powerful and painful processes of withdrawing attachments from a "loved object" which "reality-testing has shown ... no longer exists."

At the same time loss, grief, and mourning are an essential and universal human experience. Every culture's religious and healing tradition must deal in some way with these processes. To some extent each culturally distinct group of people identifies itself through how it copes with the fact of death in its eschatological practices and how it provides pathways of support for the living survivors. Cultural patterning and shaping of the grief and mourning experience appear to have as their

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objective the normal, healthy adaptation and liberation of the mourner. Yet in any culture these processes can go awry and one might expect there to be a cultural prescription for diagnosing and treating pathological outcomes.

So it is not surprising to discover in the rich history and tradition of Navajo culture and medicine a complex system of rites, rituals, and ceremonial practices dealing with the experience of loss, grief and mourning. Beauty Way, Hand-Trembling Way and Blessing Way chants encourage and facilitate normal grief and protect against pathological outcomes (Sandners, 1979, pp. 41-78). Begay (1988) describes how *Nidah* or Enemy Way (Squaw Dance) chant and Evil Way (Ghost Way) treat disturbed and/or unresolved mourning.

Grief and Mourning as Processes

In every culture the psychological processes of grief and mourning provide the means whereby the living survivors work through the loss of a "loved object." Across cultures these processes appear to follow a regular sequence.

Many writers have described the processes of grief and mourning. Psychiatrist, George Engel (1961), in a paper entitled "Is Grief a Disease?", defined grief as:

the characteristic response to the loss of a valued object, be it a loved person, a cherished possession, a job, status, home, country, an ideal, a part of the body, etc. Uncomplicated grief runs a consistent course, modified mainly by the abruptness of the loss, the nature of the preparation for the event, and the significance for the survivor of the lost object. Generally, it includes an initial phase of shock and disbelief, in which the sufferer attempts to deny the loss and insulate himself against the shock of the reality. This is followed by a stage of developing awareness of the loss, marked by the painful affects of sadness, guilt, shame, helplessness, or hopelessness; by crying, by a sense of loss and emptiness; by anorexia, sleep disturbance, sometimes somatic symptoms of pain or other discomfort, loss of interest in one's usual activities and associates, impairment of work performance, etc. Finally, there is a prolonged phase of restitution and recovery during which the work of mourning is carried on, the trauma of the loss is overcome and a state of health and well-being re-established. (pp. 18-19)

Many psychiatrists have made efforts to define the sequence and patterning of grief in order to better understand it. Bowlby (1961) defines grief as "the sequence of subjective states immediately following an irretrievable loss," and he distinguishes mourning as "the psychological process set in motion by an irretrievable loss leading to the relinquishment of the object." Hence, "shock and disbelief" as well as "disorganization and painful affects" are more the propriety of grief; while the whole process including restitution and reorganization is essential to satisfactory mourning.

Pollock (1961) gives emphases to the "adaptive" and "liberating" aspects of the grief and mourning experience. He agrees that the process regularly occurs in successive phases and stages. The initial stage of shock, the grief reaction and the work of mourning lead to a necessary liberation of the "energies of cathexis" for new

attachments. Pollock gives emphasis to the notion of growth through loss and adversity. Bereavement comes to an end when the loss is assimilated and the meaningful aspects of that attachment are entrusted to memory.

Dreams and hallucinations of the dead in association with grief and mourning experience have been reported by other writers. Matchett (1972) noted repeated hallucinatory experiences as a part of the mourning process in Hopi women. He described Hopi women as inviting images of their lost loved ones on themselves through a kind of spontaneous self induced trance state in the twilight of the evening. Shen (1986) reported similar phenomena and suggested that perhaps this was a normal characteristic for Hopi grief and mourning. Apparently, Hopi hallucinations do not seem to have the same ominous pathological connotations that they have for Navajos. Finally, Rees (1971) drawing from a large sample of widows, reports hallucinations of images of their dead husbands as part of their normal mourning experience.

Disturbed grief and unresolved mourning occur when the bereaved person is unable to complete this process. Many ways of failing the completion of this process and getting stuck are imaginable. A full account of the aberrations and pathologies associated with these processes is beyond the scope of this paper; however, the case examples presented should be illustrative.

Navajo Cultural Context

The *Dineh*, as Navajo people call themselves, inhabit the arid lands of northeastern Arizona, southeastern Utah, and northwestern New Mexico living on a reservation of about 25,000 square miles. They number about 135,000 people making them the largest tribal group of American Indians. The traditional economy of the culture was based on raising sheep and this continues to be the main stay of wealth. Although known for their silversmithing and rug weaving these traditions do not apply in every family so remain a supplemental source of income for some. Families live in close-knit matrilineal, matrilocal group encampments referred to as "camps" usually at some distance from one another and often at considerable distance from any town.

Contemporary Navajo families do not live the "leisurely and relaxed" life described by Vogt and Kluckhohn (1951) for the 1940s. Evidence of poor housing with lack of running water and electricity persist; yet, it is not uncommon to see hogan, house trailer and television satellite antenna juxtaposed. Family life styles follow suit blending past and present in uncertain harmony. Even Navajo language in common use is pidgined and punctuated with English words and references.

Formally leadership is centralized in the Navajo tribal offices at Window Rock, Arizona but rurally in remote camps leadership remains situational. Tribal elders and traditional medicine men continue to receive the respect and esteem of the people as they are sought out for counsel and healing.

Traditional Navajo religious and medical practices are complex and seem to resist Anglo efforts to understand them. Even so, the extensive work by Kluckhohn and Leighton (1946), Haile (1943), Reichard (1950), and Sandner (1979) give us a basis

for understanding the “Beauty Way” principle of the individual living in harmony and balance with nature. Illnesses arise out of disruption of these patterns of harmonic balance. Natural and supernatural forces can cause disharmony and thereby cause illness. Natural phenomena like lightning and ill winds; as well as skinwalkers, witch people and ghosts are believed pathogenic.

Traditionally, the loss by death of a close relative was perceived as a dangerous time. As Kluckhohn and Leighton (1946, p. 185) pointed out “the intense and morbid avoidance of the dead and everything connected with them rest upon fears of ghosts”. Traditionally, it was believed that most of the dead may return as ghosts, to the burial place or former dwelling especially if the deceased was not buried properly. Leighton and Kluckhohn (1948, p. 91) add the fact that ghosts were believed to be “especially malevolent toward their own relatives.”

Miller and Schoenfeld (1973) in their paper “Grief in the Navajo: Psychodynamics and Culture” describe the Navajo patterning of grief and mourning as follows:

The accepted pattern of mourning limits grieving to a period of four days. During the time of discussion of the lost members is allowed and expression of feeling condoned. However, even during this time excessive show of emotion is not looked upon favorably by the community. Following the four-day period the mourner is expected to resume his usual routine with no further expression of emotion concerning the loss. Involved in this restriction is the fear of the power of the dead person. (p. 188)

Case Examples

Case No. 1

Mrs. RC was a 28-year-old married Navajo mother of two children who was brought to the hospital emergency room by her family because of acutely agitated, wildly out of control behavior, threatening suicide. The family gave the history that she and the family had been on vacation in the mountains near Ouray, Colorado and had stopped at one of the scenic overlooks. RC’s 10-year-old daughter had been playing and climbing out on the rock overhang there when she accidentally slipped and fell 200 feet to her death. RC reacted immediately with outcries of protestation and calling out to her daughter. Family had to restrain her as she made efforts to throw herself over the precipice struggling to join with her daughter in death.

Initially in the hospital she responded to mild sedation and slept for an extended period seemingly exhausted. For the first several days in the hospital she remained withdrawn, awakening at intervals only to stare off as if in a trance. As she was invited to talk about her background she described having spent the summer with her family in the mountains in her mother’s “sheep camp.” This outing had been her first time off the reservation in several months. As she became more comfortable talking, she was able to talk about the accident and her daughter’s death. She expressed her grief in convulsions of tears and expressions of longing and sadness.

In several interviews she talked about vivid dreams in which her daughter would appear lonely and in need of comfort. Less disturbing to her were apparitional visitations, i.e., visual hallucinations, in which her daughter would appear at her bedside reaching out for her hand. RC felt ambivalent about her dreams and hallucinations both wishing for them but fearing them at the same time.

