# Clinical Paradigm Clashes: Ethnocentric and Political Barriers to Native American Efforts at Self-Healing

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**Abstract** Euro-American theories of psychotherapeutic intervention focus on therapist behavior or the therapeutic relationship, conceived in dyadic terms. The cultural prototype is individualistic and rationalistic: a one-to-one conversation in which the patient discloses and discusses innermost feelings in regular office visits. This may be appropriate for modern Euro-Americans. However, anthropological research finds that in many traditional healing systems, intervention is communal, it utilizes dramatic ritual ordeals and altered states of consciousness rather than rational conversations, and the healer–patient relationship may be less central. This article argues that the latter approach is not ignorant of psychotherapeutic principles; it has its own (however opposed to Euro-American assumptions they may be). Understanding this paradigm clash broadens our understanding of what psychotherapeutic intervention is. It also allows clinicians and policy makers to support traditional peoples in their own efforts at self-healing. Examples will be drawn from the author's work on the healing ceremonies of the Native American Church among contemporary Navajos. [cultural psychiatry, psychotherapeutic intervention, clinical paradigm clash, healing, Native American Church]

This article focuses on a basic question in the study of culture and mental health: what is psychotherapeutic intervention? Is it the modern psychotherapeutic office session in which a client agrees to rationally discuss his or her most private emotions and experiences with a professional stranger in regular office visits? Is effective psychotherapeutic intervention something that was invented by Western European doctors? Is it something owned and regulated by the American Psychological Association? Increasingly, this is the case for clinical psychologists and other practitioners of psychotherapeutic intervention in the United States. Psychotherapeutic intervention is increasingly seen as something that can be standardized, manualized (encoded in the instructions of a "how-to" manual), and regulated. However, this article aims to remind us of an important fact: psychotherapeutic intervention is a basic human activity, and it was a basic human activity long before clinical psychologists and psychotherapeutic office sessions existed. It is not owned by any particular cultural group or professional organization but is a generic activity of humankind. Claims that Freud or whoever else "invented" psychotherapeutic intervention are similar to claims that Columbus "discovered America": they are insulting to members of other cultural traditions who have also "discovered" the phenomenon in question for themselves.

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Note here that I am talking about "psychotherapeutic intervention," a broader concept than that referred to by the term *psychotherapy* as usually understood. The term *psychotherapy* is, today, typically used to refer to the tradition of rational talk therapy practiced by professional "psychotherapists." This has not always been the case, even within the European tradition. For example, if one consults historic definitions of *psychotherapy* in the *Oxford English Dictionary*, one finds that early definitions (ca. 1900) were very broad, including mesmerism, hypnotism, and, as Kellogg stated in 1897, "every means and every possible agency which primarily affects the psychical rather than the physical organization of the patient in a curative direction" (Simpson and Weiner 1989). By 1976, definitions were narrower and saturated with particular cultural and theoretical ideologies, such as that of Smythies and Corbett: "Psychotherapy consists very largely in helping people to grow up, to exchange the egocentric child's role for the mature role of the adult" (Simpson and Weiner 1989:771). The typical contemporary definition of *psychotherapy* as rational talk therapy itself reflects the increasing standardization of this activity.

In any case, given that the relevant professional guilds involved have claimed the word *psychotherapy*, in this article I instead use "psychotherapeutic intervention" to refer to the full range of psychological and relational (as opposed to purely biomedical) methods of healing the mind or soul. My aim is to draw attention to the existence and importance of a more inclusive category, referencing all behaviors and meaning structures that support mental health, including not only psychotherapy but also hypnosis, mutual help organizations, support groups, religious or spiritual explanatory systems, faith healing, and the traditional healing rituals of indigenous peoples. I treat psychopharmacology as a separate category here, although I discuss a Native American tradition in which psychopharmacology supports the patient's emplotment in a structure of meaning. I use the word *psychiatry* to refer to a broader category still, encompassing both a given society's psychopharmacological and psychotherapeutic forms of intervention as well as its diagnostic systems and definitions of the normal or healthy.

A corollary of the view that European doctors invented psychotherapeutic intervention is the view that ritual interventions of premodern societies are "precursors" that merely reflect the ignorance of people who still believe in magic rather than science (Frazer 1998). However, effective psychotherapeutic intervention is actually something that exists across a diverse range of human cultures, although its forms differ radically. If psychotherapists and clinical scholars are serious about culturally relevant treatments and multicultural competency, a broader understanding of therapeutic processes and practices is needed. This will involve an increased awareness and questioning of Euro-American ideological and cultural commitments.

In human cultures, including modern Euro-American culture, systems of clinical knowledge and systems of ideological and metaphysical assumptions are not distinct but tend to interrelate and structure one another (Good 1992, 1994; Gone 2004). This is most apparent in the domain of mental health, in which it is often hard to separate behavior that is "healthy" from behavior that is merely in line with social conventions. Systems of psychotherapeutic

knowledge typically contain tacit cultural commitments (e.g., to individualism, to rationalism, to what is locally considered "normal" sexuality, to tolerance of only culturally familiar intoxicants and medicines, to the primacy of the male sex, to particular cultural views of childrearing or maturity or healthcare, etc.). Examples of commitments to cultural ideology in Western clinical sciences include the classification (until recently) of homosexuality as a mental illness, the individualist emphasis on intrapsychic causal explanations of distress, and the equally individualist assumption that autonomy or "individuation" is the ultimate goal of development.

