

The living dead:

Interactions between the living and the dead in clinical practice



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During my 42 years as a general internist, I occasionally came across what the Anglican priest and philosopher John Mbiti called “the living dead.”¹ To some of my patients, the dead were alive in ways that were benign and to be enjoyed. To others, the living dead were flat out terrifying.

Fresh out of internal medicine residency at Cleveland Metropolitan General Hospital in the late 1960s, my family and I headed to the United States Public Health Service Hospital in Shiprock, NM. Clinical interactions at Shiprock frequently involved interpreters. I learned that terms such as allergy, that I’d heretofore taken for granted, not only had no Navajo equivalent, but that the bilingual aides were being asked to undertake the complex task of interpreting without training. Over time, I began to recognize commonly used Navajo terms. As I was about to start intravenous antibiotics on an elderly woman, I had the following exchange:

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MD: Would you ask her if she is allergic to any medications?

Aide (in Navajo): Does white man’s medicine make you vomit?

Patient (in Navajo): No.

MD: Did you just ask her if white man’s medicine makes her vomit?

Aide: Yes.

MD: That’s not quite what I need to know, I have to know about allergies to medications...

Aide: Well I don’t know about those things...what’s allergy mean anyway? If you know so much Navajo, why don’t you ask her?²

My education about the language and culture grew as bilingual staff members became teachers and informants. Patients often recounted Navajo therapies that lacked readily available English equivalents; these occasionally required a lengthy explanation. A nursing aide at Shiprock, Daisy Descheenie, was interpreting for an elderly Navajo speaker:

Aide: She says she’s had a Wind Way ceremony done. Her family thinks she might need another sing.

MD: Wind Way? Another sing?

Aide: Yeah, we call the one she had Chíshíjí, it's actually got a longer name than that. It's a four-day sing, but it's not as long as the Navajo Wind Way—that one takes nine days.

Chíshíjí? I was clueless but curious. One thing seemed clear. Many bilingual patients were best interviewed in their first language. Additionally, I began to realize the frequency with which my patients were also using one of the three major healing systems then active on the reservation: traditional Navajo religion and its ceremonies; the Native American Church; and Navajo Christian charismatic healing. Years later, anthropologist Thomas Csordas studied and commented on the ways in “which religion and spirituality are intimately entwined with health care and healing” in Navajo life.³

The contamination of the dead, Ch'íídií

The patient who first taught me about the troubles that the living may have with the dead came in for an employment-related physical exam. A seasonal ranger at Mesa Verde National Park, he mentioned that he needed to have at least two ceremonies done each year. He and his family were concerned that his work involved exposure to human remains. “There’s bones in the ruins,” he explained, “even the visitor’s center has bones...and after a rain or a windstorm we may find a piece of bone sticking out of the sand or clay, one we’ve never seen before.” While he didn’t complain, or editorialize about this, he made it clear that getting along in his life and getting along with his relatives worked better if he had Hózhóǫ́jí in the Spring and ‘Anaa’jí in the Fall.

Hózhóǫ́jí, the Blessing Way, is a ceremony that’s often used for protection, to prevent misfortune and illness. ‘Anaa’jí, the Enemy Way, is meant to dispel the influence of ‘ghosts.’ In 1963, Frank Mitchell, a traditional healer who served on the Navajo Tribal Council in the 1930s, talked about ‘Anaa’jí:

Enemy Way really has to do with whether you have killed or hurt somebody...if you hurt them in any way... their ghost is going to come back and bother you...If we have not been treating someone’s spirit right during our lives...it can come back and punish us.⁴

Speaking Navajo when recording his autobiography, Frank Mitchell used the word ch'íídií, translated as ‘ghost’ in the above quote. Key authorities on the Navajo language suggest that ch'íídií, has broader meanings.