Family showed less ambivalence about RC's reports of these experiences and when the idea of traditional Navajo treatment was explored, her husband offered that he had already consulted a "hand-trembler" known to his family and an Enemy Way sing of Squaw Dance had been recommended. As he said that this would be expensive and take some time to arrange he was told to take her to another "singer" for a Blessing Way to protect her until the other could be done. She was sent out of the hospital on pass for the Blessing Way which left her feeling quite relieved. She was discharged from the hospital and seen on an outpatient basis for four follow-up psychotherapy visits past the time of her Enemy Way "Nidah" ceremony which she talked about as having brought her great relief and comfort.

Case No. 2

Mrs. BB was a 50-year-old widowed Navajo woman who came to the office because of disturbing dreams about her deceased husband who had been drinking in Gallup, New Mexico when he was hit and killed "run over" by a train. Although she had a high school education and a good job with the Bureau of Indian Affairs (BIA), she was disturbed by what she claimed were her mother's and grandmother's ideas that she was being bothered by her husband's ghost. She acknowledged that she had trouble sleeping and sometimes felt a vague sense of his presence. Initially she decided to see a psychiatrist as she had felt reluctant and a little frightened to go "Navajo Way" as her rural traditional family was insisting. By her second and third sessions of psychotherapy she had started antidepressant medication and she was opening up to further invitation to think about what she was experiencing the way her mother and grandmother would.

BB talked about how she had begun to experience ghostly apparitional visits sitting in her home in the evening but that the medicine had helped her sleep so that hallucinations went away during the night. In psychotherapy she reviewed in detail her understanding of the gruesome accident and the care that the family had taken to make sure that his body was prepared "Navajo Way" including clothes rented, rings placed on index finger, turquoise and four sacred plants in the casket. In spite of all of this precaution she was still troubled. After the third session she consulted a "star-gazer" who diagnosed the problem saying that a piece of her husband's skull bone with hair and blood would be found at the scene of the accident and needed to be buried properly with him. Also she needed an Enemy Way ceremony which was provided for her by her family. She was continued in psychotherapy supportively and on medication until four sessions after her Squaw Dance.

Case No. 3

Miss NB was a 24-year-old single Navajo woman who came into an alcohol and drug treatment center stating that she was thinking of killing herself since she had been drinking to considerable excess since the death of her mother five months before. She had a near fatal accident while driving under the influence just the week before her first clinic visit.

NB was invited to talk about her background which she described as rural and traditional. She had been raised the next to the youngest girl of eight children. As she had been born with a congenital hip disorder, she and her mother had been especially close throughout her growing up years. In the BIA boarding school she had done especially well compensating for her obvious physical difficulty. She had gotten a good secretarial job in the BIA offices and her family had been proud of her success. She would drive many miles to visit them nearly every weekend. She had not abused alcohol to any extent before mother's death.

In about May some five months previously she described having driven up to her mother's sheep camp in the mountains. As she was out herding sheep with her mother and sisters, lightning had struck and killed her mother instantly. NB described herself as having been left stunned and horribly frightened. She remained with her family for the usual weekend period only and then returned to her job as usual leaving the funeral arrangements and the traditional arrangements for treatment of the sheep herd and family members in a "Male Shooting Way Chant" ceremony. Although she attended the funeral she reported having experienced sadness but no tears. She stubbornly refused to attend any traditional "Navajo Way" ceremonies and returned to her job.

At home alone she began experiencing insomnia with disturbing dreams vividly imaging mother. She started drinking in an effort to sleep better; then her life lost meaningful pattern. She started messing up on the job, quit eating and cared less about her appearance. She had been suicidal at the time of her roll over accident.

NB was anxious to talk and very responsive to psychotherapy. She quit drinking and accepted appropriate vitamins and antidepressant medication. She got back on track with her job and she was encouraged to reapproach her family. The family insisted that she have the appropriate ceremonies in order; Male Shooting Way, Blessing Way and finally Evil Way (Ghost Way). She continued in psychotherapy throughout and she was maintained on medications. Interestingly, toward the end of therapy after her ceremonies she reported healthy pleasurable dreams again including one involving her mother in the afterlife taking care of and raising a child whom she had imagined to be the female fetus she had aborted some years before.

Discussion

Each of the three women in these case examples experienced profound loss in the death of someone to whom they were deeply, meaningfully attached. Each of them lost loved ones suddenly in freak accidents over which they had no control.

In retrospect, RC's reaction was the most natural, normal and unconflicted. She had no hesitation or embarrassment about availing herself of both medical systems—White Anglo doctor/hospital and traditional Navajo medicine man/chantway. BB struggled in conflict over who to see and what to do seemingly caught between the two cultures. With some respectful nudging and coaxing, she too made use of both systems. Finally, NB was most conflicted about allowing herself any expression of her grief at all, not wanting to deal with the fact of her mother's death. Not until her own near death experience in a roll over accident in a car did she become willing to get any help from either system. In the end, NB was able to bridge successfully back and forth between the two cultures and the two healing traditions getting something of what she needed from each one.

Although the kind of "bridging" or "coupling" across cultural context and medical traditions can be very useful, it also can be touchy and temperamental. Respect for the patient's ego defenses, as well as the therapist's empathy, interest, patience, and concern for the well being of the patient in his/her family context are essential threads in the weave of any transcultural theory effect. Conscious, deliberate listening and pacing with the patient's process, and attention to his/her interdependent, interpersonal world are equally important.

Finally, in discussion of these cases, taking them in reverse order, one is reminded of what Pollock (1961) has suggested. That is, NB in losing her mother lost her past; BB in losing her husband lost her present; and RC in losing her daughter lost a part of her future. All three women were traumatized and all had manifestations of pathological mourning.

Summary

Few experiences in the human life cycle approach the richness, intensity, depth and complexity of grief and mourning. Mind, body (heart), and spirit (soul) react and respond voluntarily and involuntarily in simultaneous interplay. Culture shapes and patterns this weave of the fabric of grief and mourning.

Navajo culture allows for the bereaved's experience of significant dreams and hallucinations of the deceased person. Even though these experiences in cultural context may harbingers "ghost attacks" or "ghost illness" they may announce to hallucinophobic culture's such as our own another dimension of the full range of grief and mourning experience. Perhaps all clinicians would serve their bereaved patients better in asking them about such experience. Dreams of the dead and all varieties of hallucinatory experience may be more in the realm of variation than deviation when it comes to grief and mourning experience.

In the cultural wisdom of traditional Navajo medicine, a Navajo medicine man has been quoted as saying:

In the old days
Everything spoke to the Dineh (the people)
The rocks, the grass, the trees—
They all taught us
But nowadays
The Dineh have gotten so busy
That the rocks, the grass and
the trees don't speak anymore
Or maybe the people
have just forgotten how
to listen

When it comes to grief and mourning, therapists need to learn how to listen with open minds and open hearts to the full range of human experience which constitute the grief and mourning processes.

Clinical experience teaches that significant dreams and all kinds of hallucinations are ubiquitous in the normal grief/mourning spectrum. Culture shapes and patterns these processes and interprets and judges significant aspects of the individual's experience. The intensity, frequency and affective response to dreams and hallucinations seems to lead to a determination as to whether these experiences are deemed "normal" or "pathological" in a given cultural context.

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A CONSIDERATION OF CONSTITUTIONAL FACTORS IN AGGRESSIVITY

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Let me clarify the relationship of my professional background to work with the Indian Tribe discussed in this paper and with its members.¹ I am a physician, with some specialized training in human biology, and am committed to the theory and practice of psychoanalysis. For the past six years I have been full-time in the Department of Psychiatry, at the University of Colorado School of Medicine. In addition to my teaching responsibilities, I have been doing research in many aspects of human behavior, working with many disciplines and methods as the occasions required. With respect to the subject matter of this paper and the field from which it comes, I believe that I must say that I am not an anthropologist. This is so despite the fact that the discipline of anthropology might claim this material as closest to the concerns of that discipline.