The interrelationship of clinical knowledge and cultural ideology is revealed by the fact that, as society changes, psychiatric knowledge changes with it. Consider the cultural values encoded in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–III*; American Psychiatric Association 1980). The diagnostic criteria for Antisocial Personality Disorder include "repeated sexual intercourse in a casual relationship" (American Psychiatric Association 1980). Whoever wrote this criterion had a cultural value system that identified casual sex as diagnostic of an antisocial personality. But by 1994, repeated sexual intercourse in a casual relationship had become more of a cultural norm than a deviance and, as such, the criterion was dropped from *DSM–IV* (American Psychiatric Association 1994). One wonders how consensual sexual intercourse in a relationship could medically be considered antisocial behavior in the first place, when it is so obviously the opposite. Here we clearly see the influence of moral ideologies on medical diagnosis.

In spite of these historical shifts, many Euro-American clinicians continue to believe that their understandings are culture free. Intelligence tests in particular are interpreted as scientific measures of inherited biological potential or neuropsychiatric integrity. This naive interpretation facilitates the use of these tests in supporting misleading racist and ethnocentric arguments (Hernstein and Murray 1994). As a practicing clinician, I have administered these tests many times. However, I often felt silly asking several of the items on the most widely used IQ test to an immigrant from a non-European country. To my amazement, the subject's IQ score decreases if he or she does not know the author of a particular centuries-old German or English novel. One's "intelligence" decreases if one cannot identify the main theme of a particular chapter of the Judeo-Christian bible, or the meaning of narrowly local colloquial (and outdated) English language expressions, or the distance between a particular large American city and a particular large European city. In addition, the whole activity of completing geometric puzzles as quickly as possible is probably unique to a narrow group of cultures and assumes a particular level of motivation in the subject.

This relatedness of clinical understanding and cultural ideology (including the naive scientific ideology discussed in the previous paragraph) becomes problematic because of the fact of human cultural diversity. The societies of the world do not agree on fundamental issues of personhood, sexuality, health, consciousness alteration, religion, or childrearing. Instead, human societies have developed unique and heterogeneous ways of understanding and adapting to local environments, maintaining relationships among consociates, and

sustaining mental health. As such, a society's members are likely to respond more to therapeutic interventions that are appropriate to their unique histories of adaptation.

In this article, I describe differences between modern Euro-American understandings of psychotherapeutic intervention and understandings of psychotherapeutic intervention prevalent in many Native American communities. In particular, I focus on the Navajo communities in which I have done ethnographic field research as well as clinical practice. My contention is that the deep cultural differences between Euro-American and Native American cultures constitute a paradigm clash in which the psychotherapeutic interventions of Native American cultures are not recognized as therapeutic interventions by members of Euro-American cultures but are, rather, seen as mere aesthetic performance, religious tradition, superstitions, even drug abuse or manifestations of mental illness. For this reason, as well as for political reasons involving the hegemony of Euro-American clinical disciplines and culturally favored psychoactive substances (among other factors), Native American and other traditional forms of intervention have not been taken seriously by most Euro-American clinicians or by the U.S. population at large. This lack of cultural awareness has resulted in a situation in which Euro-American interventions may function as forms of cultural proselytization (Gone 2005, this issue) in Native American communities. Among the various ritual interventions used by the Navajos, I pay special attention to one in which the clinical paradigm clash and resulting level of intercultural misunderstanding are especially intense: the Peyote Meeting of the Native American Church (NAC; Calabrese 1994, 1997, 2001).

## Field Research

The Navajos or, as they call themselves, the *Diné* (meaning "the People"), are an Athabaskan-speaking people who have a matrilineal clan-based system of descent. The Navajo Nation comprises a large area of semiarid land in the states of Arizona, New Mexico, and Utah. The ancestors of the Navajos are believed to have migrated to their present territory between the four Sacred Mountains from Alaska and Western Canada in the 15th or 16th century (Kunitz and Levy 1994). The Navajos learned agriculture from their new Pueblo Indian neighbors and, by 1800, sheep herding had become the dominant subsistence activity (Hester 1962). Today, members of the community are engaged in a variety of occupations as a wage-labor economy continues to develop. Other Athabaskan-speaking groups have settled in areas to the south and east of the Navajos and have become the peoples we refer to as the various Apache tribes.

I conducted a total of two years of clinical ethnographic research within the Navajo Nation between 1990 and 1998. During my first summer, I lived with the rural family of an elderly Road Man (as ritual leaders of the NAC are called), herding their 150 sheep and goats in exchange for meals (mostly mutton) and a cot in the hogan (the circular log cabin that is the traditional Navajo dwelling). Subsequent summers were spent increasing my contacts in

other communities and building rapport with individuals there. The project culminated in a full year combining fieldwork with a clinical placement at a treatment facility accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), run by a Navajo Road Man, and administered by the Navajo tribe.[1]

My Navajo fieldwork was stimulated by an interest in traditional healing systems that are especially well preserved among the Navajos as compared to other Native American societies. It was also stimulated by a specific interest in the NAC given the Supreme Court case of *Employment Division of Oregon v. Smith*, 494 U.S. 872 (1990). In their decision in this case, the Supreme Court abandoned the view that the burden of proof rests with the government to demonstrate a compelling interest in denying religious freedom. Members of the NAC were judged to be "guilty of a Class B felony" (see Calabrese 2001).

