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Clinical Case Study

PSYCHOSIS AND SHAMANISM IN A FILIPINO-AMERICAN IMMIGRANT

CLINICAL HISTORY

A. Patient Identification

Mr. A is a 47-year-old, single Filipino-American man who sought care at a county outpatient clinic in a western state of the United States. He is small in height (5 feet 3 inches) and build, and wore casual clothing.

B. History of Present Illness

Mr. A first came into treatment because he began experiencing negative hallucinations of evil demonlike spirits trying to convince him to join them by killing himself. They appeared daily for three months before he finally came into treatment.

At intake, the patient reported feeling confused and felt that there was "something wrong" with him. Specifically, he was bothered by the hurtful demonlike voices and images, could not sleep well at night, experienced anhedonia, and lost his job. He had difficulty taking care of his daily needs and did not shower for weeks at a time. He was slightly disheveled, evidenced blunted affect, and giggled to himself, but had some insight.

Mr. A reported a long and continuous history of auditory and visual hallucinations that began when he was 22 years old. At that time, he experienced a significant number of stressors, including his family's emigrating to the United States without him. He began to feel depressed and eventually his girlfriend broke up with him because he became emotionally distant and unavailable. Mr. A was unable to attend to his poultry business and as a result it went bankrupt. Afterward, he became suspicious of his extended family members, who he felt were trying to take advantage of him by stealing his clothes and money. He reported no history of alcohol or substance abuse.

After this sequence of events and while still in the Philippines, Mr. A reported having a spiritual calling and converting to the Church of the

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Latter-Day Saints. He said that God called out to him, appearing before him as an "old man with a long beard dressed in white." God told him to give up his worldly possessions and become one with him and the Earth. Moreover, Mr. A said that God gave him the power to heal others and sent him on a mission to help people. His fellow church members reacted in disbelief to this calling, which was unusual by Mormon standards. As a result, Mr. A quit the Mormon Church three months later. Nevertheless, God continued to visit him and took him to heavenly places that were filled with beautiful scenery, music, and serenity. He reported feelings of elation, as if he was in heaven, and reported having new-found energy but disturbed sleep. Mr. A followed God's instructions, giving away most of his material goods while he was in the Philippines, and continued to function moderately well.

Mr. A reported that God gave him the power to heal others. He said that he was just one of many of God's healers and that there are numerous healers in the Philippines, including many fraudulent healers. He also reported that healers have different levels of power, some being stronger and more active than others. He indicated that he was a lower-level healer and that he was not able to cure major illnesses such as his own arthritis or his sister's cancer. Mr. A reported being a healer who had fallen off-track and become inactive over the years.

His previous powers were limited to helping cure people of minor illnesses (e.g., cold, flu, feelings of sadness and confusion), which he reported doing for a number of years while he was in the Philippines. He could see and cultivate the healing energy of plants, rocks, water, and other natural objects. He also stated that in the past when he was healthier he could turn clay into gold. Mr. A reported other visual and auditory experiences that began after his initial calling and continued to the present. They included seeing and communicating with various mythical creatures (e.g., dwarves, mermaids, giants, and a giant snake with a human head). He believed that the mythical creatures were his friends and reported that they talked to him and supported him through difficult times. For example, Mr. A said that the giant snake with the human head would often fly him around the city and also take him to beautiful heavenlike worlds. His hallucinations were so prominent that he could see a dwarf in the same room with the clinician during the first session.

After he came to the United States at age 28, Mr. A reported changes in his hallucinations that he did not experience in the Philippines. Specifically, he reported that he was sometimes abducted by aliens, who implanted a chip in his head and used him to help monitor human activity on Earth. He was not afraid of the "friendly" aliens who visited him every couple of years and

who would park their giant-sized spaceship above the city. He also saw giant insects and ghosts that walked around the hospital, which used to be an old army barracks. Mr. A indicated that his experiences had been continuous since the age of 22 and, up until recently, beneficial.

C. Previous Treatment

Mr. A did not seek any psychiatric treatment until the evil demonlike figures appeared 3 months before his presentation to the clinic at age 47. Specifically, he had no prior experiences with psychotherapy or psychiatric medications, and he has never sought care from spiritual healers.

D. Social and Developmental History

Mr. A was born in a mountain village northwest of Manila, Philippines. His entire family emigrated to the United States when he was 21 but he reported staying behind because he had to finish his nursing degree. He eventually joined his relatives in the United States when he was 28 years old. He is the youngest of five children, having one older brother and three older sisters. When Mr. A was 15, there was a landslide in his village and 26 people died. He indicated that his home was destroyed and his family had to rebuild their lives.