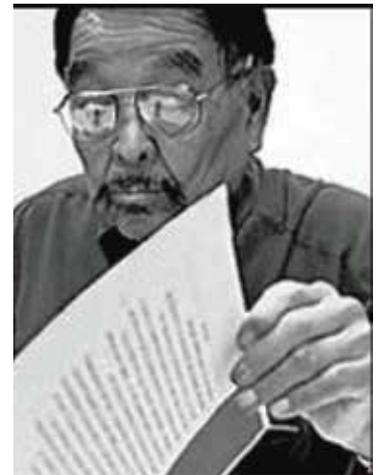
Writing about Navaho (old spelling, 1943) soul concepts, the Franciscan Priest Berard Haile described ch'íídií as “something which manifests itself even after the ‘wind soul’ has left the human body...and can hardly be identified with that part of an individual’s self which after his death...is called...‘his ghost.’”⁵ Anthropologist Gladys Reichard (1950) wrote that ch'íídií “may in fact mean ‘the contamination of the dead,’”⁶ in its broadest sense.

Slim Curly, a Navajo ceremonialist, recorded ‘Anaa’jí, the Enemy Way ceremony, and Berard Haile published the Navaho text with an English translation. During the ceremony, the men chant about the dead enemy and about the scavengers:

Now the bent bow of the Ute enemy, of the enemy man, is scattered abroad...his excrement is scattered, bones are scattered abroad, his corpse lies there, Rah, Rah...The big crow really spreads his feathers, his own young are eating all the flesh, Rah, Rah...Slim coyote... drags the corpse...to a suitable place, Rah, Rah...⁷

Taylor MacKenzie, MD, a Baylor-trained Navajo surgeon and colleague at Shiprock, and I were struck by the gruesome imagery, especially the coyote and crow chewing on the corpse. Concerned that the ceremony portrayed a bad image of the Navajos, MacKenzie said, “See? That’s why this stuff shouldn’t be published!”

Over the ensuing years, listening to patients’ stories in multiple sites changed my early view of the Enemy Way. The graphic images chanted in the Enemy Way could just as easily portray a century filled with warfare, ethnic cleansing, and genocide with “more than 50 million people...systematically murdered in the past 100 years.”⁸ By this measure, the Enemy Way chant merges into current realities. It’s a precursor to the instantaneously transmitted media that enter our homes. The violence is there for all to see.



Taylor McKenzie, MD (1931–2007), the first Navajo medical doctor, Vice President of the Navajo Nation, and the first Navajo Nation Chief Medical Officer.

The Navajos stirred my interest in working across boundaries of language and culture. When I took a position at the University of Colorado Medical Center as Director of Medical Clinical Services (1970–1976) I had the good fortune of working with Sydney Margolin, a psychoanalyst and professor of psychiatry who was engaged in extensive cross-cultural health care. We recorded, studied, and treated patients with firmly held traditional/folk explanations for their illnesses in his Human Behavior Laboratory.⁹

Margolin's teachings and patients, like the Mesa Verde park ranger, led to my reporting three cases of Ghost Illness in tribal patients (Navajo, Salish, and Hmong) in an issue of *American Indian and Alaskan Native Mental Health Research*.¹⁰

The emergence of PTSD as a diagnosis

In my view, post-traumatic stress disorder, PTSD, tops the diagnostic categories in which the dead are likely to play a role. In 1978, a healthy man with vague stroke-like symptoms was hospitalized in the U.S. Public Health Service Hospital in Seattle. I was ward attending that month on its 12-bed open medical wards. The patient, who bitterly referred to himself as a "Vietnam Graduate," turned out to be the first full-blown PTSD case we'd seen, at a time before the diagnosis existed.

Our team was faced with a diagnostic puzzle. At times, the patient would lose it and disrupt the entire ward. I had an urgent page one afternoon, "You'd better come up here right now, your patient is going nuts!" He'd awakened from a nap crying out, and was yelling at the nursing staff, ward aides, and house officers when they approached him. As he eventually told us, he'd experienced a recurrent terrifying dream that involved an air strike. He saw body bags and the faces of the men lying there. "But it's more than just a dream," he said, "I often see them after I wake up, sometimes it happens when I'm wide awake."