The story of my involvement with the Indian Tribe which is the subject of this paper is as follows. When the Tribal Council sought help from the University of Colorado School of Medicine their emissary, Dr. John Jones, applied to the Department of Preventive Medicine.² Dr. Jones, who had the confidence of the Tribal Council, presented their chief complaint, "there is a sickness in the people and they are dying out." Dr. Jones knew these Indians very well, for he had been a Public Health Officer of the area that contained their Reservation. Moreover, he had conducted health surveys of the Tribe and was very well informed about the incidence of selected diseases among it. It should be pointed out that the chief complaint reported by Dr. Jones was in reality contrary to his knowledge of them. However, because he appeared on their behalf, he expressed the Indians' ideas first and then later gave his own invaluable account. The Acting Chairman of the Department of Preventive Medicine, after having established that the chief complaint did not indicate an epidemic and that, in fact, the population of this Tribe was increasing, suggested to Dr. Jones that he consult the Division of Psychosomatic Medicine of which I was then in charge. After a preliminary exploration of the situation I accepted an invitation from the Tribal Council to do what I could.

It should be emphasized that my own personal relationship to the Tribe was influenced by two major factors. First, I was invited for a particular purpose. It is apparent that this circumstance is strategically different from the investigative situation of the anthropologist. The latter, as a rule, is obliged to impose his presence on the people to be studied. Secondly, I was a "medicine man" whose influence was in tangible medicines and procedures. The name given to the White physician clearly distinguished him from the Indian medicine man.

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It took me over two years to understand what their use of the term “sickness” meant and to interpret the hidden meaning of their notion that they were dying out. In a sense, I could say that this understanding of sickness and interpretation of dying out are the thesis of this paper. My initial effort to establish a somatic reference for this “sickness” was unsuccessful. The Indians seemed to talk in terms of psychological and behavioral allusions rather than in terms of medical or physiological complaints. There were references to alcoholism, “bad feelings inside,” apathy, negligence of family, apparent loss of self-interest, and irreplaceable losses of property, machinery, and other personal possessions.

I shall not go into detail about my arrangements with the Tribal Council or of the evolution of my methods of working with this Tribe, nor will I have time to discuss the techniques that were developed to solve many of the problems of communication, interpretation, analysis, and data reduction.

I quickly recognized in the behavior of various members of the Tribal Council that my description of history taking and of diagnostic study aroused a great deal of anxiety. They reacted with frank uneasiness and displayed moderately sadistic humor.³ Their joking and teasing of each other seemed to be based on the notion that each person would be intruded upon, his innermost secrets exposed, and that somehow he would be helpless and no longer able to protect himself. Because it seemed that they worried about shame and exposure, I declared that my relationship to the Indians would be that of a physician to his patient and that what transpired between the patient and his physician is a secret and available to no one without the permission of the patient. Moreover, because I also would regard the Tribe as a whole as a patient, I would keep all tribal knowledge a secret until the Tribal Council had authorized me to report my findings. Incidentally, this authorization was given to me about a year ago after four years of work. This approach was effective, for as I learned later exposure and shame were two of the most unpleasant affects this Tribe could experience and, secondly, the Tribe had mixed feelings about being the subject of another academic study.

An interesting example of this reaction to shame and exposure occurred when the Indians, under the guidance of interested White people, set up a “Workshop on Alcoholism” to which was invited a panel of experts. An impasse was reached when it became apparent the Indians would not present any case histories to the panel, for the Indian in question would be immediately recognized and thereby shamed and exposed. This occurred despite the fact that all the tribal people knew who the alcoholic Indians were anyway. Behind this apparent inconsistency is the Indian’s hypersensitive concern with intraspecific hostility and gossip. The further significance of this will be discussed later in another context.⁴

A preliminary evaluation of their medical and psychiatric problems, with the assistance of Dr. Jones, disclosed the following.

1. A multiphasic health survey had unexpectedly revealed an exceptionally high incidence of hypertension, diabetes mellitus, obesity, and malnutrition.⁵

2. A high infant mortality existed, apparently out of proportion to the utilization of the very good available medical care. These Indians have access, through Blue Cross and Blue Shield, to the same physicians and hospitals used by the non-Indian people. In addition, the United States Public Health Service and their facilities were available to them.

3. A high incidence of violent death and injury due to accidents was noted among these Indians under the age of 50. Alcohol, automobiles, and the use of mechanized, combustible, or explosive equipment were prominent contributing factors. It should be pointed out that while it is true that alcohol interferes with judgment and the kind of physical coordination necessary for the handling of vehicles and other machines, these conditions are not necessarily the explanation for violent accidents.

4. There was tension and often conflict with segments of the surrounding non-Indian community whose members tended to regard this Tribe as delinquent, shiftless, and alcoholic.

5. There was alcoholism of varying degrees. The leaders of the Tribal Council were concerned primarily with that type of drunkenness which interfered with the individual's ability to work, care for his family and himself, and which antagonized the non-Indian community. It is of considerable interest, however, that the Indians within their own value system were not critical of each other's drinking for these reasons. It should be emphasized that the Tribal Council was using standards to which they, as individuals, did not subscribe. Many of them, while not alcoholics in the clinical sense, were on occasion involved in escapades while drunk.

6. There was an alleged inability or disinclination of this Tribe as a whole to develop into farmers, ranchers, mechanics, technicians, and professionals in proportion to the resources and facilities available to them. This Tribe now has a great deal of money which had come to them through a successful land claim suit, and as royalties from oil and other minerals on their Reservation. The Tribe had developed an outstanding rehabilitation program which intended to use their tribal resources to help their own people to adapt to the new conditions. This program, however, has highlighted the fact that within their culture there exists a certain lack of work incentive or work ethic.

From the point of view of assessing the importance of aggression, in the dynamics of the present life situation of this Tribe, it is essential to reconstruct its manifestations during pre-reservation days. This is not easy to do for many reasons. Prominent among these reasons is the highly slanted nature of literature about this Tribe. The earliest references go back to the 16th Century when Spanish priests from Mexico sought to traverse the Rocky Mountains. The accounts emphasize the Tribe's gluttony, greed, black skins, animal-like subhuman traits along with their lack of response to efforts to convert them. I have corresponded with many Catholic scholars who maintain the files, catalogues, and indexes of all available writings and reports by the exploring priests. This includes the Vatican collection as well. Although my inquiries were primarily concerned with this Tribe's language, the amount of verified information is notably small. These Indians very quickly came into bitter conflict with transcontinental travelers, trappers, miners, ranchers and

farmers. The accounts of these struggles stress the Tribes' savagery, cruelty, and indifference to agreements. These reports on the Tribe were greatly influenced by the interests of the reporters. The Tribe, collectively and individually, do not know their own history. As a matter of fact, their language does not contain a term for the abstraction of history or background.⁶

They are not remarkable for any indigenous arts and crafts. Such work as they turned out was obviously derivative and not elaborated along any lines that could be designated as this particular Tribe.⁷ Collections of their folk tales, myths and legends are meager but revealing (Kroeber, 1901; Lowie, 1924). They are obviously influenced by other Indian tribes and by non-Indians. The identifiable extraneous elements are over-determined in their selection, thus revealing the attitudes of this Tribe to certain other Indian tribes and above all to their White conquerors. This material is exceedingly rich in the varieties and examples of aggression and in the expectations of pain and pleasure, that is, the value placed on these instinctual aims and objects.

The reconstruction of the past, therefore, is a complex based on (a) admittedly selected and often biased historical material, (b) an analysis of their reported folk tales and myths according to methods comparable to those of Kluckhohn, Roheim, Devereux, MacGregor, Posinsky, and others,⁸ and (c) an analysis of the data of the current manifest behavior of the Tribe and its children, adolescents, and adults.

The information on the Tribe and individual members was obtained in the following ways.

1. Interviews with Bureau of Indian Affairs (BIA) personnel, Public Health Service officials, and with an unselected group of older White people who had lived closely with the Tribe all their lives; and with school and law personnel.
2. Review of Agency and Public Health Service files, and Superintendent reports, etc.⁹
3. Interviews of the oldest members of the Tribe on the Reservation using bilingual Indian interpreters.¹⁰ These talks sought to cover early recollections and experiences.
4. Interviews with tribal leaders concerning the problems of the tribe as seen by them, family trees of tribal members, individual Indians or families who needed medical care or who were in difficulty with the law, schools and other social agencies.
5. Study of reservation life in a free-floating manner by living on the Reservation during the summers and at various times during the year.
6. By serving as a physician in the tribal clinics where I examined many Indians, took medical and developmental histories, learned much of their Indian language; learned about the theories and practices of the medicine man and the Indian pharmacopeia; learned about their fantasies of the body anatomy and function (e.g., pregnancy and birth; heard their dreams, descriptions of affects, tribal and personal secrets, their attitudes towards property, money, and White man's values, their interpersonal relationships and family life).¹¹
7. By serving as a screening and referring physician for the Indians. I arranged for their admission to the Colorado General and Psychiatric Hospitals where they

would stay for several weeks to several months. This made it possible to conduct a variety of physiological studies as well as psychological tests. These hospitalized Indians would be seen by residents and by me. The hospitalized Indians provided a unique opportunity for information. I was the only person known to them and I was a link to the Reservation, the means to their well-being and to the gratification of their needs.