Mr. A reported doing well in school but not well enough to pursue his initial goal of getting a medical degree. After graduating from college, Mr. A worked as a taxi driver for one year, began a poultry business, and also helped out with nursing duties at his uncle's medical clinic. He finished a degree in nursing at age 22 but remained in the Philippines for another six years because he was waiting for his immigration papers to be processed.

Mr. A denied family problems as a reason for why he did not emigrate with his family and stated that his family wanted him to join them. He reported a close and stable relationship with his family while growing up. He described a good relationship with his father, who passed away when Mr. A was 33 years old. However, he indicated that his relationship with his mother was somewhat conflicted because his mother is a very strict woman who had high expectations for him to do well academically. He believed she may have pushed him so hard because she did not have the opportunity to attend college. It was after his family moved to the United States without him that his life took a turn for the worse (e.g., losing his job and girlfriend) and that his shamanistic calling took place.

Mr. A reported joining the Church of Latter-Day Saints for the first time while he was in the Philippines, shortly after his family moved to the United States. He stated that he did so because of his religious calling, and

also because he was lonely and wanted to meet friends and have a religion "like everyone else." His conversion to the Mormon religion when he was 22 years old is interesting because, given the long history of Spanish influence and colonization in the Philippines, most religious Filipinos are Roman Catholic. This call to convert to the Mormon tradition directly preceded his initial shamanic calling and experiences. After Mr. A's religious calling, he continued to function well. In fact, this experience helped him cope with the stresses that he encountered immediately after his family's departure.

After coming to the United States, Mr. A worked at fast-food restaurants for one year until he passed the nursing licensing exam. He began working as a charge nurse at a nursing home but quit one month later after he saw a patient die. At that time, he reported not being able to think clearly; he felt nervous and confused, and later became depressed. He had symptoms of posttraumatic stress disorder (PTSD) and was not able to get the images of the dying patient out of his mind. Because of this experience, he returned to the fast-food industry for several years, then worked at a recycling agency for a few years until he was fired. His boss thought that he was taking drugs, but he reported that he was not. Six years ago, at age 41, he started working as a nurse again. However, he was fired from his job because his coworkers thought that he had "mental problems" when he told them that he saw ghosts. He was rehired at another nursing facility and fired again because his supervisor thought that he was mentally ill, and because he had difficulty thinking clearly and performing his duties. He found another job as a nurse but quit this job because he began feeling uncomfortable after seeing another patient die. Two years ago, he stopped looking for nursing jobs because of these recurrent themes in his life, and took some more time to rest and recover.

Mr. A currently lives in a van that he parks in front of his older sister's house, where she and his mother live. He reported a conflicted relationship with his sister, but she allows him to come into the house to eat and use the bathroom. He currently has no close friends but has some acquaintances that he rarely sees. He has a dog that lives with him in his van and keeps him company.

E. Family Psychiatric History

Mr. A described a family history of schizophrenia, PTSD, and depression. Specifically, Mr. A reported that his late father was diagnosed with schizophrenia when he was in his early 40s and began taking thorazine when Mr. A was 12 years old. Specifically, his father experienced

combat-related flashbacks and reported seeing ghosts of dead Japanese soldiers walking around the house. Mr. A indicated that his father was depressed and stayed in bed sleeping most of the time. This diagnosis of late-onset schizophrenia provided by Mr. A's father's doctor was complicated by the PTSD his father experienced as a consequence of his military service in World War II, and it is unclear whether he truly had schizophrenia or misdiagnosed PTSD.

Mr. A's brother, who he believed may have had schizophrenia (this diagnosis was unconfirmed), committed suicide because he was depressed and had a "mental breakdown." Mr. A reported that his sister was possessed by the devil and frequently changed from looking like an angel to looking like a "scary, crazy woman." When asked whether his sister also had schizophrenia, Mr. A said no and restated that she was possessed by an evil spirit, exorcised and healed by a local healer, but reported that she developed cancer soon afterward and passed away. His father, brother, and sister experienced their problems prior to Mr. A's shamanic experiences. It is possible that Mr. A's culturally influenced expression of his own illness, which occurred last, was influenced by their experiences.

F. Course and Outcome

Mr. A was provided medication management by a psychiatrist and weekly psychotherapy by a psychologist. He was treated with a moderate dose of risperidone, which seemed to reduce his hallucinations and delusions substantially. His more prominent hallucinations began to disappear and be replaced by sounds of music, paintings, and less prominent characters such as little figures socializing among themselves. As a side effect of risperidone, Mr. A described minor stiffening of his hands, increased nervousness, dizziness, and loss of balance, all of which gradually dissipated over time. Mr. A's thoughts became clearer and he became more disappointed because of his inability to cope with his distress and work-related difficulties. In anticipation of the possibility that his depression would worsen as his psychotic symptoms diminished, Mr. A was prescribed a moderate dose of fluoxetine as a preventive measure. Mr. A was adherent to his medication regimen and this facilitated an overall decrease in his psychiatric symptomatology.