During his last tour of duty in Vietnam he was calling in air strikes. "They kept giving me coordinates closer and closer to their own position. They were screaming at me to 'DO IT!' I yelled, 'That's right where you are!' 'You got it asshole, call it in, we're dead meat anyway.'"

He called the air strike. There were no American survivors. His commander blamed him for the deaths, "The son-of-a-bitch made me put them in body bags."

His stroke-like neurological symptoms cleared quickly, and his toxicology screen came back negative. Unsure what to think, our team called for help. The consulting psychiatrists' diagnosis of gross stress reaction came from the first *Diagnostic and Statistical Manual of Mental*

Disorders of the American Psychiatric Association (DSM-I, 1952). The DSM-I made reference to stress caused by combat or civilian catastrophe. The second published manual, DSM-II in 1968, omitted any such diagnostic category.

Our consultant suggested a tricyclic, and commented, "I've followed a number of the World War II and Korean War vets with combat-related troubles that last for years." While he didn't use the term "flashbacks," he spoke of vets experiencing intrusive, frightening memories, and interactions with the dead. He explained, "It's a kind of stress-induced hallucinosis." He cited a long list of prior names for the syndrome including combat fatigue, war neurosis, and shell shock.

No official diagnosis for war-related stress disorders was available between 1968 and 1980¹¹ when PTSD became an official part of psychiatric lexicon (DSM-III, 1980). Since the hospital had a contract to care for active duty military and retirees, the patient continued to see us in the clinic for nearly 20 years. He acquired the new diagnosis of PTSD in the early 1980s.

Questions about the diagnosis have continued.^{11,12} Anthropologist/ethnographer Allan Young argued in 1995 that PTSD is an invented, culture-bound diagnosis, tied to the 20th century:

The disorder is not timeless....Rather it is glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented by the various interests, institutions, and moral arguments that mobilized these efforts and resources.¹³

Both PTSD, and 'Anaa'jí appear to be culture-bound. The literature reveals that the definition of PTSD was impacted by conflicting societal conventions—legal issues/definitions, military recruitment issues, the terrible cost of the illness to veterans and their families, the fiscal cost to the health care system, etc.

Nonetheless, interactions between the living and the dead are a commonality shared by PTSD and 'Anaa'jí. The Veterans Administration has incorporated 'Anaa'jí in therapeutic efforts to treat Native American veterans.¹⁴

A 1964 commentary about Navajo ghost sickness/illness, "speculated that since in fact there is no ghost, the symptoms derive from the patients' own beliefs and attitudes."¹⁵

My own ghost illness article was written after a Welsh general practitioner, Dewi Rees, reported that nearly 50 percent of Welsh widows and widowers reported auditory, visual and even tactile interactions with their deceased spouse while in a waking state. He disallowed experiences

that occurred lying down, napping, or excused as in seeing “the deceased in their mind’s eye.”¹⁶

Many of my widowed patients were delighted, even relieved to talk about similar experiences. One was a recently widowed woman recovering from a pulmonary embolus. I first met her while making rounds on a weekend. She appeared startled when I entered her room. While she assured me that she was well prepared to go home and described excellent family support, she continued to look uneasy. Sensing that something was troubling her, I shared brief stories told by some of my widowed patients. She spontaneously explained, “My husband was standing at the end of my bed when you walked in.”

When I presented her case at grand rounds, in 1993, about one-half the internists in attendance thought she needed a psychiatric consult. None had heard their own widowed patients report similar experiences. However, the patient reported that she and her widowed friends enjoyed talking about these experiences finding them pleasant and helpful.

Rees reported that while his widowed patients freely discussed their experiences with friends, none had reported the events to their physicians. Rees’ findings have subsequently been documented in multiple studies and cultures.

Dealing with trauma across language barriers

My patient revealed the presence of her husband in the room only after I’d engaged in telling stories about other widows. Storytelling played a major role in cross-cultural counseling carried out in multiple languages at Asian Counseling and Referral Clinic in Seattle (ACRS) where I saw patients once a week for more than 25 years. Interpreter case managers provided the language interface as well as the continuity critical to dealing with traumatized patients. And some of the interpreters had experienced traumas similar to their patients.