## The Peyote Meeting

The Peyote Meeting of the NAC is among the most misunderstood rituals within the contemporary United States. It has been mischaracterized as everything from an invocation of the Devil to a sexual orgy to "drug use in the guise of religion" (Stewart 1987:17–30, 128–147; see also Aberle 1991:205–223). But the all-night Peyote Meeting is actually a very formal and controlled ritual with a beautiful symbolic structure (see Calabrese 1994). It is also a form of therapeutic intervention that can be analyzed using anthropological and clinical concepts.

The claim that ritual peyote use is a treatment modality will appear controversial to those who have not immersed themselves in Native American clinical contexts and in the lives of those recovering from alcoholism in Native American communities. However, a situation of confusion reflecting a paradigm clash between two cultural traditions of clinical interpretation is suggested by the fact that the same U.S. government that classifies peyote as a Schedule I drug (defined as dangerous and with no therapeutic uses) also classifies the Peyote Meeting as an accepted intervention for substance abuse in Native American communities. The Peyote Meeting has its own "client service code" on the U.S. Indian Health Service's code list 13. This code list is used for reporting provision of services to the Indian Health Service. The entry for NAC treatment in the IHS document reads as follows:

> 04: Native American Treatment: Participation in Native American Church Ceremonies (Peyote Church) led by a Road Man, who has been recommended by a local NAC chapter, and conducted primarily for the purpose of treating persons with alcohol and drug problems. This code should not be used for those Native American Church services conducted for general prayer service, birthdays, or other purposes. [Kunitz and Levy 1994:202]

This contradiction within the U.S. federal government structure itself calls for a questioning of the validity of peyote's Schedule I status. In addition, a recent study by Halpern and colleagues (2005), researchers at McLean Hospital—Harvard Medical School, compared

mental health and neuropsychological test results of three groups of Navajos: one group of NAC members who regularly use peyote; one group of Navajos with a past alcohol dependence but currently sober at least two months; and one group reporting minimal use of peyote, alcohol, or other substances. Results of this study, which used the Rand Mental Health Inventory (RMHI) and a battery of standard neuropsychological tests, indicated that the peyote group showed no significant differences from the abstinent comparison group on most scales and scored significantly better on two scales of the RMHI. Furthermore, among NAC members, greater lifetime peyote use was associated with significantly better RMHI scores on five of the nine scales including the composite Mental Health Index.

Peyote Meetings are called for the purpose of healing a patient ("doctoring meetings") as well as for expressing thanks and for supporting continued health ("appreciation meetings"). The Peyote Meeting takes place in a circular enclosure, usually a tipi but sometimes a hogan open to the east. Inside the enclosure, a crescent mound of earth is constructed and a line drawn along the top to represent the "Peyote Road." Participants enter the tipi at sundown. The Road Man places an especially fine peyote cactus, most often called "Mother Peyote" or "Father Peyote," on top of the moon altar. Peyotists are taught to maintain focus on this peyote, sending their prayers through it. After an opening prayer, which states the purpose of the meeting, peyote is passed around and drumming and singing of peyote songs begins. The ritual continues until dawn of the following day, when there is a ceremonial breakfast of corn, meat, fruit, and water, and the participants go outside to greet the sun. Healing experiences reported after these rituals include impressive visions interpreted as divine messages or warnings, important new insights about one's life, feelings of rejuvenation or holiness, and desires to transform one's behavior (Aberle 1991; Calabrese 1994).

I argue that the ritual process of the Peyote Meeting involves a dialectical relationship between two practices often encountered in cultural psychiatries: therapeutic emplotment and consciousness modification. The term *emplotment* concisely captures the ritual-based symbolic or rhetorical approach to shaping consciousness studied by anthropologists and often referred to as "symbolic healing" (Dow 1986) or "the effectiveness of symbols" (Lévi-Strauss 1963). Emplotment is a familiar term both in narrative studies and in medical anthropology (Ricoeur 1984; Good 1994:144; Obeyesekere 1990:267). *Therapeutic emplotment*, as defined in this article, refers to interpretive activity or application of a preformed cultural narrative placing events into a story that is therapeutic, either in that it supports expectations of a positive outcome, makes illness or treatment comprehensible, discourages unhealthy behaviors, or otherwise supports health. In the Peyote Meeting, emplotment of the patient in a therapeutic narrative structure is aided by a technique of consciousness modification. The term *consciousness modification* refers to any cultural technology used to alter the consciousness state of self or others. This includes pharmacological techniques and behavioral techniques such as fasting, ritual ordeals, or prolonged dancing.

A dialectic between a structure of meaning (e.g., a myth) and a technology of consciousness modification is found in many initiation rites and healing ceremonies in which society has an

important message to "implant" in the mind of the individual. In initiation rites, these messages focus on a change of one's social status and the rights and responsibilities that go with it, for example "you are now an adult" or "you are a warrior" (see Herdt 1987; Turner 1967; Van Gennep 1960). Secret or otherwise vital teaching is often presented after an exhausting ritual ordeal or after ingestion of a psychoactive substance. Healing ceremonies aim for a change in the health status of the person and are typically characterized by transformation symbolism and messages such as "you are healed." The consciousness modification technology in such rituals makes the mind more malleable—in other words, more open to social messages—by altering the individual's attention and suggestibility. This is an effect noted for various hypnotic induction methods as well as for certain psychoactive substances and painful or exhausting ritual ordeals (Grob and Dobkin de Rios 1994; Sjoberg and Hollister 1965).

