

*Ghost Illness**A Cross-Cultural Experience with the Expression of a Non-Western Tradition in Clinical Practice*

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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, page 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, page 96)

Introduction

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 essay.

Ghost illness appears to be a culture-bound syndrome. Spirits or “ghosts” may be viewed as being directly or indirectly linked to the cause 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 exists in many non-Western cultures, but the terms coexist 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 essay. 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. . . .

(Lewis and Lewis, 1984)

Tell them not to trouble us.
 Or not to come here
 and take anyone else away.

(Dusenberry, 1962)

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 essay will review three patients who come from cultures which have well-documented views regarding illness caused by the dead. The patients are Navajo (a Southwestern Native American tribe), 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 (Amoss, 1978, and Collins, 1980) and Hmong (Chindarsi, 1978) people have ancestral religious process, and both groups have ceremonial means to deal with ancestral interference and malevolence. 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 I: A Navajo Woman with Ghost Illness

<i>Date of Onset</i>	<i>Problem List</i>
May 1977	1) Bilateral accessory breasts
1972	2) Infertility, 5 years duration, resolved 1977
July 1977	3) Postpartum 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, but massive swelling in both axillae (armpits) 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 postpartum 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: First, 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 my 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 reemerged, increasing in frequency during the postpartum 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’iidii* dreams.” (*Ch’iidii* 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* (a system which blends religious beliefs and prayers with the use of herbs, massage, and other traditional healing methods). 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 rule out problems that might contribute to the prolonged postpartum depression. (This included an evaluation for postpartum hypothyroidism.)
- 3) Lengthy discussions were undertaken regarding the couple’s disparate beliefs and backgrounds. Each spouse had made prior concessions to the other’s background; 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. (page 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, postpartum 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, *sá*, 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 sound unusual to the reader. However, establishing blame for a death is not an uncommon circumstance among the Navajo. The mother’s 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 connection being made 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. According to Western psychology, 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 too 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 hadn’t 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 reestablish her role as an active mother and wife.

Case II: Salish Woman with Ghost Illness

<i>Date of onset</i>	<i>Problem list</i>
Summer/Fall, 1976	1) Rheumatoid arthritis
Long-standing	2) Diabetes mellitus, insulin dependent
Long-standing	3) Obesity
1976	4) Positive tuberculin, treated with INH
Summer, 1976	5) Hepatitis related to INH therapy
Fall, 1976	6) Depression
Long-standing	7) Asymptomatic diverticulosis

This middle-aged woman (who was a well-known traditional healer) 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 evaluations 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 being done for an individual who had multiple arthritic complaints. The incident had occurred about three months prior to her admission. 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” is a common practice used by Salish groups to prevent dangerous spirits from sticking to healers and participants 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 wasn’t 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 eighteen 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; Jilek, 1974; Collins, 1980). 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 its 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, page 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’ opinions 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 noticeable swelling of the metacarpophalangeal joints, 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:

- 1) 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.
- 2) 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.
- 3) Both were filled with anxiety and had severe bereavement problems.
- 4) The daughter's grief reaction was likely exacerbated by the emergence of her rheumatoid arthritis.

Additionally, 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 circumstance. 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 III: A Hmong Refugee with Ghost Illness

<i>Date of onset</i>	<i>Problem list</i>
September, 1976	1) Headaches, sleep disorder
Long-standing	2) Amebiasis, hookworm
October 31, 1977	3) Miscarriage
1975	4) Refugee, monolingual

The patient is a nineteen-year-old, monolingual Hmong woman. She was born in the northern 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 seventeen 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 twenty-four to forty-eight 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 fifteen-month period. The physicians involved had recorded a variety of impressions of her problem: migraine, cluster headaches, and “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 reevaluated 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 came 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 man and then the soul of the old

man went with the ghost and he died. . . .” (Chindarsi, 1978, page 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 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 twenty 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 to 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 forty-eight hours, a number of relatives and other Hmong refugees gathered, and 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 an ancestral meal aimed at rectifying the situation. The deceased parents were addressed by prayers and the missing permission was sought.

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 her 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, I will next discuss the prevalence of the ghost illness phenomena. It will be linked to: 1) the epidemiology of human experience with death in family members, 2) the impulse to die during bereavement, and 3) 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 foreordained 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 Island groups (Johnson, 1981; Sharp, 1982; Lazar, 1985), the Thai (Tambiah, 1980), African peoples (Bohannan, 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, pages 101-102).

Human Experience with Death in Family Members

The epidemiologic basis for reactions to a death and to dying are brought into sharp focus by a number of striking studies of mortality among the immediate survivors of death in the family. Rees (1967) reported on the mortality of bereavement among 903 close relatives (widows and family members) in Wales. Over 12 percent of widowed individuals died within one year of losing a spouse. Widowers died at the rate of 19 percent and widows at the rate of 8.5 percent. Overall, these rates represented a seven-fold increase in death when the bereaved group was 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 percent in the first six months of bereavement. Helsing 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, Kaprio, 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 death in the United States between 1949 and 1951. Kraus and Lilienfeld (1959) demonstrated that death rates for widowed individuals ranged from four times greater to more than ten 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), widowed males committed suicide at rates that were 6.9 to 9.3 times the rate seen in the married groups. The death rate by motor vehicle accident follows a similar pattern, with rates for the bereaved exceeding rates for controls by factors of 3.1 to 5.9. These studies point to one clear fact: the survivors of death in a family are at increased risk, especially the spouse. Kraus and Lilienfeld (1959) 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 disabilities, 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 regimen . . . 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 for 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 Native American patients, for instance, shows a remarkable incidence of direct and frequently recent experience with death. These 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 whose 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 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 phenomenon 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 implications dreams hold for the living. Individuals from these societies must be dealt with in a fashion that takes their dreaming patterns into account, especially as their dreams may help to explain their own explanations of disrupted health or life patterns.

Fourth, patients from a wide variety of backgrounds may sense that dreams are causative. Additionally, 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 percent) had post-bereavement hallucinations. Many of these hallucinations lasted for years; at the time of interview, 106 (36.1 percent) people 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 hallucinations. 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 percent of the women and 12 percent 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 that 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 percent 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 percent had experienced hallucinations or illusions of the dead spouse. Additionally, in 1969, Yamamoto and colleagues reported interviews with twenty widows in Tokyo and found that 90 percent 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 essay illustrated a relationship between ghost dreams and suicidal ideation. Similar dreams, ruminations, and hallucinations of the dead have been reported to the author in suicidal American Indian patients, survivors of suicide in Alaskan 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, 1990). 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 significant clinical problems. Accommodation to disparate beliefs often requires that solutions fit the context of the patient's belief system and simultaneously deal with both the Western and non-Western traditions.

Note: Bob Putsch, who makes his home on Phantom Springs Ranch at Canyon Creek, Montana, was a founder of the Cross Cultural Health Care Program in Seattle, Washington. Since it began in 1992, the CCHCP has been “addressing broad cultural issues that impact the health of individuals and families in ethnic minority communities in Seattle and nationwide.” The essay that follows was originally published in a 1988 volume of *American Indian and Alaska Native Mental Health Research* with a series of papers dedicated to Sydney Margolin, MD, who had been a professor of psychiatry at the University of Colorado. Margolin incorporated traditional systems of belief and therapy into his care of patients and he taught the author about ghost illness. This essay also appeared, in somewhat different form, in *Sacred Realms: Essays in Religion, Belief, and Society*, edited by Richard Warmes, James Garber, and Jon McGee (Oxford University Press, 2004).

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