

Bear spends time in our dreams now: Magical thinking and cultural empathy in multicultural counselling theory and practice

Joseph E. Trimble*

Western Washington University, Bellingham, Washington, USA

(Final version received 23 July 2010)

Traditional lifeways and thoughtways of ethnocultural clients can impede the success of psychosocial interventions. Frequently hidden from the view of outsiders, traditional belief systems and practices are a source for explanations of various experiences ranging from occurrences of natural phenomena to the cause and treatment of physical and psychological conditions. Magical thinking as it's referred to in the psychiatric literature often is a source of many of the explanations. However, conventional mental health counsellors may view magical thinking as unrealistic and thus an obstruction to intervention. Given this consideration, magical thinking and its relevance for promoting cultural empathy form the major theme of this article. Challenges to the genuineness of an ethnocultural client's magical thinking calls into question a counsellor's cultural sensitivity and competence. Conversely, counsellors who establish a culturally resonant relationship with ethnocultural clients come to realize that magical thinking can dominate their clients' worldviews. Depending on the counsellor's values and willingness to suspend judgment, in time, respect and rapport can promote cultural empathy and advance the counselling relationship.

Keywords: culture; clinical diagnosis; magical thinking; American Indian; cultural measurement equivalence

Introduction

The influence of traditional healing practices, sacred rituals, and ancestral knowledge is one of the major impediments to the success of conventional psychosocial intervention with ethnocultural clients.¹ Often hidden from the view of outsiders, ancestral traditions are often the source for explanations of various events ranging from natural phenomena to the cause and treatment of physical and psychological conditions. Magical thinking is one widely used explanation and occurs when "the person believes that his or her thoughts, words, or actions might, or will in some manner, cause or prevent a specific outcome in some way that defies the normal laws of cause and effect" (American Psychiatric Association, 2000, p. 825).

Providing that clients discuss magical thinking experiences counsellors may view such thinking as an obstruction to successful treatment intervention (Serban, 1982). Given this possibility, magical thinking and counsellor cultural empathy form the major theme of this article. Additionally, this article's objectives are to emphasize

*Email: Joseph.Trimble@wwu.edu

the importance of inclusive cultural empathy in the counselling process and to encourage the reframing of "individualistic empathy" into inclusive cultural empathy.

Magical thinking gives people the opportunity to explain and control what they believe is uncertain. Rituals and ceremonies, for example, give people the feeling they're not completely helpless and at the mercy of the uncontrollable (Rosengren, Johnson, & Harris, 2000; Nemeroff & Rozin, 2000; Subbotsky, 2010). What some counsellors may see as unexplainable is believed to be authentic, controllable, and comprehensible by insiders. (Ayan & Calliess, 2005).

Though culturally naive counsellors may find multicultural clients' explanations dubious, the presence of folk beliefs and ancestral traditions must be acknowledged because they exist and persist in all of the world's populations. Many would argue some sort of magical thinking exists in all cultures (Shweder, 1977; Subbotsky, 2010). Most important, these practices and belief systems are almost impervious to change, deeply rooted as they are in the flow of daily life.

Eventually counsellors of ethnocultural clients come to realize that magical thinking, ritual, ceremony, and spirituality dominate their clients' worldviews. Depending on the counsellor's value orientations and willingness to suspend judgment, in time they learn that respect for their clients' worldviews will advance the counselling relationship and support their own development of cultural empathy (Pedersen, Crethar, & Carlson, 2008; Ridley & Lingle, 1996). If a counsellor challenges the legitimacy and value of what is real and authentic for traditionally oriented ethnocultural clients the query will likely call into question a counsellor's perceived multicultural competence by the client.