The ritual symbolism of the Peyote Meeting depicts the human self or life course in the arc of the crescent moon altar and symbolically embeds this depiction of the self in natural transformative processes of gestation, birth, and the dawning of a new day. The message is one of a natural transformation and renewal of the self to facilitate the goal of living harmoniously into old age. This is an emotionally potent message for Navajo Peyotists and its form somewhat resembles the central mystical formula of the traditional Navajo religion, *Sa'ah naghái bik'eh hózhó.* This Navajo phrase is not easily translated but it conveys the sense of a beautiful, harmonious condition arising out of the natural completion of the human life course in old age (see Witherspoon 1974).[2]

## Ten Areas of Cultural Difference Contributing to the Paradigm Clash

In what follows, I will highlight various areas of cultural difference in basic approaches to psychotherapeutic intervention that contribute to the paradigm clash between Euro-American and Native American interventions. These distinctions are listed with particular Native American contexts in mind, specifically the Navajo communities in which I lived and worked. However, these areas of cultural psychiatric difference would also be applicable to many other cultural contexts in which ideological and clinical assumptions differ from those of contemporary European and Euro-American cultures.

### Individualist Dyad versus Communal Group Process

The most typical contrast drawn between modern Euro-American cultures and many non-European cultures is that between an individualist ideology and more communal or collectivist ideologies (e.g., Shweder and Bourne 1984). The distinction is often overemphasized, as any society has its own individualist elements and modern Euro-American culture has its own communalist elements. However, this difference in cultural emphasis is helpful for understanding differences in therapeutic systems. When one thinks of psychotherapeutic intervention, what typically comes to mind in the Euro-American context is the therapeutic dyad: a patient (often reclining on a couch) and a therapist (often taking notes or calmly

probing with questions). The model is that of a conversation or cooperative relationship. Working with the adolescent clients I treated on the Navajo reservation convinced me that individual therapy sessions were not very useful. Clients were typically unwilling to adopt the role of a cooperative therapy patient. My identity as a Euro-American undoubtedly played a role. However, I had much more success in my group therapy sessions and with milieu interventions.

A cursory glance at the ethnographic literature reveals that the calm, rational discussions characteristic of Euro-American talk therapy are not the approaches to healing used by the majority of human societies (e.g., see Dobkin de Rios 1972; Katz 1982; Kennedy 1967; Lévi-Strauss 1963).[3] Anthropological research reveals the centrality of ritual approaches to healing in many cultures outside the industrialized West. In these traditions, a technique of emplotment of the patient in ritual symbols, songs, and myths is typical, often in connection with a technique of consciousness modification. Ecstatic emotions and liminal symbolism predominate. From one perspective, Euro-American talk therapy may be seen as more decentered from a particular cultural tradition than these ritual forms (being more secular and cosmopolitan and less explicitly based in cultural myths). But talk therapy can also be considered a very modernist, Euro-American enterprise in that it tends to limit itself to calm, rational argumentation within individual-to-individual relationships and discussions. This second perspective characterizes Euro-American talk therapy as following its own deeply ingrained cultural templates.

Psychotherapeutic process, for most psychotherapy researchers, refers to elements of verbal interaction and interpersonal relationship between a therapist and a client in one-to-one settings. However, psychotherapeutic intervention in many cultural traditions is not a dyadic conversation but rather a dramatic communal ritual. Rather than being excluded from the dyad for reasons of privacy, a patient's significant others are present and participating. Victor Turner even argued that among the Ndembu of Zambia healing was actually aimed at the group rather than the individual. Turner writes that "the patient will not get better until all the tensions and aggressions in the group's interrelations have been brought to light" (1967:392). This is also true to some extent for the NAC rituals that I have studied in that healing is not limited to the patient but is also aimed at relationships and is ultimately available to anyone attending the ritual. This is similar to some of the ideas of family systems and group therapy approaches to psychotherapeutic intervention in the Euro-American tradition, although the central paradigm of psychotherapy remains the individualist dyadic one.

**The Role of the Healer**

Another difference between Navajo and Euro-American psychotherapeutic healing approaches has to do with the role of the healer. Many Western theories of psychotherapeutic efficacy focus on personal properties of the therapist. The most familiar example is probably Carl Rogers's (1995) emphasis on the therapist's empathy, warmth, and

genuineness. Even anthropological theories of therapeutic process such as the influential theory of James Dow (1986) are healer-centered. In Dow's model, (1) the experiences of healers and healed are generalized with culture-specific symbols in cultural myth, (2) a suffering patient comes to a healer who persuades the patient that the problem can be defined in terms of the myth, (3) the healer attaches the patient's emotions to transactional symbols particularized from the general myth, and (4) the healer manipulates the transactional symbols to help the patient transact his or her own emotions. Note that the healer is central to each of these stages.

However, Dow's model may still be too tied to Euro-American psychotherapeutic assumptions to be applicable across cultures. This is because, in many healing traditions, the healer's role is less central. For example, in the Peyote Meeting, the Road Man's role seems less important than the nature of the milieu that he manages. He is a role model, leads the ceremony, prays for the patient with the other participants, and may administer specially blessed medicine to the patient. But there is little direct verbal interaction. It is often said that the patient is responsible for his or her own healing, that one does the ceremony for or on oneself, or that the real healer is the Peyote spirit present in the sacramental medicine. The most important therapeutic communications are often those that come to the patient not from the healer but directly from God or the Peyote spirit in the form of visions or other sacred experiences.