An elderly Mien woman, referencing the source of some of her nightmares, described her escape from Laos across the Mekong:

It was dark when we crossed, we were afraid the soldiers on the Lao side would spot us. We thought we were safe



Navajo medicine man teaching his daughters.

when we made it to the Thai side, but the Thai soldiers came with guns. They forced us into deep mud along the riverbank. No one could run. The women started screaming, “Help us, they’re robbing us...” We had our jewelry and earrings torn off. The soldiers beat some of the people and robbed us all.

She was silent for a moment, then continued:

One young woman was taken away. She had a bad leg all her life and she limped, but she was very beautiful. She was raped by the soldiers.

There were long pauses throughout in her story. Then the interpreter spoke up, “I know I’m not supposed to speak for myself but I was there, my family crossed in the same boat.”

He pointed to his knees and said, “The mud was up to here, we could barely move, people were screaming. I thought they might kill us. It was still dark and I remember looking back at the lights on the Lao side and thinking: ‘What did we come here for?’ I couldn’t believe what was happening.”

Witness, victim, patient, interpreter—roles are sometimes blurred in the clinic.

Stories are the key

Traumatized patients are often reluctant to disclose. I first met a Cambodian woman referred by a family physician for a variety of somatic complaints, and presumed

depression. Severe, recurrent headaches were the most consistent symptom. Her records revealed multiple visits to clinics and local emergency departments. She had undergone major medical and specialty evaluations and treatments. Nothing was found, and nothing seemed to work including a variety of medications.

This was her second mental health clinic referral. Her unhappiness, she said, was entirely due to the daily experience of unrelenting physical symptoms, especially while alone in her apartment with her two young children, and when it was quiet. In an effort to distract herself she spent her days wheeling the children around a mall. She rejected the notion that what happened to her during the Pol Pot regime could be related to her current troubles.

It was storytelling and talk about dreams involving the dead that broke the ice of this Cambodian woman's previously undisclosed history.

Sometime before she reached the age of 11 years, her entire family was taken out to be killed. She witnessed the deaths of her mother and father, and then she was struck on the head and thrown into a trench. She got up and ran. She was shot in the thigh, beaten, and thrown back into the trench. She thinks that she was unconscious because she woke up underneath a body and remembers that it was nighttime. She crawled out of the trench and was found, helped, and hidden by an elderly couple.

Thinking about what happened gave her nightmares and made her feel sick. Talking about it was worse. "That's why I wander about in the mall with my children, that way I don't hear people calling out, I don't hear the screaming, the pleading, and sounds of people being killed."

Years later, Devon Hinton, MD, and his colleagues focused on dreams of the dead among Cambodian refugees with PTSD.¹⁷

Dreams and interactions with the dead can be used to help resolve a diagnostic dilemma.

I had an urgent request to see a 58-year-old Iñupiat trapper from a North Slope Alaskan village, initially admitted two months earlier for unrelenting right upper quadrant and flank pain. The house officer who called me held the phone aside saying, "Can you hear him? That's him shouting in the background!"

Extensive inpatient evaluations in three different hospitals, including a university referral center, failed to reveal a diagnosis. He was being managed as a chronic pain problem, and had been placed on methadone. When the gastroenterologists proposed yet another test, a liver biopsy, this heretofore mild mannered, polite man became disruptive, threatened to leave the hospital, and demanded increased medication.

Prior to the onset of his pain, the patient had been an active hunter and trapper in a remote village accessible only by boat or float plane. He was born and had lived in times when storytelling dominated Iñupiat households, and dreams were discussed extensively, especially dreams of the dead.¹⁸

Because he was agitated, upset, and likely frightened, I decided to avoid asking questions and to undertake an interview based on storytelling and dreams, a strategy that I outlined in a chapter on cross-cultural methodology.¹⁹

I introduced myself, sat down, and mentioned that I'd taken care of a man from a village near his home who was such a powerful dreamer that dreaming helped him decide where to hunt. The patient discontinued moaning and holding his side, sat up, and with great animation shared a story about going hunting with his brother:

We had set a fire and gone to sleep...it was still light, you know, the time of the midnight sun. I dreamed the caribou were standing in a long line in a valley. I walked down the line in front of them. You could even see the smoke coming out of their noses. Then the big one at the end stepped right out in front of me!