Mr. A attended weekly therapy for three months. His stated goals for therapy were to understand what had been happening to him, to work again, and to live a normal life. When asked during his initial month of therapy what he thought his diagnosis was, Mr. A said that he did not know. In order to be sensitive to Mr. A's experiences, the therapist spent time

talking with him about his healing powers and the mystical creatures he saw. Mr. A responded positively to this approach. For example, Mr. A reported that everyone has a color-associated aura. Upon further inquiry, he reported that his own aura was purple and that the therapist's was orange.

After a month of therapy, Mr. A began entertaining the possibility that he had schizophrenia. He began to relate his negative experiences with demons to symptoms of schizophrenia provided in an educational handout. The next two months of therapy focused on discussing his desire to obtain and maintain employment, evaluating what had interfered in the past, developing a healthy daily activities schedule, and reducing isolative behaviors. Mr. A and his therapist discussed the feasibility of seeking part-time employment after his symptoms became more stabilized. They also discussed the type of work that would be more appropriate given his current health status and the possibility of endangering others if he were to work as a nurse again. The therapist also helped Mr. A apply for Social Security disability insurance and general relief. Individual psychotherapy ended after three months due to the conclusion of the therapist's rotation. At that time, Mr. A evidenced a reduction in psychotic symptoms and depression, greater clarity of thought, and increased self-care. Nevertheless, since he continued to experience residual psychotic symptoms, fatigue, and limited ability to adhere to a daily schedule, he agreed that he was not yet ready to enter the job market and would reevaluate his readiness with his psychiatrist in the future.

G. Diagnostic Formulation

Axis I:	295.90	Schizophrenia, Undifferentiated Type
	296.32	Major Depressive Disorder, recurrent, moderate
	R/O	Bipolar Disorder with Psychotic Features
	R/O	Posttraumatic Stress Disorder
	R/O	Schizoaffective Disorder
Axis II:	R/O	Schizoid Personality Disorder
	R/O	Schizotypal Personality Disorder
Axis III:		Osteoarthritis
		Hypertension
		Diabetes Mellitus
Axis IV:	Unemployment	
	Financial problems	
	Limited social support	
	Family conflict	
Axis V:	At intake:	GAF = 45
	Current:	GAF = 55

H. Differential Diagnosis

As described in previous sections, Mr. A's psychiatric problems were preceded by multiple stressful events, beginning with the emigration of his family to the United States without him. A period of depression associated with these stressors appeared to precede his shamanic calling. Nevetheless, throughout the initial course of his illness, culturally endorsed and supportive psychotic symptoms seemed to confer a sense of companionship and safety, which helped to alleviate his stress and depression. Mr. A's visual and auditory experiences could be seen as fulfilling a role similar to that of the imaginary play figures that children often create for companionship during their earlier years. These figures, along with his shamanic calling, were interpreted to be culturally normative by the patient, and could be interpreted as such given the shamanic and animistic traditions evident in Filipino culture. In contrast, his symptoms were atypical of those associated with schizophrenia in the United States, which are typically stressful and upsetting.

According to Mr. A, it was not until he moved to the United States and had difficulties keeping a job because of witnessing the death of patients that he began to have distressing psychiatric experiences. These began as feelings of anxiety, confusion, and restlessness, increased energy, sleeping difficulties, and cognitive distraction but later turned into feelings of depression, anhedonia, and subtle cognitive decline. Because his psychiatric difficulties returned each time a patient died, PTSD was considered a rule-out diagnosis. However, Mr. A denied having such symptoms after the landslide destroyed their village when he was 15 years old; otherwise, his symptoms after the death of his patients could be seen as retraumatizing events in an already predisposed individual. Mr. A also denied past or present alcohol or substance abuse.

Mr. A presented with a complex clinical picture that was difficult for his clinical team to diagnose because of the fluctuating progression of his illness and the interwoven cultural issues involved. At intake, the treatment team discussed several diagnostic possibilities, including shamanic illness, but settled on a provisional diagnosis of Psychotic Disorder Not Otherwise Specified. Because of his experiences, several rule-outs were considered at the time, including Bipolar Disorder with Psychotic Features, PTSD, Schizoaffective Disorder, Schizophreniform Disorder, Schizoid Personality Disorder, and Schizotypal Personality Disorder. Three months later Mr. A's diagnosis was changed to Schizophrenia, Undifferentiated Type, for two reasons. First, he now met the criteria for six months of maladaptive and continued psychotic disturbances, including the three months prior to the

onset of treatment. Second, the team felt that his expression of psychiatric distress deviated from normative shamanic experiences. This is described in greater detail under Cultural Formulation.