Magical thinking definitions

Magical thinking has been given considerable attention generating numerous resources for exploration and study (Serban; 1982; Brown, 1993; Glucklich, 1997; Stevens, 2001; Subbotsky, 2010). In summarizing the components of magical thinking in alternative and contemporary medicine, Stevens (2001) emphasizes its five key elements: (1) Forces in nature that are separate from and operate independently of any spiritual beings and from those identified by science; (2) Forces that are energized by a mystical power that exists in varying degrees in all things; (3) Everything in the cosmos is actually or potentially interconnected; (4) Words, thoughts, or actions that not only represent other things can take on the qualities of the things they represent; and (5) They follow the laws of homeopathy and proximity. Frazer (1996) argues that magical thinking relies on the laws of similarity and contagion. Effects appear to resemble causes and thus are attributed to elements if they appear to be associated with one another. Consequently, magical thinking produces an effect that is derived from a similar element or action as though there exists an affinity between the elements.

In summary, magical thinking consists of intuitive notions of likeness and resemblance where objects are given meaning following an associative process. Objects are believed to be subject to influence by personal and magical manipulations to gain control over one's life events. In that vein, the person believes mystical power exists in all things and that they are inextricably connected

to one another. Moreover, things connect to one another because they are thought to have innate qualities that facilitate cohesiveness.

Psychiatric, psychological, and psychoanalytic definitions

The DSM-IV-TR (American Psychiatric Association, 2000) defines magical thinking as "the erroneous belief that one's thoughts, words, or actions will cause or prevent a specific outcome in some way that defies commonly understood laws of cause and effect. Magical thinking may be a part of normal childhood" (p. 825). The definition is not that far from the ones provided in the previous discussion with the exception that the word *erroneous* gives it a distinct psychiatric slant and thus tends to pathologize the thought process.

In the DSM-IV-R magical thinking is listed as some of the symptoms for obsessive-compulsive (OCD) and schizotypal personality disorders. With OCD the person believes that ritualized actions possess a mystical quality that influences a course of action. Magical thinking thus is associated with daily rituals, such as the continuous washing of hands and arranging clothing in a precise manner among countless actions and associated beliefs. In short, magical thinking may be the cause or explanation for the rituals and highly stylized forms of behaviors; put another way, if the ritual or routine is not carried out in a precise manner, misfortune may fall upon the individual (Zusne & Jones, 1989).

Magical thinking is considerably more apparent in schizotypal symptoms and diagnoses. In essence, "interpersonal defects (are) marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities" (American Psychiatric Association, 2000, p. 701). Two of the major symptoms can include "odd beliefs or magical thinking that influences behavior that is inconsistent with subcultural norms (e.g. superstitiousness, belief in clairvoyance, telepathy, or 'sixth sense'); in children and adolescents, bizarre fantasies or preoccupations) and unpleasant perceptual experiences, including bodily illusions" (American Psychiatric Association, 2000, p. 701).

Classic psychoanalytic explanations of magic and magical thinking began with the early writings of Freud (1938) in his classic book *Totem and Taboo* (Freud, 1946). According to De Mijolla-Mellor (2005), Freud considered magical thought to be the tendency for humans "to subjugate the world together with simple speculative curiosity" and thus "pushed humans to create their first cosmic systems" (p. 1). De Mijolla-Mellor goes on to add "magic can be seen to belong to a narcissistic system, while animism implies, with the recognition of the inevitability of death, the initial recognition of *ananke* (destiny, fate)" (2006, p. 2).

Scales to measure magical thinking and schizotypal personality disorders

A few scales to assess degrees of magical thinking and personality disorders have been developed and used in a number of studies; all of them are based on the symptoms for the mental disorders and patterns of thoughts described above, although the items are more inclusive of the definitions and descriptions. A few are highlighted in this section.

To assess borderline personality disorders, Bohus, Limberger, Frank, Chapman, Kuhlter, and Stieglitz (2005) developed the Borderline Symptom List (BSL) to assess

self-perception, affect regulation, self-destruction, dysphoria, loneliness, intrusions, and hostility. The self-rating, 95-item checklist contains seven factors and demonstrates moderate reliability. Elements of magical thinking are contained in the items: "felt the presence of someone who was not really there," and "tortured by images" which are part of the Intrusions subscale.