8. Examination of the children of this Tribe by an experienced child psychologist along with direct observation of their behavior on the Reservation.

This information made it possible to construct many hypotheses about the continuation in the present of the apparently forgotten ways of the past. It will become apparent later in this paper that the basic concepts of the past can be identified in disguised and distorted forms in the new context of the present. This feature accounts for much of the so-called maladaptive, pathological, and inflexible behavior of many of this Tribe of Indians.

Before the advent of the horse in the Tribe's life early during the 18th Century, it is probable that the smallest possible groups of the Tribe moved about on foot in an incessant search for food. They were subject to the economic truism of nomadic food-gatherers that the smaller the groups the less territory to be covered in order to obtain food, and the less depletion of food resources there would be in the territory as a whole. At the same time, however, they had to be large enough to defend themselves and their source of supplies. This made for highly ambivalent relationships with neighboring family groups and with members within a given family group. The rivalry and envy inherent in a struggle for survival under these circumstances was tempered by the constant awareness of recurrent needs for mutual defense against invading Indian groups. The development of a kinship system (matrilocal and matrilineal) helped to provide the necessary equilibrium between these almost mutually exclusive attitudes towards individual and group needs.

The fusion of a kinship system, (i.e., of a different order of libidinal components with the economic, aggressive, and more archaic pregenital libidinal system) raises an interesting question. The culturalists, of necessity, would seek to emphasize the economic and environmental issues in this question and possibly concede the libidinal factors were secondary in time and importance. It is justified, however, to point out that the so-called economic and environmentally determined behavior of the nomadic family is mobilized around pregenital drives.

Hunting, raiding, and defensive fighting characterized the direct expression of this Tribe's aggressivity. Most, if not all, of this seemed related to the control of their land and the securing of game. It appeared to be of no matter whether food was obtained in the hunt, or by raiding other Indian tribes, or as a share in the successful kill and food gatherings of the same tribe. The folk tales reveal manifest aggression between men and women, not on genital levels but because of failures to provide food, shelter, and protection for each other. Women are frequently represented as depriving, inconstant, traitorous, and at times physically destructive.

The reservation life created many problems, none of which were predicted or recognized. To begin with, the reservations and the groupings of the Indians on them did not correspond to the reservation tribal kinship and band groupings. Over

a period of time, the kinship lines became hazy and in most instances beyond recall. The biogenetic implications of this condition for "inbreeding" will be discussed later. Secondly, the system of tribal leadership which was pragmatically based on hunting, raiding, and fighting prowess failed by default on the reservation. The values for such traditional leadership simply did not exist in reservation life. There were sporadic rebellions, some of which were called massacres. Leaders sprang up and Indians spontaneously grouped around them. Leadership, in terms of the values of the conquerors, apparently never developed despite encouragement and even bribes as it is suggested. When the Indians did negotiate and complete a treaty with the Whites, tribal backing was related to the profits of the deal and not to a concept of loyalty to their representative or of an ethical code.¹²

It was apparently believed that the Indians would follow the historical destiny of conquered peoples, namely, identification with the victors. History, however, contains many examples of what has happened when such identification did not occur. The conquered peoples and their nation were exterminated.

It is obvious that this "join them if you can't beat them" outlook tends to operate as a massive homogenizer of peoples and their ways. The rise and fall of empires, for example, tends to provide one of the ecological settings in which the biological and psychological unity of many can develop. In several centers of the Western Hemisphere, notably, Central and South America, this process has been proceeding independently of the same course in the Eastern Hemisphere. It should be emphasized, however, that whatever biological and psychological homogeneities come to be established in the two hemispheres, they need not necessarily be the same. When it is considered that the two geographical groups have had more or less independent development over thousands of years, such a hypothesis gains some support. This isolation, incidentally, is relative; for there is no reason to suppose that only one migration of Indians had occurred, or that prehistoric contact with the Eastern Hemisphere had not taken place from time to time.

American Indians have not identified with their conquerors. The American people, depending on regional and national conditions, have had markedly ambivalent and inconsistent attitudes towards the American aborigines. These have consisted of attempts at ruthless extermination, reactive and overdetermined benevolence and idealization with playful imitation of Indian ways in nature, concerted efforts to transform the Indian into a middle-class American Christian while urging them to retain their Indian culture.

It would be an oversimplification to attribute this failure to identify to the stubborn reaction of a defeated and oppressed minority. Three arguments should be considered in this connection. One is that not all Indian groups in the Western Hemisphere have the same historical and subsequent political relations with the White man as the Indians of the United States. Practically all of the latter have treaties with the United States which represent solutions to conflicts over land, rights of various kinds, and other economic issues. In Bolivia, Ecuador, and Peru the Indians of the Andes are not in the minority and neither acculturation and certainly not assimilation have occurred.¹³ In British Columbia, along the Pacific Coast and the inland rivers, the Indians were not in the same pattern of economic

conflict with the Whites as the Indians of the United States. Warfare did not occur and I have been told by the Commissioner of Indian Affairs for the State of British Columbia that treaties with these Indians do not exist. Here too, the Indians collectively and individually are sharply differentiated from the White people. The second argument is based on the observation that Indians appear to identify with each other and to assimilate each other's culture when brought together by proximity, conquest, or forced migration, such as by the United States. Third, the African Negro, following his forced transplantation to the United States as a slave and, despite his status as an oppressed minority, did identify with the American White culture. In this connection, it is of interest to ask why it was necessary to obtain slaves from Africa when there was a huge aboriginal reservoir on this continent. The history of slavery among the Indians is complicated by the fact the Indians readily enslaved each other according to the formula of victors and losers. The social and economic role of the slave depended upon the social and economic organization of the enslaving tribe, as well as upon the distinctions between a slave, a prisoner, and an adoptee. One thing is clear, however, despite attempts by the White people to enslave Indians, this practice was never securely established.

On the Reservation, the direct expression of aggression by the Tribe was entirely stifled by ruthless supervision and the attitudes of settlers around the Reservation. There was no consideration of the consequences of suppressed aggression, although the descriptions of Indian aggressive and sadistic behavior were well documented. These were regarded as ethical problems and were dealt with accordingly by political and moralistic measures. This behavior was not phenomenologically evaluated as possibly having determinants outside of so-called free will. A hunting economy, moreover, very rapidly became impossible, partly because the Indians were more or less restricted to their Reservation which did not contain enough territory to support their population band because game and other food supplies were markedly decreased by the activities of miners, ranchers, farmers, and the general opening of the west by land allotments. Furthermore, hunting and raiding by the Tribe were rarely ends in themselves but were regarded primarily as means of gaining food and other necessary supplies. This Tribe would accept without conflict other methods of obtaining these. Within the framework of their food gathering economy, they would seek the easiest means to their ends. Because the Tribe never became self-sufficient in this externally transformed life and environment, it was necessary for the Government to provide rations in accordance with treaty agreements. This, plus what the Tribe would provide for itself, became the basis of their marginal existence until recently when ironically enough, the rocky crust of the irresidual Reservation turned out to cover vast mineral wealth.¹⁴

Their material and physical needs are now more than amply met, although their attitudes toward choices of nutrition, homes and sanitation arouse concern among Public Health Service and other professionals on these matters. They have small, lower middle-class homes with electricity, new automobiles, pick-up trucks, radios, television, good clothes, and an elaborate race track.¹⁵ The Reservation looks prosperous although there are no signs of livelihood activity. They do not appear to treasure the material goods they can now purchase, for their obsolescence rate

exceeds even that which was built into these goods. They do not invest their income nor do they accumulate it in the form of capital or savings. The Indian is typically "penniless" although there are some striking individual exceptions.