CULTURAL FORMULATION

A. Cultural Identity

1. Cultural reference group(s). Mr. A is a first-generation Filipino immigrant who came from a mountain village northwest of Manila. He grew up in this predominantly rural area but is fairly educated compared with most Filipinos. He immigrated to the United States 19 years ago to reestablish family ties and is moderately acculturated. It was relatively easy for Mr. A and his family to acculturate because they could speak English and were familiar with American culture prior to migration. This is a result of the U.S. historical influence on and occupation of the Philippines.

2. Language. As with many Filipino immigrants, Mr. A is fluent in English, Tagalog, and Ilocano. Nevertheless, Mr. A is most fluent in Tagalog, and conducting therapy in English had its limitations. For example, Mr. A had greater difficulty expressing his emotions than talking about concrete events.

3. Cultural factors in development. Mr. A's development was influenced by his experiences growing up in the Philippines, his individual and familial psychiatric illness, and his postmigration experiences. He had difficulty recalling his early childhood experiences but did indicate that they were positive. He reported that his family used to be very much like the expected norm for Filipino families. They celebrated traditional holidays, ate meals together, and were very close and cohesive. They began growing apart when his father developed the symptoms that resulted in his schizophrenia diagnosis and began to withdraw emotionally, leaving the burden of raising the family to Mr. A's mother. Two of Mr. A's four older siblings had difficulty coping with life and became "crazy." As Mr. A was the youngest in the family, this had a significant impact on his growth and development. The family relations grew more distant over the years; they became more isolated and stopped engaging in extended family and community practices that were typical of village life.

4. Involvement with culture of origin. Mr. A's social network began to deteriorate with his initial religious calling. He became more isolated and eccentric as he took on the shaman role. This isolative pattern continued

after he moved to the United States and was compounded by his lack of familiarity with American culture and customs. He still eats predominantly Filipino food and adheres to Filipino holidays.

5. Involvement with host culture. Mr. A emigrated to the United States when he was 28 years old, and like many first-generation immigrants, he strongly identifies with his Filipino cultural background. Because Mr. A's family had emigrated to the United States seven years prior to his arrival, it was easier for him to adjust to his new environment with their help. It is important to note, however, that because many Filipinos are fluent in English, few culturally based health, education, and social services programs have been developed for this commonly overlooked group. Access to these types of resources could possibly have helped Mr. A gain earlier access to the treatment system, find and maintain appropriate employment, and develop a social support network. Lack of attention to these remediable stressors eventually led to a decline in Mr. A's mental health. Mr. A is not very involved with American culture. He has no U.S.-born friends and the only interpersonal contact he has is with his immediate and extended family. Although he is no longer involved with any organized religion, he sometimes goes to local churches of various denominations to receive free meals.

B. Cultural Explanation of the Individual's Illness

1. Predominant idioms of distress and local illness categories. Mr. A's condition is complicated, due to the fluctuating level of impairment associated with his symptoms and the thorough cultural embedding of his presentation. Filipino culture contains diverse and widespread concepts for healers and shamans. While the term *manggagamot* is used to denote a physician, it is also used to identify people who are healers, medicine men, or shamans. The word *mananambal* more specifically denotes a shaman (Henry 1986). Shamanic practices in the Philippines are more widespread in rural settings, such as the patient's home village, than in urban areas. Successful healers have an elevated social status and are well respected within these communities.

Psychiatric views of shamanism sometimes do not distinguish between these practices and the psychotic experiences of people with schizophrenia. Walsh (1990) noted that the only distinction many psychiatrists make between shamanic and schizophrenic episodes is the degree to which they are accepted by the person's culture. He identifies two questions that must be answered in order to distinguish between true shamanic practices and episodes that would meet the criteria for schizophrenia. First, are the

experiences during the initial shamanic calling (which sometimes occurs when the person is in a state of crisis) consistent with psychosis? This, however, is not a sufficient criterion, since some shamans who do not go on to develop chronic psychosis can experience transient psychotic states during their initial calling. Second, do these psychotic experiences have the chronic and nonintermittent course often seen in schizophrenia? Walsh notes that only a small percentage of shamans experience initial crises and only some of these experience short-lived psychoses. He concludes by emphasizing the reality of shamanic experiences that are distinct from psychosis. Another criterion that can help distinguish shamanic practice from schizophrenia is the exceptional psychological well-being of many shamans and their level of community service. People diagnosed with schizophrenia rarely make such contributions. Interestingly, in some social groups where shamanism is common, there are culturally defined illness labels for individuals suffering from psychopathology who inappropriately claim a shamanic presentation.