Western mainstream psychotherapy research approaches tend to have little to say about such experiences. In the Peyote Meeting, it seems that therapeutic messages are implicit in the symbolism of the ritual and have already been "implanted" in the mind of the patient through socialization. The healing ceremony "activates" these messages in an impressive way that, in combination with other ritual alterations of consciousness and the supportive presence of the community, may lead to cognitive and behavioral change in the patient.

**The Expectation of Calm Self-Disclosure to a Professional Stranger**

One critique of scientistic approaches to psychological assessment and intervention is that they too often take the client's motivation for granted (the motivational interviewing approach of Miller and Rollnick 1991 is a notable exception). Just as neuropsychological testing assumes that the client is motivated to construct puzzles as quickly as possible (which they often are not), psychotherapy often assumes that the client is willing to disclose and rationally discuss his or her deepest emotions to a professional stranger in therapy sessions.[4] However, this sort of disclosure seems specific to Euro-American psychotherapy. Some Native American healing rituals, such as the sweat lodge or Peyote Meeting, involve expression of emotion but this expression occurs in an emotionally charged group context involving a supportive gathering of family and friends. Other rituals, such as the traditional Navajo healing ceremonies called "sings," do not focus on disclosure or emotional expression.

As a clinician working on the Navajo Reservation with Native American adolescents who had very severe problems with alcoholism and substance abuse, I found that individual therapy sessions and Alcoholics Anonymous were not appealing to the majority of these young people. However, most had some interest in Native American ceremonies, and it was standard practice for me to attend a weekly sweat lodge ritual with my patients. Self-disclosure in the sweat lodge was not a personal choice but a spiritual duty, and a lot of useful clinical information was made available that could be discussed later in an individual session or in milieu interactions. Clinically relevant information deriving from these rituals was summarized in a therapy note added to the patient's chart.

**The Time Factor**

This brings to mind another difference in approach: the temporal duration of the intervention. In the Euro-American situation, patients (or outpatients, at least) tend to be straightjacketed into the professional office hour. They are assumed to be ready to self-disclose within this period of time and it is assumed that their problems can be addressed effectively (at least for the current session) within an hour. This contrasts strongly with Native American forms of intervention that seem, in some cases at least, more realistic. In the Navajo context, for example in the sweat lodge or Peyote Meeting, six or seven hours of ritual ordeal may elapse before the patient is ready to disclose or express feelings. The duration of traditional Navajo healing rituals may extend to five or even nine nights. From a comparative perspective, this is a huge dose of psychotherapeutic intervention.

**Secular versus Spiritual Intervention**

This brings us to another aspect of difference between modern and traditional forms of psychotherapeutic intervention that may result in misunderstandings reflecting paradigm clash: secular intervention versus spiritual intervention. When one begins to study psychotherapeutic intervention across cultures, one is immediately led into the study of religious or spiritual systems. Likewise, when one begins to study comparative religion, one finds that the religious leader—the shaman—is also frequently the psychiatric and psychotherapeutic practitioner. A separation of these two roles only occurred late in social divisions of labor, and in many societies did not occur at all.

A particularly vexing question for psychotherapists and psychotherapy researchers alike is the role of spiritual or supernatural beings. Modern secular clinical approaches tend to see talk of spiritual beings as diagnostic of psychotic disorder. However, for most of human history, spiritual beings have been an intimate part of how people healed. This heritage continues in many traditions that were never secularized. Within the NAC tradition I have studied, peyote is believed to facilitate a direct communication with divinity and this sort of ritual experience can be the foundation stone on which a recovery process is built.

I have done research on the role of the Peyote spirit in child development, specifically superego formation and parental control of children (Calabrese 1997, 2006). Children are

taught that Peyote is an omniscient being that knows "if you are good or bad." The fact that one's visions, which are typically interpreted as divine communications, contain material from one's most intimate thoughts, guilt feelings, or memories experientially confirms Peyote's omniscience. Peyotist children told me that Peyote comes to "know who you are." One child told me that the Father Peyote "knows if you have smoked or drunk." Peyote is referred to as "Mother Peyote" or "Father Peyote" and it acts as a sort of parental figure, enforcing moral prohibitions (esp. against alcohol consumption) when parents are not present. Because it is seen as an omniscient spirit, it is believed that Peyote knows when children are misbehaving (e.g., drinking or using drugs of abuse) no matter where they are.

According to the anthropologist Paul Radin, "If a person eats Peyote and does not repent openly, he has a guilty conscience, which leaves him as soon as the public repentance has been made. . . . If a Peyote-user relapses into his old way of living, then the Peyote causes him great suffering" (1914:5–6). Peyote is thus experienced as a spiritual entity, a relationship is established, and the omniscient gaze of the morally evaluative divinity becomes present in the subjectivity of the worshipper, facilitating social control. So we can see peyote as helping in the creation of the "panoptical gaze," a system of social control as Michel Foucault (1979) wrote about it, or, to be more psychological, a culturally structured superego or conscience. This is just one of the aspects of spirituality in the NAC that can be considered therapeutically and developmentally useful.

**Change as Rational Decision versus Ecstatic Experience or Hypnotic Suggestion**

There is another contrast concerning the mechanism of therapeutic change. The dyadic model of rational discussion of one's problems tends to imply a model of change as a rational decision. Thus, Western therapists engage in "collaborative empiricism" and may use "cost–benefit analysis" and other rational methods to help patients achieve insight into their problems. Here I just want to point out that in more traditional approaches, therapeutic change may involve ecstatic emotions, visions, conversion experiences, feelings of religious significance, relationships with divinities, and various forms of suggestion.