Despite all these various changes in their circumstances, there still persists inflexible personal and social pathology that are the instinctual derivatives of aggression. In short, the problem of their aggression still remains to be accounted for. What are the origins and determinants of this aggression? What are its characteristics and intensities? What are the defenses and transformations in the present tribal life situation? And, finally, what is there about the Tribe's aggression that causes it to override the external controls that appear effectively to regulate non-Indian aggressivity? Freud (1930/1961; 1950) proposes that repression is the precondition both for civilization and for its cost, namely, mental disease.

To explore the question of origin, we have to consider the factors that would tend to predispose to an intensification of innate characteristics. Further, we must look for those environmental conditions which the innate factors would seek out selectively and, in the interaction, become reinforced. With regard to the innate factors, the highly competitive hunting, nomadic food-gathering economy undoubtedly came to place a very high premium upon manifest aggressiveness both in the man and in the woman.¹⁶ The traits derived from this instinctual aggression would make for successful hunting and the defense of resources. Under these circumstances, such characterological features (i.e., properties of the ego) would function as an essential intrapsychic guarantee of survival by facilitating the discharge of this aggression. In this case, does the pleasure principle prevail and as a consequence, the overriding effect of complementary innate instinctual and ego factors become decisive for a nomadic, hunting and food-gathering economy? Can ethological concepts be applied in the sense that the gestalt of instinctual intensity and facilitating defense mechanisms will seek that environment and way of life that will provide maximum optimal releaser and discharge stimuli?¹⁷

The extent to which such generic aggressive drive fused with specific ego mechanisms can be inherited is, of course, unknown as far as humans are concerned. The study of the inheritance of behavior in man is much too new for the availability of laws and principles that can be applied to the questions raised in this paper. The behavioral traits associated with certain congenital diseases are not necessarily pertinent, for the bodily disease exerts both psychic and organic influences. The detailed study of twins has great promise despite the immense number of factors to be controlled by what amounts to a community of investigators. The epidemiological studies are inconclusive, primarily because of inadequate phenomenologic, taxonomic and etiologic formulations of mental disease. Moreover, most populations are not genetically stable enough to be used as a controlled variable. Freud, in his psychoanalytic methodology, offers a strategic advance over the uncertainties of the epidemiological approach. To begin with, he provides theories and operational hypotheses about the forms and functions of the mental apparatus that are constitutional and inherited, as well as their lines of development in the sense of Anna Freud. We are given a framework, partly metapsychological and partly biological, built out of instinct and libido theories and the structural design

of the ego in psychogenetic, species and ontogenetic terms. That these principles applied to society and to biogenesis are used only by analogy is not a valid criticism, first because psychoanalysis does not claim these propositions as validated homologies and unities. It derives these principles from the study of individuals and leaves it to the research of other disciplines to deal with them. Moreover, we must recognize that the relationship of psychoanalysis to the prehistory of man and to anthropology is only partly due to the larger category of a "science of man." The present state of this relationship is mostly due to Freud's particular personal interest in the origins of man and of his ways.

Freud stressed the role of constitutional elements in his model of the mental apparatus and in the concept of "complementary series" in the etiology of mental disease. The constitutional factors of a given intensity would interact with genetic and environmental factors. The resultant would be the form and content of health or disease and their stability. Psychoanalytic technique would discover that which was modifiable and therefore more likely less constitutional, and that which was not modifiable and therefore more likely to be more constitutional. It should be pointed out that in this so-called "therapeutic test" Freud concerned himself with psychoanalysis as science of man and not with psychoanalysts as more or less knowledgeable practitioners. Freud further hypothesized that inasmuch as instincts originated in hypothetical tissue states, it would be possible to influence instinctual behavior by specific manipulations of the tissue states. Psychoanalysis cannot instigate these biogenetic or metabolic tissue states and cannot point them out. It must rely on the new findings of biology, as Freud did in his time. The growing knowledge of the ego and of its biological origins greatly complicates the application of the concept of "complementary series." We are obliged to analyze the ego as a resultant of its own inherited design interacting with psychogenetic experience and with constitutional instinctual intensities.

The difficulties in such an investigation are due to the fact that we do not have genetic "behavioral markers" equivalent to such somatic markers as color-blindness and hemophilia. Neither do psychoanalysts work with individuals of sufficient genetic homogeneity (except twins) to differentiate biogenetic from psychogenetic. Finally, psychoanalysts cannot set up experiments in which a comparatively homogeneous population can be reared in two environments, each offering significantly different psychogenetic influences.¹⁸

We know a great deal about how instinctual drives are influenced by psychogenetic, developmental and environmental factors. We cannot make adequate quantitative correlations except in relative terms. The experimental evidence from animal breeding and from ethological research supports the hypothesis of the inheritance of behavior based on aggressive drives.

The other factors to be considered are the value systems which influenced the choice of mates among this Tribe. Kinship processes, while ethnographically important, are not immediately pertinent. The elders among this Tribe, interviewed by me, stressed the importance of the mate as a hunter and provider. Hence, the way

of life was not only an expression of aggressivity, but was both a determinant of and determined by the process of natural selection. In short, there was a complementary biogenetic reinforcement of aggression.

Up to this point, I have stressed the biogenetic or genotypical factors in aggressive drives and a few adaptive or phenotypical circumstances that entered into the process of natural selection.

There is an additional and notable psychogenetic reinforcement of aggressive drives, namely, child-rearing practices among these Indians. In the nomadic, food-gathering economy, at least among this Tribe, the birth of a child is not the highly sentimentalized, idealized occasion that it has become in our sessile food-producing economy of plenty. It is no secret, however, that our own birth rates and child care practices are quantitatively affected by the changes and state of our economy. These are dramatically documented and illustrated during the post-war periods of many European countries. Children were abandoned by families and by society. As the economy recovered, so did responsible attitudes toward children. To the food-gatherer, the birth of a child meant that the vigorous, self-sufficient food-gathering activities of the mother are decreased. Moreover, mobility, a necessity for survival, becomes limited partly by her own temporary post-partum state, but mostly because of the need to transport the infant, feed it, and in general be concerned about its welfare. It is conceivable during a period of drought for example, when game and vegetation would be scarce, the birth of the child would be a calamity. There are many allusions in legends, folk stories and interestingly enough, in dreams, to the effect that in hard times or abandonment by a mate, infanticide and cannibalism would be practiced.

In any event, under favorable economic circumstances, the child would be encouraged to be on its own as soon as possible. The chances are that this early self-sufficiency would occur somewhat after 18 months of age, when the child's toddling ability would be well established. Many of these Indians still practice cradling. In this connection, the effect of cradling—a controversial subject—is to be considered.¹⁹ With the development of some degree of self-motivated mobility, the child comes to lose its one-to-one relationship with its biological mother. The mother withdraws from the child to resume her food-gathering and sexual activities. Such separation at the libidinal phase of development, theoretically present between 18 and 24 months of age, would act as a fixation point. The genetic effect would be the enhancement of those traits that undoubtedly characterized the successful hunting, raiding, nomadic tribal Indian. The biologically, socially, and otherwise comprehensively weaned child tended to become somewhat more related to the less physically and sexually active grandmother or to an older, maternal aunt. By and large, however, the child belonged to the group and apparently maintained a nominal relationship to a family for kinship reasons. It might be suspected that although the child was not treated punitively or with active hostility or rejection (unless he was a twin), he was certainly not given many demonstrations of affection. The child in effect, has almost complete license. The absence of restriction and punishment and the apparent extreme tolerance has been interpreted as a child's paradise provided by loving, all-accepting parents. It would appear from the present

picture that this empathic sentimental view is not quite realistic. The underlying attitude to the child was indifference, colored by the reluctance to commit intraspecific aggression.

In brief, we can hypothesize that the libidinal fixations of these child-rearing practices tended to reinforce the natural selection factors of aggression and aggressivity. The direct and manifest expression of this fixation would be on anal sadomasochistic levels. Under the regressive influence of suppression of the manifestations of such anal instincts, we would predict the character traits of oral sadomasochism, possibly a safer adaptation to reservation existence. Today, on the Reservation, this Tribe continues what amounts to the same attitude toward their children. Children are rather casually regarded. The Agency people and those tribal Indians who are welfare-minded spend a good deal of their time rescuing children from their parents, finding foster homes for them, or remonstrating with or threatening the indifferent or negligent parents. The White man's moral and ethical commitment to a child is not characteristic of this culture in the past, and is certainly not yet characteristic of their culture on the Reservation. It is as though the child were regarded as a homunculus—that is to say, the equivalent in every way of an adult, albeit a tiny one. Consequently, it is often difficult to get parents of the Tribe to give their legal consent for various medical procedures and psychological examinations that are indicated for the child. This Tribe's parent, more often than not, takes the position that it is for the child to decide and not the parent.