Mr. A's initial shamanic calling fell within the normative limits of shamanic experience in the Philippines, as did his experiences of mythical creatures and his ability to heal others. His experiences were chronic and nonintermittent, however, which is less typical of shamanism and more characteristic of schizophrenia according to Walsh (1990). Moreover, Mr. A did not meet the criterion of functioning exceptionally well psychologically, nor were his role or contributions recognized by the community in the Philippines or the United States. Therefore, it appears that Mr. A's illness can be best described as a prodromal or low-grade chronic psychosis, where his illness progression was contained and his ability to function preserved by cultural protections and the embodiment of the shamanic role. For the most part, his beliefs and psychotic experiences served an ego-protective and supportive function. They were not problematic during most of their duration, providing additional evidence that his experiences were atypical of more severe psychoses. Unfortunately, the level of distress associated with these experiences was greatly exacerbated after Mr. A's migration to the United States, where his difficultly adapting to a new cultural context, his loss of cultural protections, and the stresses he experienced at work exacerbated his prodromal symptoms and led to a more deleterious illness.

2. Meaning and severity of symptoms in relation to cultural norms. Shamans have a culturally sanctioned role and are seen as magicoreligious specialists by many people in the Philippines (Demetrio 1991; Henry 1986). Mr. A's belief in his ability to heal is common among traditional healers, who believe

that they receive their powers after being visited by the spirit of a deceased shaman, a saint, the Virgin Mary, Christ, or God. In interviewing a shaman from the Philippines, Henry (1986) reported that the shaman got his healing powers from an old man with a long white beard, which is similar to Mr. A's reports.

Filipinos living in rural areas of the Philippines are also known to believe in and have experiences of a variety of mythical creatures (Demetrio 1991; Henry 1986). For example, some Filipinos report the existence of *dwendes* or dwarves, small spiritlike people, and *capre*, good or bad giants who live in the forests. Mr. A's experiences with dwendes match folk views that dwendes support and protect people they befriend, and typically only show themselves to people with whom they have this special relationship (Henry 1986). Animal-like creatures with human characteristics, similar to the snake with a human head that communicated with Mr. A, are also described in Filipino folktales. Other spirits and ghosts have cultural reality in many Filipino settings, with the type of mythical creatures varying by region. For example, the Visayas Islands, in the mid-southern Philippine archipelago, are known for reports of *aswang* or vampires. Sailors and fishermen from coastal regions still describe experiences of *multo* or mermaids. Therefore, Mr. A's belief in and interaction with mythical figures could not be simply dismissed a priori as the result of psychosis.

Because of the American involvement since the 1898 invasion, the Philippines has received more Western influence than many other Asian countries. As a result, culturally sanctioned shamanic and animistic practices are more common in rural than urban areas. Although Westerners and more Westernized Filipinos might perceive Mr. A to be a fraudulent healer and *baliw*, or crazy, adherents to more traditional Filipino customs might perceive him to be normal or simply eccentric. Mr. A indicated that many people in the Philippines did not consider him crazy, but that many of his American coworkers thought that he was.

3. Perceived causes and explanatory models. At the time of his initial visit, Mr. A was confused and did not understand what was wrong with him, nor did he admit to the possibility of having a mental illness. Mr. A believed that his shamanic experiences were part of who he was, and did not question whether they were real or imaginary. His belief in mythical creatures and healing powers was embedded in a cultural context that provided some acceptance of his views and experiences. In fact, his symptoms often helped him cope with stress and provided a sense of social support in relation to his social isolation and separation from his family. This could be construed as a

form of denial of his actual life difficulties, with the mythical creatures fulfilling the function of a culturally sanctioned and organized defense mechanism that allowed for adaptive affective associations.

For much of therapy, Mr. A thought of himself as a healer who had strayed from the path and become spiritually ill; this was more culturally acceptable than being mentally ill. He continued to feel that evil spirits were able to affect him because he had become vulnerable to their influences. The therapist used Mr. A's explanatory model (EM) to develop a treatment plan for managing his stress and accompanying symptoms. Because the stigma toward mental illness is a large deterrent from initial help-seeking and often increases the likelihood of premature dropout and nonadherence among Filipinos as well as many other cultural groups, it was important not to invalidate Mr. A's EM and to address these issues directly. Specifically, the therapist did not attempt to invalidate Mr. A's shamanic experiences but, instead, focused on helping him get rid of the evil spirits, the primary reason for seeking treatment.