With the cases I worked with on the Navajo reservation, where substance abuse problems were often very severe, standard rational approaches were not very useful. In many cases, a radical transformation involving a shift in consciousness, and often a shift toward spiritual life, seemed the only way to interrupt dangerous behaviors and initiate change. This sort of shift was facilitated by ritual interventions. In addition, these rituals could also provide an ongoing aftercare program in areas of the reservation where there were no twelve-step meetings.

**Individualized Narratives versus Preformed Narratives**

This leads to another difference between Navajo and classically Western approaches to psychotherapeutic intervention: whether therapeutic narrative structures are collaboratively

constructed in an ongoing therapeutic conversation and individualized for a specific patient or preformed by cultural tradition (as in ritual symbolism or sacred songs). A good modern psychotherapist is most often nondirective. He or she tends to elicit and work with the significant narratives of the patient or at least works collaboratively to fashion a unique therapeutic story that is carefully tailored to the individual patient's life history. In contrast, traditional healing more often embeds the patient in preformed narrative structures that are implicit in myths and ritual symbolism. I think of this in terms of the "laying on of narratives." A vivid example of this occurs in traditional Navajo sings, in which a sand painting depicting a particular myth is created and the patient is literally placed on top of this narrative-laden mythic depiction. Some common therapeutic plot structures of this sort include death and rebirth as in the symbolism of the Peyote Meeting (Calabrese 1994), a journey to retrieve a lost soul, sucking out of a malevolent object (or similar purifying rituals), a historic victory over evil, ingestion of a medicinal or magical substance, and the rite of passage. When these therapeutic plot structures help form basic cultural structures (e.g., Christ's death and rebirth in Christianity), I refer to this as "culturally embedded therapeutic emplotment," in which an enculturated person is always emplotted.

An intermediate category between individualized and preformed narratives involves stereotypical formulas for ritualistically telling one's own story according to a predetermined cultural pattern. These also facilitate therapeutic emplotment. Consider the personal narratives ritualistically repeated by members of Alcoholics Anonymous and other self-help groups: "Hi. I'm Bob and I'm an alcoholic" (after which the crowd says "Hi Bob" and Bob launches into a description of his disease and then moves to a description of his recovery). This ritual performance resembles the common death–rebirth narrative structure. The actively drinking self is shifted into the past tense (and, thus, rhetorically nullified) and the narrative of a recovered Bob is fashioned in the present tense (a revised self). Those who have converted to the NAC or have had a life-changing vision tell similarly structured stories, as do "Born Again Christians," "GROWers" (Corrigan et al. 2002), and others. This situation may be considered a hybrid of therapeutic self-emplotment and culturally embedded therapeutic emplotment: the actual narrative is constructed by the individual but it follows a preformed cultural template very closely. This approach is not characteristic of psychotherapy, which suggests that Alcoholics Anonymous and other mutual help organizations are, in some ways, closer in structure to traditional healing than to modern clinical services.

### Psychotherapeutic Intervention as Remedial–Stigmatized versus Preventative–Valorized

In the Western mode, psychotherapeutic intervention tends to be remedial and stigmatized. Most Euro-Americans do not see a therapist unless something is wrong and even then, going to see a therapist may be seen as a personal failure. This relates to the stigma generally associated with mental illness in U.S. society (Corrigan and Calabrese 2005; Link and Phelan 2001). The ideological roots of the Euro-American view in this case may be the

optimistic view of normality or mental health as a biological given rather than a social or personal construction, which in turn accounts for the view of all psychiatric problems as invading disease entities rather than possibly being problems intrinsic to the human condition (see Calabrese 1997:251–252). In contrast, for Navajo members of the NAC and in many other Native American healing practices, psychotherapeutic intervention is seen as preventative and growth-oriented as well as remedial. Stigma connected with ritual treatment is not as apparent. In fact, the person who actively seeks psychological harmony through ritual is valorized rather than stigmatized.

**Dualist Separation of Meaning-Centered and Pharmacological Interventions versus Integration**

The example of the Peyote Meeting also illustrates another difference: that between the Cartesian mind–body split typically underlying modern clinical approaches and the treatment of the whole individual in many Native American community based approaches. The biomedical clinical approach involves a dualist separation of mind and body and a division of clinical labor that separates psychopharmacological intervention from meaning-centered intervention. A dialectic between emplotment and consciousness modification lies at the heart of many cultural psychiatries, including Euro-American psychiatry and Navajo Peyotist psychiatry. However, given a dualist philosophical base, the psychotherapeutic and psychopharmacological interventions in the Euro-American system tend to be institutionally separated (into clinical psychology vs. psychiatry) rather than integrated. This tends to mask their interaction at the level of the lived experience of patients.

A dialectical relationship between mind and body, emplotment and consciousness modification is more apparent in Navajo Peyotist cultural psychiatry, in which emplotment and consciousness modification occur simultaneously and work together as parts of the same ritual intervention. Psychopharmacology is employed to achieve insight as well as emplotment in a socially desired and health-facilitating narrative of transformation and relationship with Peyote (psychedelic substances are known to alter suggestibility as well as insight). In contrast, Euro-American psychotherapies (aside from hypnosis, which itself is dyadic and talk-based) tend to eschew radical modifications of consciousness and rely on rational discussions.