This dramatic dream was told with energy, gestures, and detail, "I knew exactly where the caribou were, woke my brother up, and we went down there and shot some Caribou!"

Acknowledging the dream, I opted for a declarative statement, "I think you've been dreaming the dead...I'm not certain who, but that's what I think." He paused, and then described two dreams of deceased relatives—his parents and another brother:

My mother and father were sitting on the ice with wet clothing...they asked me to help them change their clothes...I noticed that my socks were wet so I sat down and changed my own socks...

My brother was in a skin boat setting a seal net, he asked me to help...I sat down on the shore and told him what to do...but I didn't touch the net.¹⁹

The dreams were frightening. Each led to a long-distance radiophone call to his wife from the hospital. She shared his fears: "You didn't touch their clothes, did you?"

When asked what would have happened if he had touched the seal net or his parents' boots or clothes, he quickly stated, "Then I would have been like them."¹⁹

The patient went on to reveal a complex story of events

in the village that began in the preceding August when as a village elder and minister, he witnessed a fight in the schoolyard in which a boy punched a younger girl in the face knocking her down. He upbraided the boy, and gave him a stern lecture about his behavior. This led to a village dispute of major proportions in which nearly one-half of the congregation left his church. Over the next few months the boy's grandfather (a well-known shaman) accused the elder/minister of flying at night, and reported seeing a ring of light visible around his home at night—accusations which imply that he was dangerous, working evil in the community, and not a Christian minister who could be trusted.

Later that fall, the patient and his wife began to think that they might have to leave the village. In January, when he slipped and fell down a snow bank he concluded that it was not an accident. He'd injured his right side, and felt that the boy's grandfather was responsible. He felt trapped, unable to seek traditional Inupiat treatment due to his position as a minister, "If I had gone to a healer, they would have said that I don't believe...that Jesus isn't strong enough." He had relied on prayer, and began sleeping with his Bible under his pillow.

Once his history was revealed, I assured him that the physicians were not withholding dangerous information, and that there was no evidence that he had a serious or potentially lethal illness. Relieved of his story and dreaded fears, he rapidly improved, was weaned off of methadone, and became pain free.

Before discharge from the hospital, he dreamed of his deceased brother, and this time, was delighted. The dream implied that he had good years and good hunting ahead.

An ancestral shrine

While our minister/patient relied on Christian beliefs to handle his fears, some patients rely on family shrines to seek help. One Cambodian patient with severe PTSD experienced recurrent abdominal pain whenever she had nightmares and sleepless nights. To deal with her pain, nightmares, and flashbacks, she prayed to a favorite grandmother who died before the "bad times." It was during the process of talking about her prayers that her care providers learned about the pictures of her husband and son. She kept them in an ancestral shrine at home.

Her eight-year-old son, who had wandered home from a re-education camp to see his mother, was killed right in front of her. He wasn't supposed to be there, a soldier caught the child and bayoneted him.

The mother had already lost her husband during the Pol Pot regime. He'd been declared to be revolutionary trash

and was beaten to death in front of their house. People weren't supposed to mourn for trash. If you did, you might be killed yourself. Her husband's body lay in front of the house for a day-and-a-half before she dared move him.

Believing she would be killed for having pictures of her husband and son, she buried the pictures in a can, and later sewed them into her clothes.

She showed the photos to us during a visit her case manager and I made to her home. Later, she brought them to clinic and shared them with others in her therapy group. Her action opened the floodgates encouraging other patients who then brought in mementos and stories of their families, of their lives, and of their dead relatives. The group was overwhelmed by everyone's need to talk, and had to increase the frequency of its meetings.