Mr. A was gradually enculturated into the medical model, with the point of focus placed on reducing his negative psychotic experiences, rather than discrediting his shamanic experiences. Carefully timing the introduction and integration of the medical EM with the cultural EM was of therapeutic value, increasing acceptance of and confidence in Western psychiatric treatment and improving treatment adherence. Enculturating Mr. A too quickly into the medical model and invalidating his cultural experiences would have resulted in a conflict between his cultural EM and his psychiatric treatment, thereby hindering his willingness to accept the therapist's recommendations. Mr. A entertained and gradually accepted the relationship between stress and psychiatric disturbance as he and the therapist reviewed the different problems surrounding what they collaboratively defined as his first psychotic break, the point at which the evil spirits began to bother him.

A combination of culturally sensitive psychoeducation and antipsychotic medication led Mr. A to question the normality of some of his experiences. He eventually began to accept the possibility that he might be suffering from schizophrenia, but he continued to believe that his schizophrenia occurred after his arrival in the United States and was precipitated by difficulties adjusting, making social connections, and maintaining employment. Although his medication took away the evil spirits and dulled his shamanic experiences, Mr. A continued to adhere to his shamanic beliefs and did not think that his shamanic experiences were part of his schizophrenia. Mr. A accepted that his depressive symptoms and hurtful hallucinations were the results of stress, psychiatric illness, and his inability to work. The therapist adapted the therapy by enculturating Mr. A to the medical model, targeting

negative symptoms that cultural resiliencies and coping methods failed, and decided not to invalidate Mr. A's cultural experiences, which seemed to serve as a culturally protective factor.

Enculturating the patient to the medical model can be beneficial because there needs to be a match between the patient's understanding of the illness and the methods used to treat the problem. Nevertheless, practitioners must be careful not to alienate the patient by forcing medical interpretations on him or her, especially if they are culturally inconsistent with the patient's beliefs. For this reason, the therapist did not override Mr. A's belief that his shamanic experiences, which first began in the Philippines, were not schizophrenia. His cultural views of his shamanic experiences were therapeutic, and invalidating these experiences would have been counterproductive at this juncture in treatment.

4. Help-seeking experiences and plans. Mr. A's EM played a large role in his help-seeking pathway. In particular, he did not seek psychiatric help for his shamanic experiences because he did not see himself as mentally ill, and he was functioning sufficiently. Prior to the crisis that led to his presentation at the clinic, his shamanic symptoms mostly served a beneficial and protective role by helping him cope with stress and social isolation.

Mr. A's most recent experiences were more detrimental and his EM led him to see himself as a shaman who had "fallen" off-track and become spiritually ill. He was unsure as to the cause of his problems, and responded to them based on what he believed was culturally appropriate. For example, he coped with his distress after witnessing patients die by quitting his job and taking time off to rest and heal naturally. This is what he believed other shamans would have done to deal with the problem. When asked if he had considered seeking help from other healers to resolve his most recent problems, Mr. A responded by saying that they are hard to find in the United States., and that he initially felt that he could resolve the problems on his own.

Mr. A sought psychiatric help only when he was no longer able to tolerate the demonlike figures that tried to make him hurt himself. His treatment-seeking was also precipitated by his depressive feelings associated with not being able to work and with his financial conflicts with his sister. Seeking psychiatric help was particularly difficult for Mr. A because of the stigma toward mental illness in Filipino culture, and possibly also because he did not want to entertain the idea that he too might be "crazy" like other members of his family.

C. Cultural Factors Related to Psychosocial Environment and Levels of Functioning

1. Social stressors. Prior to Mr. A's shamanic experience in his early twenties, he experienced multiple social stressors. These included his separation from his immediate family after their migration to the United States; his breakup with his girlfriend; his conflict with his extended family, who he thought were stealing from him; his poultry business's going bankrupt; and the financial difficulties associated with giving away his material goods. After his shamanic calling, however, Mr. A's functioning improved and it seemed as if his cultural interpretation of what happened had a therapeutic affect. Upon emigrating to the United States, he experienced additional stressors (e.g., loss of employment, estrangement from family, difficulty establishing social ties) that negatively impacted his functioning.

Although these stressors would be distressing to anyone, the collectivistic cultural context of Filipino communities made them particularly damaging to Mr. A. Loss of family support due to the familial psychiatric illness and his relatives' subsequent emigration left him alone and open to stigmatization. It is likely that many in his social environment saw this as evidence that his family was suffering from mental illness and believed that Mr. A was left behind when they moved to the United States because he himself was crazy.