The competition for food and survival in the nomadic days, together with the developmental fixations, tended to foster envy, gluttony, aggressiveness, aloofness, withdrawn behavior, absence of personal tenderness and sympathy, in short, disinterest in group activity apart from the satisfaction of these highly narcissistic traits. To a very large extent, this personality structure persists on the Reservation in varying degrees of disguise. These Indians quite typically do not help each other out, are not inclined to become involved in group activities, except for defensive purposes, and certain religious ceremonies, such as the Sun Dance. They are quick to see momentary advantages of others as favoritism or as their deprivation. The trust funds of children are under frequent assault by the parents who find it difficult to understand the concept that the child is entitled to the same economic security as the parent with his present per capita payment. The average tribal Indian on this Reservation still is not a rancher or a farmer, or capable of competitive economic self-sufficiency in our culture. He does not use a concept of capital and future returns. He is preoccupied with the here and now. His language does not even contain the terms that would make it possible to explain another economy to him. They, however, do understand the food producing economy, but still take the attitude of the food-gatherers. This is not a moral or ethical position—it is the persistence of an anachronistic mode of adaptation. Whether it is a constitutional or biological necessity remains to be seen.²⁰

These Indians regard a sum of money the way his recent pre-reservation forebears regarded a fat antelope or buffalo. It was to be consumed as rapidly as possible. He

is apparently no more inclined to use the reproductive ability of money than he was to use the analogous capacity of the animals he hunted. Even today, ranching and sheep herding must be subsidized or it would be a total loss. The Tribe is enthusiastic about owning race horses, mostly because of the anachronistic prestige that many horses meant a successful hunter and raider, but also partly because of their passion for gambling.²¹

The Tribal Council and associated committees make up the executive, judiciary, and legislative institutions of the Tribe. This is a system that the United States Government installed about 30 years ago to encourage experience in democracy. The various members, however, are concerned about their functions during office hours almost exclusively. Outside of that time, they withdraw into themselves, are difficult to find, and are relatively indistinguishable from the other tribal members.

Under the conditions of reservation life their aggressions may not be directly expressed and consequently we see several individual and some corresponding group pathological solutions. One is regression, and here we note the tendency to gluttony, alcoholism, and obesity so characteristic of these people. Secondly, there is the overt indifference to feces and dirt.²² Thirdly, under the stress of self-imposed inhibition of manifest aggressivity, we see the psychosomatic problems of obesity, diabetes, and hypertension. In the psychological sphere we see the seclusiveness, asocial behavior, indifference to the welfare of the fellow tribal member, hidden reliance on magic and ritual, accident proneness and self-destructive behavior.

Suicide and homicide occur under remarkable circumstances. This Tribe, despite all of its withdrawn behavior, indifference to other members and conflicted aggressivity, finds it almost impossible to commit intraspecific homicide.²³

Diabetes and hypertension are model diseases for the demonstration of psychogenetic and biogenetic factors. Both have psychosomatic etiological hypotheses based on aggression. As far as this Tribe is concerned, another contributing factor to the diabetes and hypertension, in addition to psychosomatic and possible endocrine pathology, is based on the very high incidence of consanguinity among these people. Reservation life has created two conditions that favors consanguinity. First, it impaired or destroyed the tribal marriage and kinship customs. Second, the population decreased rapidly from what may have been as high as 10,000 to possibly 1,500 or 2,000. Under the circumstances of a reduced population, the destruction of a method for avoidance of consanguinous marriages and some opposition to exogamic marriages, consanguinity in varying degrees became inevitable. We have documented this by detailed family trees of members of two of these Indian Tribes. It is well known that diseases such as hypertension and diabetes can follow certain inherited patterns that will influence both their incidence and severity. These Indians appear to have an excessive incidence of congenital disease. Those which I have begun to follow are musculoskeletal, such as congenital hips and muscular dystrophy. I have family histories of marked incidence of hypertension often associated with other congenital anomalies. The effect of this inbreeding on behavioral traits among these Indians remains to be evaluated. One might expect that the problems of aggression would be intensified, a hypothesis that is impressionistically confirmed by White "old timers" and

interestingly enough by the older Indians, many of whom are in their 80s. The reliability of these informants is suspect for many reasons, not the least being envy and resentment over the affluence and tribal influence of the younger tribal adults.

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Notes

1. Thirty or more years ago, as an undergraduate at Columbia University, I attended lectures in Anthropology by Franz Boas and Ruth Benedict. At that time, these eminent anthropologists and teachers left me with a clear concept of the field of anthropology and of the work of an anthropologist. Since then the immense changes in the subject matter of anthropology and in the techniques used by anthropologists have left me far less confident about these concepts today. Nevertheless, according to academic conventions, I am not an anthropologist, despite the fact that anthropology is developing more and more subspecialties many of which are closely related to my own professional experience and interests. I have in mind such subspecialties as genetic anthropology and blood-group studies, biochemical anthropology and endocrine profiles, psychological anthropology and the culture-personality controversy, prehistoric anthropology and the origins and evolution of man, to mention but a few. As a rule, these subspecialties evolved as a consequence of advances in scientific disciplines other than anthropology. They provided new concepts and tools, and were used by anthropologists to attack an awesome array of unsolved problems.

In addition to this changing technology of anthropology there has also been a transformation in the subject matter and in the anthropologist's relation to it. I think it is fair to say that it is an exceptional situation today when an anthropologist can study a truly aboriginal people; that is, the groups in society investigated by anthropologists are complex biological, psychological and cultural mixtures of aboriginal ways and the ways of our own culture.

These developments in technology and changing subject matter have blurred the boundaries between anthropologists and other behavioral scientists. More and more anthropologists must either be competent in two or more disciplines, or work with collaborators whose methodology he may not understand as indeed they may not understand his. When a multidiscipline team approach is used it is often difficult to decide on truly professional grounds which representative of what discipline should be the responsible investigator. In any event, the workers from the disciplines are obliged to struggle against tendencies to overestimate the weight of their data and contributions in comparison with those of other team members. The late Professor Clyde Kluckhohn, who was invaluable as a consultant and a resource person both to this project and to me, emphasized that the problem of the interaction of culture, personality and psychology fell to the anthropologist mostly by default. The anthropologist is not sufficiently prepared by training and experience to apply the theories and practices of clinical psychology including psychoanalysis and clinical psychiatry.

2. In 1956, when this Indian Project of the University of Colorado School of Medicine was begun, Dr. Jones was Medical Director of a Health Unit. Without his perceptive guidance and excellent relationship with these people, it is doubtful whether this project would have gotten under way.

3. Sadistic, ironic, sarcastic, and contemptuous remarks often make up the point of jokes, repartee, or the style of banter. The safe "bleeding off" of aggression in the sense of Freud's "Psychopathology of Everyday Life" can be illustrated by the following two anecdotes. The river in the valley which contained the Indian reservation, began to flood. The waters were rising rapidly and began to move into the areas where many Indian families were living. I offered to make our large 4-wheel drive Army vehicle available for any assistance or rescues that might have to be made. The tribal leaders who responded said that the Indians would take care of themselves. As we watched the rising, flooding river, I asked one tribal leader about his estimate of the speed of the rushing water. He said,

"I could throw you in and we would both find out." On another occasion, after a conference in which I attempted to explain how the old ways of the Tribe's people were hidden in the very problems that the Tribal Council had asked me to study, there was a good deal of pleasure amongst several of the Indian participants over recognizing the points that I had made. One of the Indians, with whom I have a very good relationship kept looking at me with that attitude and expressive silence which indicated that he was searching for words with which to say something. When I asked him what he was thinking about he finally said in his tribal language, "I would like to have you for a trophy." This remark was in part a compliment and a sign of esteem despite the obvious personal disadvantage to me in being converted to a trophy. It meant that I had "power" which this Indian would concretistically or magically acquire by possessing a material part of me, such as my scalp. The relationship of this mixed libidinal and aggressive gratification to pregenital instincts and to the defense mechanisms of incorporation and introjection is worthy of note.