However, talking about violence doesn't prevent flashbacks. On one of her clinic visits she appeared with a cast on her right arm. She'd been leaving Safeway with groceries in her arms when she suddenly saw the soldiers in the act of bayoneting her son. She screamed, ran, tripped over a parking barrier and broke her arm.

Reburial of the dead

More than one traumatized patient has said, "I don't want to talk about it. What do you want to dig up that old rotten stinking stuff for? We buried it long ago."

Since there are no words in many Southeast Asian languages for mental health, counseling, or psychology, a Lao coworker/interpreter responded by first agreeing with the patient, "You're right, we do dig it up, and it's hard to talk about." Then he added in Lao, "but after we dig it up, we help clean the bones and then we help re-bury them."

He called upon a long-standing traditional healing practice—reburial of the dead which is occasionally used as a therapy for the living. It is also practiced on ancestral days when burial pots are reopened, ancestral meals prepared and offered, and the bones are cleansed, re-interred and the pot is closed once again. As a metaphor for talk therapy or counseling, cleaning up the bones provides rich meaning in Lao. Reburial of the dead also speaks to the central question, can memories of the dead ever be put to rest?

PTSD and interactions with the dead

PTSD, a diagnosis that has been challenged as having political, social, and non-psychiatric overtones,^{11,20} has become a catchword in medical and popular vernacular. Omitting a diagnostic category for war trauma from the official psychiatric nomenclature between 1962 and 1980



Eskimo (Inuit) hunting reindeer, illustration by Le Breton, from *L'Illustration*, Journal Universel, No 529, Volume XXI, April 16, 1853

puzzled observers.²¹ As neuroscientist and neuropsychiatrist Nancy Andreasen, PhD, MD (AΩA, University of Iowa, 2001, Faculty), points out, “the existence of a valid syndrome occurring as a consequence of severe stress cannot be questioned.”¹¹

It is likely that the descriptive details that define the diagnosis of PTSD will continue to evolve. A new language to describe the reality of the frequent interactions with the dead that occur in PTSD, bereavement, and other clinical circumstances may need to be developed.

Rees, who described the hallucinations of widowhood in 1971, and established the normalcy of human interactions with the dead, wrote in a chapter entitled “The Bereaved and the Living Dead:”

There will always be problems with words like ghosts, apparitions, hallucinations, after-death communications, illusions, pseudo hallucinations and a sense of presence, all of which have been used in reference to the subject matter of this chapter. I had hoped to circumvent this dilemma by not using any of these words but this I have been unable to do. In fact, I have added to the confusion by introducing the term ‘living dead’ which Mbiti says is the African way of referring to people who have died.¹

In many ways, the term “living dead” captures the reality of these encounters for individuals who’ve experienced trauma, loss, or have been threatened with death.

Over the last 25 years, psychiatrists have cut back on time spent with patients while relying heavily on medications. During that same time, primary care providers, pressured to increase productivity, have shortened visits. All the while, to me, it seemed that spending time talking with patients not only revealed undisclosed life histories, but occasionally solved diagnostic dilemmas.

Waitzkin and Magaña writing about traumatized patients, began their article with a quote from Leslie Marmon Silko’s book *Ceremony*, wherein an older shaman says:

I will tell you something about stories...
they aren’t just entertainment.
Don’t be fooled.
They are all we have you see,
all we have to fight off
illness and death.

You don’t have anything if you don’t have the stories.²²

I’ve often wondered: Is Silko’s shaman talking about the story behind the ceremony, like the rich myths that support Hózhóǵǵí and ‘Anaa’jí, or the story of the patient?

Sometimes I think I'm being too linear, that my professional language, which refers to flashbacks and to ghosts as hallucinations, doesn't quite get it. Then I think about what my patients have experienced, and what they have to say. You don't have anything if you don't have the stories.

Author's Note:

Taylor McKenzie, MD, was the first Navajo medical doctor. He also served as Vice President of the Navajo Nation, and was the Navajo Nation's first Chief Medical Officer.

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