Mr. A was also affected by the stress associated with acculturating to a new environment after coming to the United States. His experiences with shamanism and mystical creatures adversely affected his ability to maintain a stable social and occupational status in the United States. Part of therapy involved discussing the disadvantages of telling people about his shamanic experiences. In particular, although in the Philippines some might accept that he was not baliw, Mr. A concluded that the American culture was different and most Americans would believe that he was "crazy." In the United States, his difficulty holding down a job was a severe blow to his feelings of independence and limited his financial contributions to his family. In a collectivistic setting, where greater importance is placed on family and social networks than in more individualistic cultures, this resulted in even greater feelings of shame, loss of face, weakness, and uselessness.

2. Social supports. Because Mr. A was experiencing psychiatric difficulties prior to migration, he had even more difficulty than typical immigrants adjusting to his new environment and developing a support system. This was further exacerbated by the familial psychiatric difficulties of his childhood environment. Specifically, he may not have been able to develop appropriate

social relations skills because family members were distant, were unavailable, and may have modeled inappropriate interactions due to their psychiatric illness. In contrast to the expected cohesive family structure and community involvement typical of Filipino culture, Mr. A suffered an acute lack of support, resulting in feelings of loneliness and isolation. This environment of social deprivation could have contributed to his need for the support of the mythical figures that talked to him and accompanied him through hard times. These figures continued to be a primary source of support after he migrated to the United States and struggled to cope with a new setting. The clinical team would have attempted to involve Mr. A's family in therapy, but he opposed this suggestion, saying that he did not want to bother them and wanted to work out his problems on his own.

3. Levels of functioning and disability. Mr. A's functioning was poor after his family left him alone in the Philippines and he lost his job and girlfriend. It improved after his shamanic calling, however, and he was then able to function moderately well, although somewhat less well than before his family left. This decrement was partly related to God's telling him to give up all of his worldly attachments (i.e., money and material goods) so that he could be closer to the Earth. Mr. A's level of functioning deteriorated after he moved to the United States and had difficulty adapting, limiting his ability to effectively navigate his social and occupational environments. He experienced depressive symptoms, cognitive confusion, anxiety, and feelings of isolation, which increased after witnessing the death of patients and losing his job. Fortunately, Mr. A's condition improved rapidly with medication and psychotherapy.

D. Cultural Elements of the Clinician–Patient Relationship

Although the therapist, a Taiwanese American psychologist, and the patient were of differing ethnic, albeit similar racial backgrounds, Mr. A was able to rapidly develop a strong working alliance with the therapist. This positive relationship was achieved through the use of several culturally sensitive interventions (Hwang et al. 2006), some of which are described below.

Specifically, the therapist was sensitive to and accepting of the patient's belief system. He devoted time to joining, engaging, and inquiring about Mr. A's views on and experiences with shamanism, and did not challenge their veracity, an approach to which Mr. A responded positively. The therapist explored cultural norms and customs and consulted with Filipino doctors for additional opinions. Because Filipino cultural norms generally advocate great respect for expert authority figures, the therapist reinforced

this attitude in the patient. He told Mr. A that, as a doctor with substantial experience treating people with similar problems, he believed that it was very important for Mr. A to comply with treatment and be open and honest with him. The therapist also raised the issue of treatment dropout and normalized the fact that many patients feel like dropping out of therapy at some time during the course of treatment. Mr. A appreciated the therapist's taking an authoritative role and taking the initiative to raise issues proactively.

The therapist also adapted cognitive-behavioral therapy by providing greater structure and direction, and by talking about cultural stigmas toward mental illness and its treatment. Because of Mr. A's cultural unfamiliarity with psychotherapy, extra time was devoted to orienting the patient to therapy at the beginning of treatment and intermittently throughout. Specifically, topics for the orientation included the structure of therapy, the types of healing mechanisms, the therapist's and patient's roles and expectations, the course of treatment, and typical reactions and impediments to successful treatment. Therapy orientation helped Mr. A feel more comfortable and increased his confidence in the therapist and the treatment.

In addition, the therapist made a point of discussing the process of therapy, noting the incongruence between typical Filipino behavior in medical settings (more passive listening and expected compliance) and what the therapist was asking of the patient (to heal through process-oriented and discussion-based talk therapy). The therapist made a concerted effort not to fill in moments of silence that were longer than usual. This allowed Mr. A greater opportunity to work through his discomfort and formulate his thoughts and experiences without interruption, to which Mr. A responded positively.