4. These Indians feel ashamed when talked about by others. For example, he may be told that he thinks he is too good, or too important, or too rich, to be like the rest of his tribe. He may learn that his behavior means to White people that he is stupid, helpless, a drunkard, a fool, etc. These statements may all be true of a given individual, but they become shameful only upon exposure. The essential element is that the feelings of shame follow openly stated criticism, threats of rejection, and deprivation. The psychic determinant of this shame is in the early withdrawal of the mother from her child, followed by the casual transfer of her functions to others in the Tribe. Shame is regarded as induced by others and not as a consequence of the shamed individual's behavior. The remedy for shame is not to change one's behavior but to modify the behavior of the critics. This leads to externalized or internalized aggressive action, to be discussed further on.

5. This survey was completed in 1954. Arrangements are currently being made to repeat this in a much more extensive form.

6. Without going into a linguistic analysis of the form and structure of their language, suffice it to say that on the level of communication the language is remarkable for two features. The first is, that it cannot convey readily concepts based on abstractions or generalizations. These Indians are obliged to cite a series of cases from which the abstraction or generalization can be inferred. The second is that the denotative and connotative values of terms are related to elemental needs and their gratifications. For example, objects are defined by such properties as their relevance to water, food, shelter, battle, hunting, raiding, etc. A given species of tree would be given a name indicating the proximity to water or the fact that it yields an edible food. Of considerable interest are the relationship of these linguistic properties to the dream work of psychoanalysis. The elements of dreams are manifested by allusions, images, and representation of the parts for the whole, all organized around an unsatisfied need or wish.

7. These people were skilled workers in beads, leather, and basketry; skills which, for the most part, they acquired from the Indian tribes with whom they came into contact. As far as is known, they did no metal work or pottery. There are many photographs, in recent years, of these people dressed in colorful feathers, beaded leather work, silver ornaments. It is probable that the modern Indian wears these items on ceremonial occasions with the same, self-conscious idea as a Boy Scout or a member of an Indian lore group, namely, that he is wearing a costume.

8. I am especially indebted to the late Dr. Clyde Kluckhohn for his extraordinary and perceptive guidance. Gordon MacGregor has performed a similar service for me as he did for Eric Ericson by helping to clarify my professional identity with respect to anthropology in particular.

9. Aside from Hrdlicka, Ales, (Physiological and Medical Observations Among the Indians of Southwestern United States and Northern Mexico,) Bureau of American Ethnology, Bulletin No. 34, 1908, data on the physical and medical characteristics of this Tribe are meager, indeed. Public Health records date back to about 1946. These are, for the most part, inadequate and difficult to interpret up until about 1954. Since then, satisfactory records are available. Mr. James Canan, Superintendent of the Agency, has been of invaluable help in innumerable discussions with me about this tribe. Public Health officials and BIA officials in the area offices could not contribute much in terms of their actual experience with this Tribe. This was due, for the most part, to the hostile, somewhat negative attitude which the Indians seemed to take towards representatives of the Government.

10. The Tribal Council provided the bilingual interpreters. For the most part, these were Indian men and women of this Tribe who had better than average education, that is, up to the high school years,

and who had lived away from the Reservation for a period of time. Their command of English was excellent, although their vocabulary and modes of communication were classifiable at the lower middle-class grammar school educational level. All interviews were recorded on tape. As a rule, the microphone was the only sign that the discussion was being recorded. The tape recorder was located in one of our vehicles at a considerable distance from the interview. The vehicle was equipped with power supplies, all operated and monitored by an assistant. The interpreter was given a list of specific questions to be asked of the subject and a list of topics to be discussed with the subject. Although I was present throughout, I specifically requested that no translations be made during the interview. I did make notes, however, on the affect of display of the two Indians.

Following the interview, which might run for several hours, the interpreter returned with us to my headquarters and proceeded at once to translate the interview into English. The translation and my questions in the course of it were all recorded on tape. It soon became apparent that the translations revealed many psychological inconsistencies and my suspicions were aroused. We then arranged for the tape recording of the interview to be translated by other bilingual Indians of this Tribe who did not have the list of questions and topics that were used by the original interpreter. These so-called "blind" translations of the interview quickly revealed the distortions, misrepresentations, and attitude both of the interpreter and of the subject being interviewed.

It was apparent that both the interpreter and especially the subject interpreted the questions and the topics under discussion in terms of a stereotype of the White man. To begin with, they did not wish to be shamed in terms of sexual matters, personal cleanliness, ethics and morality. There seemed to be an extraordinary effort to please me by offering information which they felt I wanted. The analysis of these tapes provided penetrating insights into conflicts and anxieties within the interpreter. The interpreter had, in effect, asked these questions of himself or herself; the resulting inner response caused the question either to be distorted or caused the interpreter to suggest answers to the subject.

11. Of considerable interest is the Indians' relationship with me. All the Indians knew that I was a physician and that, in most respects, I functioned like one in that I did physical examination, prescribed medication, did minor surgery, occasionally set fractures, and reduced dislocations. In addition, I was used as a neurological and psychiatric consultant by practicing physicians in the area of the Reservation and the Public Health Service. There was another factor, however, that brought the Indians and me together within a different frame of reference. This had to do with their realization that I knew, understood, and talked to them in terms of their value system, their concepts of health and disease, their superstitions, their fantasies of function and structure of their own bodies. I have been given many Indian names, the general meaning of which could be translated as "the doctor who speaks with his mind in yours;" a nice example of psychoanalytic symbiosis!

12. The fact that acculturation must be differentiated from assimilation has given rise to a considerable semantic controversy. In acculturational processes, the groups appear to maintain their identities with varying degrees of compatibility. In assimilation, one group loses its identifiable characteristics and thereby ceases to exist.

13. By means of the able and protective help of the Government and other interested supporters including lawyers, the Indian Tribes have made sound arrangements with various companies to explore and extract minerals from their reservations. These monies have resulted in the setting up of substantial trust funds for the Tribe as a whole and especially for the Indian children as they become formally registered on the tribal rolls. All Indians receive a per capita payment which averages around \$1,500 a year, this Tribe is receiving somewhat less. These Indian children receive about 40% of the per capita, the remainder being held in trust until they are about 18 years of age. This means that Indian children born since the per capita payment system has been installed, will receive as much as \$15,000 to \$18,000 out of their trust funds when they become 18 years of age.

14. These Indians built this race track with their new found wealth, not only because they are deeply interested in horses, but also because of their passion for gambling. They have a variety of gambling games, playing cards being the most popular.

15. There are many anecdotal accounts and descriptions of the behavior of these women in war. They have been described as fighting side by side with the men. They are noted for their looting activity during and after combat; in fact, there is a woman's dance known as the Lame Dance in which the staggering, distorted postures of the women are intended to represent the enormous burden of loot resulting from successful raids and combat.

16. There are vivid descriptions by Indian and White prisoners of this Tribe's war dances as they

prepared themselves for battle. One such description of a scene which occurred in the 1880's tells of this tribal raiding party that intends to seek out United States Army units. The uniform of a cavalry soldier was placed on a pile of brush, the dancing Indians circled around it with increasing signs of hostility and rage, finally culminating in an explosive attack with drawn knives and other arms upon the uniform. This account and other descriptions suggests that the behavior once aroused must run its course.

17. In this connection, this project is engaged in a crucial investigation that may help to shed some light on the distinction between biogenetic and psychogenetic factors. For reasons having to do with many Indians' indifference to children, there are about 60 Indian children from this Tribe that are being reared in White, middle-class, foster homes. The expense for this is borne by the tribal funds. This group of children will be compared with Indian children from this Tribe being reared in Indian foster homes and those children being reared in comparatively intact Indian family situations. It is hoped that this investigation will provide some information as to the modifiability of the behavior of this Tribe. The children in the White foster homes were placed there at different ages beginning with birth. In the event that modifiability is possible, we may obtain further information as to the age after which modifiability decreases.

18. We are comparing the development of this Tribe's children being reared by cradling with a group of infants who are not being cradled. The study includes evaluations of the mothers and of the family life.