Psychopharmacology in the Euro-American context aims at correcting a malfunctioning biochemical mechanism, whereas psychopharmacology in the NAC aims at interrupting the addiction process, reawakening spirituality, supporting emplotment, and facilitating the patient's insight. Psychopharmacological intervention to facilitate radical shifts in perspective, therapeutic emplotment, or insight is not standard in Euro-American psychiatry. We may call the NAC's approach a semiotic–reflexive paradigm of psychopharmacology in contrast to the rather limited agonist–antagonist (materialist) paradigm of Euro-American psychiatry, which focuses on fixing discrete neurochemical imbalances at the molecular level. In the absence of serious research on both traditions, it is not acceptable to assume that

the molecule-focused Euro-American psychiatric paradigm is the only valid approach and that the higher order semiotic–reflexive paradigm is ignorant or mistaken. The safest assumption is that this is a psychopharmacological paradigm clash and, thus, interesting for cross-cultural research.

### Clashing Psychopharmacologies: Synthetic–Processed versus Natural Plant Forms

Dominant Euro-American norms limit psychoactive substance use to only a few culturally familiar substances: mass-produced tobacco products, alcohol, caffeine, and various approved psychiatric medications. Another U.S. cultural norm is abstinence from consciousness-altering substances often denounced in moral terms as "evil" or "sinful." Clinical psychopharmacology is limited to the exclusive use of lab-created psychological medicines that are profitable for drug companies and that are rationalized scientifically (although they often have significant negative side effects of their own). The psychoactive plant medicines of other societies have been labeled in classic Western biomedicine as drugs of abuse or are assumed to be inferior to lab-created medicines, ensuring the hegemony of the Euro-American cultural norms and the incomes of drug companies. However, members of the NAC and many other Native Americans and other cultural minorities continue to trust their sacred plant medicines precisely because they are culturally familiar products of the natural environment rather than inventions of the Euro-American scientist.[5]

## Conclusion

The paradigm clash between Euro-American and Navajo Peyotist traditions of psychotherapeutic intervention is profound and multifaceted. The generative sources of these contradictions are differences in basic cultural orientations to epistemology, the person in social context, the role of spirituality in healing, and the separation or integration of mind and body. These differences derive from particular social histories and adaptations over time to unique local contexts. The analysis presented here illustrates the complex relationship of clinical understanding and cultural ideology and contributes to critiques of biomedical hegemony and the view that the cultural Other holds culturally determined and often erroneous "beliefs" whereas medical science provides "straightforward, objective depictions of the natural order" (Good 1994:22).

This article contributes to a psychiatric anthropology of therapeutic process and therapeutic response through a detailed consideration of the therapeutic event from the perspectives of Navajo Peyotist and Euro-American cultures. This analysis demonstrates the diversity of cultural paradigms of psychotherapeutic intervention and the close fit of cultural formations and therapeutic practice in each context. Many studies of therapeutic process across cultures search for "common factors" in psychotherapy (e.g., Frank and Frank 1993), possibly following the assumptions of the psychic unity doctrine (Stocking 1982:115–123). My analysis suggests that healing traditions may approach intervention using structurally dissimilar and philosophically opposed rather than common factors. We need to study "uncommon

factors" in therapeutic intervention, those that are unique to particular cultural traditions or groups of traditions.

Euro-American psychotherapy derives from a cultural orientation that can be described as individualist, positivist, rationalist, secular, and mind–body dualist. It emphasizes the dyadic (one-to-one) healer–patient relationship within a positivist approach that emphasizes the single patient as a source of data to be collected in isolation from the patient's social contexts, sequestered within a private office and within the one-hour time slot. Therapeutic change is typically characterized as a rational decision arrived at through cost-benefit analysis or weighing of evidence. There is an expectation of calm self-disclosure and rational discussion of one's deepest emotions to a professional stranger in hour-long therapy sessions in which an individualized health-facilitating narrative is collaboratively constructed by therapist and patient. A form of mind–body dualism is revealed in the Euro-American approach to psychopharmacology. Euro-American culture has divided into separate clinical disciplines the psychopharmacological approaches to mental health intervention (psychiatry) and the semiotic and behavioral approaches (clinical psychology). The interventions in each of these disciplines have become increasingly polarized and autonomous.

In contrast, Native American traditions of intervention and especially the practices of Navajo members the NAC tend to be communal, focused on experiences rather than reasoning and conversation, and embedded in a system of spiritual understandings and practices. Healing may involve ecstatic experiences or hypnotic suggestions forged in a symbolically structured ritual context that may extend for many hours or days (unlike the rather limited psychotherapeutic office hour). This process involves an integrated understanding of mind and body and a more meaningfully integrated approach to psychopharmacology. Although Euro-American psychopharmacological intervention has followed a very materialist agonist–antagonist paradigm, paying the bulk of its attention to effects at the molecular level, psychopharmacological intervention in Native American rituals like the Peyote Meeting tends to follow what may be called a semiotic–reflexive paradigm. This approach emphasizes the ability of certain psychoactive plants (working in close coordination with structures of meaning and behavior) to facilitate therapeutic emplotment, meaningful emotional experiences, and insight. Rather than being institutionally separated, psychopharmacology and meaning are aspects of the same intervention. Use of psychoactive medicines is aimed at higher-order mental processes and transformative experiences rather than micromanagement of a person's mood state and level of arousal.