The gradual enculturation of the patient to the medical model took advantage of the positive rapport with the therapist and was done using culturally congruent terms. The discussion focused on shamanic healing powers and how shamans engage in self-care. A cultural bridge was developed between these beliefs and Western therapy concepts such as stress management, healthy coping, and daily activity scheduling. Rather than being asked to accept a Western diagnostic label directly, Mr. A was provided psychoeducational pamphlets and was asked to discuss how his symptoms were similar to or different from those of patients with schizophrenia. He was encouraged to come up with his own conclusions over time. Mr. A responded positively to these strategies and gradually accepted that his most recent difficulties were associated with schizophrenia.

E. Overall Cultural Assessment

Mr. A's case posed an interesting challenge in terms of distinguishing psychiatric difficulties from culturally determined normality. For example, although the patient believed he could heal others, this could not fully be interpreted as a delusion, since believing in healers and shamans is not abnormal in some segments of Filipino society, especially in more rural areas. In addition, Mr. A's visual and auditory hallucinations of mystical creatures and the positive affect associated with these supportive figures were atypical of psychosis seen in the West, raising questions about the accuracy of a diagnosis of schizophrenia.

The therapist used four heuristics to help determine whether Mr. A had schizophrenia or whether his experiences were within culturally normal limits of shamanism. These included assessing Mr. A's level of dysfunction, ability to fulfill social roles as a shaman, length and chronicity of illness, and cultural consistency of psychotic expression. It was quite apparent that Mr. A's most recent psychotic experiences were maladaptive and decreased his ability to function healthily. It seemed that the shamanic experiences surrounding his initial calling were for the most part adaptive up until his move to the United States. They helped maintain his level of functioning in the Philippines, and were not consistent with typical Western psychotic expression. On the other hand, shamans are typically exceptionally healthy and aware individuals, which was inconsistent with Mr. A's experiences. It was also clear that Mr. A is currently unable to fulfill his role as a healer, and it is questionable whether he was able to do so effectively in the past.

For this reason, we believe that Mr. A's shamanic experiences in the Philippines were a prodromal or low-grade psychosis, the progression of which was contained by his cultural embodiment of the shamanic role. After he arrived in the United States and had difficulty adjusting to his new environment, his psychosis became more florid and maladaptive. These most recent damaging psychotic experiences met the six-month criterion required for the diagnosis of schizophrenia.

Defining the boundary between what is normal and what is pathological is more difficult when working with those who stand at the intersection of multiple cultures, and when interpreting through differing cultural lenses. In addition, psychotic processes are likely to be shaped by their cultural environment and manifest themselves according to what appear to be socially consistent themes (e.g., persecutory delusions involving government agencies in the West). Mr. A's experiences were culturally consistent with, but not typical of, psychosis in the Philippines; also, they were not highly prevalent among traditional healers. In addition, they evidenced a degree of

cultural pathoplasticity that is atypical of shamanic experiences. Specifically, the cultural content of his delusions remained constant until Mr. A moved to the United States. Then Mr. A began to experience psychotic beliefs more typical of Western society, such as being abducted by aliens and feeling that he was being followed by the police, which are atypical of traditional shamanic experiences. Even though Mr. A was exposed to Western influences prior to migration, he did not manifest such experiences in the Philippines, probably because they would have been culturally incongruent, maladaptive, and rejected by his social environment, likely leading to the view that he was mentally ill.

Taken as a whole, the available evidence suggests that Mr. A's psychotic experiences, at the present time, are consistent with the diagnosis of schizophrenia. Although it is possible, albeit unlikely, that he had true shamanic experiences in the past, it is improbable that his current condition is the result only of culturally sanctioned phenomena. Moreover, his current experiences are atypical of traditional shamanic practice and have become maladaptive.

It is important to note that the decision to give Mr. A the diagnosis of schizophrenia was not automatic, and that cultural and psychiatric issues that became apparent over time had to be carefully scrutinized. Complicated diagnoses such as in the case of Mr. A are not always either/or distinctions, and all possibilities need to be considered in arriving at an accurate diagnosis. Rather than adhering to rigid and concrete definitions of illness, therapists need to open-mindedly explore possible cultural explanations that might influence diagnostic accuracy.

Mr. A eventually accepted the possibility of having schizophrenia, but no direct attempts were made to challenge his shamanic experiences, which he continued to believe in. Instead, treatment focused on reducing the patient's maladaptive experiences and improving his functioning. By the end of treatment, Mr. A's negative psychotic experiences had subsided. In addition, his shamanic experiences also decreased, but he continued to have intermittent contact with some of his mystical friends. Mr. A believed that the antipsychotic medication dulled his ability to participate in the spirit world, and felt this to be an acceptable trade-off. Overall, Mr. A developed more insight and awareness into his problems and was able to engage in more effective self-care.

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