19. See endnote number 18, above concerning this tribal Indian foster child project.

20. The Indians of this Tribe accumulate horses that are only occasionally used for their limited herding in ranching. Originally, horses provided the mobility required for wandering, hunting, raiding, and the gathering of women from other tribes. The number of horses possessed by an Indian of this Tribe thus became the sign of successfully gratified aggression and sexuality. This sign anachronistically persists in a primitive, ritualized form of possessing horses. As mentioned above, these Indians do not breed horses for the purposes of developing any particular stock or bloodline. The horse, therefore, has become a symbol and in the true psychoanalytic sense it is a link to the past (i.e., the basic concepts of psychoanalytic symbolism as described by Rank and Sachs and elaborated by Jones) in that, by association, it represents successful hunting, raiding, fighting, "many scalps," much food and accumulation of women.

21. In this connection, the following anecdote is illustrative. In the course of a discussion with a tribal leader as to what is meant by understanding these people, he remarked ironically and sarcastically, "So you think you understand these people? Let me see if that is so. Suppose you went to so-and-so (I suspected at once what the tribal leader had in mind, for so-and-so is outstanding even among these people for the amount of fecal effluvia from animal and human sources on the property around his house) and you said to him, 'clean up around you,' and he said, 'no,' and then you said to him, 'clean up around you', and he said, 'no,' and then you said to him, 'why not?' and he answered, 'because I am a member of this Tribe.'" The tribal leader continued by asking me would I understand this. I chose to respond by the method of analogy often used by these people when they wish to convey a generalization or an abstraction. I said, "yes, it's like telling a man from this Tribe to leave a woman and to go to a man instead." He nodded in agreement. This man is a strong supporter of my activities among his people.

22. Following this paper are a series of brief case histories dealing with the problems of suicide and homicide. [Editor's note: The case histories referenced by Dr. Margolin are not printed with this article. Patient confidentiality cannot be guaranteed in the absence of the author.] These people have a deep-seated, inflexible fear of sickness, sick people, dying and death. Sickness is often seen as punishment, the effects of revenge through magical means, and above all, the activity of ghosts. The ghost of a dead person, particularly of this Tribe, operates in many ways. (a) He can be a moralistic, punitive figure operating under the law of Talion. The ghost is appeased by humility, modesty, subordination of pleasures of the flesh, and by the return of possessions that once belonged to the ghost. (b) The ghost sees all living people as rivals who are victorious in remaining alive. Consequently, he is determinantly envious and vengeful. He manifests himself by interfering with the usual expectations. He causes accidents, sickness, poisoning of food and water, disappearance of game, the loss of necessary articles, fainting spells, pains of various sorts, weakness, anorexia, insomnia, terrifying dreams, etc. A ghost is especially malevolently inclined towards anyone who in any way contributed to or is responsible for his state, or who appears to be enjoying what the ghost left behind. (c) A ghost lives in a kind of limbo

for one or two years, during which he is especially dangerous but after which his threat generally diminishes. The ghost is the epitome of the envy and rivalry, resentment, and hostility so much a part of the character structure of the people of this Tribe. This similarity suggests the psycho-genetic origin of the ghost and his function as an external control as an abortive super-ego, so to speak. The character traits are related to the pregenital fixations of a child of this Tribe. In fact, the period of time that the ghost is dangerous corresponds to the interval that the infant is biologically dependent on the mother in a one-to-one basis. In a sense then, the ghost has a double meaning; one, the danger of the deprived mother to the child, and two, the danger of the depriving child to the mother. (d) The suicide attempts by members of this Tribe, as shown in some of the case histories, are clearly related to the role of the ghost as an externalized rather than an internalized object.

In my work with these people I have not discovered any who showed in any clear way the signs and symptoms of obsessional compulsive neuroses or of obsessional compulsive character disorders. Neither have I seen any cases of true depression characterized by feelings of unworthiness, inadequacy and hopelessness, psychomotor retardation and guilty ruminations. In short, psychopathology based on severe superego conflict is apparently uncommon. As I have pointed out in the description of child-rearing, the relationship of children to parents or their surrogates do not favor the internalization of a structured pattern of prohibitions and permissions. Ego ideals are highly narcissistic and seem to be based upon the fulfillment of elemental needs of food, drink, and material possessions. The element of shame, which I have described above, comes close to the social element of the superego. It is the ghost, however, that becomes the regulator of intraspecific homicide and suicide. As with the ghost, the living Indian is generally intolerant of any unpleasant affect associated with frustration and material deprivation, such as anxiety, envy and shame. These affects are dealt with by alcohol or severe hypochondriasis and manifest aggression.

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On May 27, 1988, the University of Colorado Health Sciences Center's Department of Psychiatry assisted the Select Committee on Aging with an important field hearing entitled, "Mental Health and the Elderly: Issues in Service Delivery to the Hispanic and American Indian Communities." The thrust of the hearing was to gather data from various experts and witnesses concerning the Committee's intention to develop a multidisciplinary approach to a community-based mental health policy and legislative program to address certain issues in service delivery to American Indians and Hispanic elderly. The following expert witnesses gave their testimony: Spero M. Manson, PhD, Associate Professor and Director, National Center for American Indian and Alaska Native Mental Health Research, University of Colorado, Denver, Colorado; Mr. Curtis D. Cook, Executive Director, National Indian Council of Aging, Albuquerque, New Mexico; Mr. James Berg, Chairman of the Board, Denver Indian Center, Denver, Colorado; Mr. Fred Acosta, MSW, MPA, Division of Mental Health, Denver, Colorado; Mr. Jose Mondragon, MSW, Servicios de la Raza, Denver, Colorado; Sheila Baler, PhD, Executive Director, Mental Health Corporation of Denver, Denver, Colorado; Priscilla Gallegos, Acting Director, Division of Mental Health, Denver, Colorado; and Molly Snyder, Assistant Director, Area Agency on Aging, Denver Regional Council of Governments, Denver, Colorado. The Denver hearing was the second in a series of field hearings focusing on the mental health needs of older American minorities. The hearings are part of a major Committee push on elderly mental health, whose centerpiece is mental health legislation sponsored by Chairman Roybal. Upon completion of the collection of field data, the Committee plans to issue a report on its findings entitled, "Mental Health and Minority Aging: The Need for an Expanded Federal Response." In this vein, The National Center has invited Chairman Roybal to give a brief synopsis of the Committee's effort to address the mental health needs of this special elderly population—Journal Manager.

Mental health concerns and care have been a neglected priority in American health care. The elderly as a whole, and particularly American Indian and Hispanic elderly, represent a dramatically underserved portion of our population when it comes to mental health. The purpose of the current hearings is to bring to the attention of the public and Congress the need for a truly comprehensive system of mental health services and to collect community-based data on the mental health needs of older Hispanics and American Indians.

Major provisions of the Elderly Mental Health Initiative are as follows.

Developing a more effective service system include:

1. Increase Mental Health Block Grant Funding by \$100 million and set aside funds for children and the elderly.

2. Expand federal and state grant program for development and coordination of community-based services and public education (increase federal funding by \$10 million).

3. Increase biomedical, prevention, treatment, and services research (NIMH, NIA, AoA) funding by \$42 million by 1991.

4. Increase mental health training funding by \$30 million by 1991.

5. Establish a National Mental Health Education Program.

Reforming Medicare and Medicaid services and cost containment include:

1. Change to an extendable 60-day annual limit on inpatient psychiatric treatment.

2. Change to a 20% copayment and an extendable 20-visit annual limit for outpatient services.

3. Extend Medicare and Medicaid coverage for in-home respite care (120 hours per year), freestanding mental health clinic, clinical psychologist, clinical social worker, and psychiatric nurse specialist services.

4. Increase nursing home mental health assessment and access to services.

5. Increase Medicare cost containment through mandatory assignment, utilization review, and prospective and indexed pricing of mental health services.

Improving quality assurance and access protection:

1. Increase conditions of participation, PRO review, sanctions, and Ombudsman review.

2. Provide and enforce a Mental Health Care Consumer Bill of Rights.

3. Develop studies on quality and access.

Although the proposals here constitute an "Elderly Mental Health Initiative," the mental health needs of elderly are but one component of a broader, national problem which affects people of all ages. Therefore, this initiative should be seen not just as a series of proposals to help elderly persons, but as the first step in reforming the mental health delivery system for all Americans, regardless of age or background.

The Honorable Edward R. Roybal
United States House of Representatives
Chairman of the Select Committee on Aging