Cheryl Mattingly (1994) and Mary-Jo DelVecchio Good and colleagues (1994) have provided sophisticated anthropological analyses of the collaborative creation and negotiation of plot structures by Euro-American clinician and patient dyads. The study presented here begins to consider how different this process may be in cultural psychiatric contexts that are less dyadic, in which therapeutic plot structures are more fixed by cultural tradition, and in which the presence of a healer may not even be necessary for a therapeutic process to occur. Such an expanded approach to therapeutic emplotment would encompass collective cultural

processes in which therapeutic structures are built into shared meaning systems that continually emplot individuals and groups and that are activated by ritual.

The analysis presented here suggests that future research on psychotherapeutic intervention in diverse cultural contexts or with minority communities within multicultural democracies should do more to take such fundamental differences into account. It is vital that Euro-Americans become more aware of the particular cultural orientations that help form modern clinical disciplines. Without an understanding of such contrasts, researchers and policy makers may succumb to the paradigm clash and judge the healing modalities of other cultures to be ineffective superstitions, pathological drug use, or mere cultural performances. In the realm of clinical services, therapeutic interventions that have evolved over centuries and are uniquely compatible with local cultural orientations and expectations may be replaced by Euro-American interventions of questionable compatibility or therapeutic value but with considerable colonizing power.

There is a growing debate in the clinical disciplines about pluralism in the context of the increasing standardization of psychotherapeutic intervention (e.g., see Chambless and Ollendick 2001; Elliott 1998; Henry 1998; Silverman 1996; Westen et al. 2004). Much of this debate centers on the so-called "empirically validated treatments" (American Psychological Association Division of Clinical Psychology 1995). It is often assumed that if a particular treatment has some empirical support, then it should work for anyone. This ignores the issue of cultural and individual differences in what works therapeutically. Because patients are not homogeneous, neither should psychotherapeutic intervention be reduced to a "one size fits all" therapy manual. Human diversity includes deep cultural psychiatric differences, often requiring therapeutic pluralism rather than standardization of treatment options.

In conclusion, dealing with cultural issues is often intimidating for Western clinicians trained to rely on implicit and unexplored cultural values or for Navajo of the NAC whose healing practices similarly rely on cultural presuppositions seldom explicitly reflected on. In fact, any traditional practice can be considered vital and necessary by the people who perform it. Faced with a diversity of claims, each nation fashions its own balance of pluralistic tolerance and forced assimilation. However, a special ethical issue is raised by traditional practices that can be shown to support health or effective socialization for members of the social group in question. My year of clinical experience working with Native American clients has convinced me that, for many Native Americans and especially the Navajo of the NAC, Euro-American psychotherapeutic interventions are often irrelevant and useless, if not harmful. The data, including the reports of Aberle and many other ethnographers, the Indian Health Service coding of the NAC ritual as a reimbursable therapy, the study by Halpern and colleagues (2005), and my own relationships with many Navajos who recovered from alcoholism using the NAC, suggest that the NAC's ritual intervention is safe and successful in fostering abuse-free lifestyles in Native American clients. Yet paradigm clashes

associated with this tradition have resulted in the Supreme Court's decision that the practice can be prosecuted as a "Class B felony."

An attack on non-Western community based approaches to intervention that can be shown to work in favor of classic Western techniques that do not work amounts to an attack on the very mental stability of Navajo and other Native American individuals and families. This sort of psychiatric imperialism is not the role of clinicians and clinical researchers. Instead, the full range of human psychotherapeutic interventions requires critical study. Therapeutic practitioners need to work to support all peoples in their efforts at self-healing.

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## Notes

**1.** This project was established under the guidance of the leadership of the Four Corners Chapter of the NAC and with the permission of the clinical facility mentioned based on a vote of its Board. IRB approval was obtained from the Social and Behavioral Sciences Institutional Review Board at the University of Chicago. This project was initiated years before the Navajo IRB came into existence and overlapped minimally beyond its establishment. The author is seeking retroactive approval of the project from the Navajo IRB. However, the present publication is a reflection on data already published elsewhere as permitted by the Four Corners Chapter of the NAC and the clinical facility (Calabrese 1994, 1997, 2001).

**2.** This comparison raises the question of the relationship between the NAC and the older religious traditions among the Navajos. Although this similarity in symbolism may resonate in syncretic ways for some Navajos, it must be emphasized that the NAC and traditional Navajo religion are distinct traditions. The NAC derived from Plains traditions that were considered unwelcome foreign influences by many Navajos and Navajo NAC members faced intense opposition from traditionalist and Christian members of the tribe. In fact, I interviewed Navajo NAC members who had been jailed by their own tribe for practicing this religion.

**3.** It should be pointed out here that the ethnographic literature also contains a few accounts (e.g., Edgerton 1971) of traditional healers who take a more empirical, quasi-scientific approach to healing even within cultures that emphasize witchcraft or ritual impurity in their understandings of illness. There are also, of course, dyadic therapeutic encounters that take place within traditional healing contexts. I am discussing a paradigmatic approach in a particular tradition that has been targeted by the U.S. Supreme Court as illegal rather than exploring the full range of Navajo or Native American healing practices.

**4.** Of course, sensitive psychotherapists may have a talent for reading beneath the patient's words, going beyond the explicit content of the communication.

**5.** The herbal industry may be considered a sort of middle ground between the two.

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