In an effort to assess all nine features of the schizotypal personality disorder as defined by the DSM-III-R, Raine (1991) developed a 74-item self-report measure that yielded positive reliability indices; the items produced nine subscales. The subscale, "Odd Beliefs or Magical Thinking" contains seven items to include, among others "Have you had experiences with the supernatural?," and "Have you had experiences with astrology, seeing the future, UFOs, ESP, or a sixth sense?." The subscale, "Unusual Perceptual Experiences" contains a few items that could overlap with magical thinking, such as, "Have you ever had the sense that some person or force is around you, even though you cannot see anyone? Psychometric analyses suggest the scale has useful diagnostic value for screening people with schizotypal personality symptoms.

To determine the relationship of the Schizotypal Personality Scale (STA) with the Borderline Personality Scale (STB), Rawlings, Claridge, and Freeman (2001) administered them to 1073 British subjects with a wide age range. Analyses showed that the STA contained a "Magical Thinking" factor; the researchers indicate that there was an overlap with items on the "Unusual Perceptual Experience" and the "Magical Thinking" subscales.

To assess levels of magical thinking in children and adolescents Bolton, Dearsley, Madronal-Luque and Baron-Cohen (2002) developed the Magical Thinking Questionnaire (MTQ) that consists of 30 questions where each asks the respondent whether something is possible or not. Based on their findings the researchers conclude that, "The findings did not support the common assumption that magical thinking declines with age from young childhood, but rather... that younger children are in many contexts well able to distinguish imagination from reality, and that magical thinking is to be found among young children and adults alike" (p. 488).

One of the more widely used scales to assess magical thinking is the Magical Ideation Scale developed by Chapman and Chapman (1980; 1987) and Eckblad and Chapman (1983). Scores on the scale range from 0-30, with higher scores indicating more pronounced degrees of magical thinking. The researchers conclude that those who score high on the scale show symptoms suggestive of predisposition to psychosis. Scale items are similar in theme and content found in the schizotypal scales described above.

The scales described in this section assess symptoms, characteristics, and patterns of magical ideation thinking following diagnostic criteria described in the DSM-III-R and the DSM-IV-TR. Magical ideational thinking appears to be moderately correlated with unusual perceptual experiences and paranormal thinking, suggesting that cognitive orientations share common dimensions. However, there is little evidence in the literature to indicate that the scales described in this section have been tested among indigenous populations where magical thinking is commonplace and thus is not considered to be indicative of emotional or behavioral disorders. The finding merits considerable attention if we are to fully understand the extent to which magical thinking and its correlates are quotidian or indicative of abnormal thinking as they exist in various forms according to an ethnocultural

population's worldview. Indeed, we may learn that the word magical may have to be eliminated when describing ideation and thought in some ethnocultural populations.

To frame the influence and assessment of magical thinking, the next section presents a short case story. The case study describes a client with troubling dreams who visits a clinical psychologist for help and receives an unacceptable diagnosis. The client subsequently seeks assistance from a traditional American Indian healer who offers a process and explanation that lead to a positive and life-changing outcome. This case story serves also to inform the content in subsequent sections of the article.

Diane and the bear dreams

I met Diane² when she was in her late 30s and a second-year graduate student in secondary education, specializing in multicultural studies. She appeared at my office door one afternoon to ask if I could help her with a term paper on the history of American Indian boarding schools. Toward the end of our long first meeting I agreed to read over a draft of her paper and provide comments.

A week later she stopped by my office to show me the "A" she had received on her paper. "I'm going to frame this one," she said with pride. Diane was scheduled to graduate in June so I asked her about her plans for the near future. Diane continued to tell me about herself that day, because, she later told me, "she felt safe." She was born on one of the Northern Plains American Indian reservations. Her mother was an enrolled member of the tribe; her father was a non-Indian who taught at an off-reservation high school. When Diane was three years old her parents moved to the Seattle area.

She did not remember much about her life on the reservation except that she had many relatives. She also admitted, with some embarrassment that growing up she knew very little about her tribe's customs, traditions, legends, or language. Her parents had decided it was best for her and her little sister to leave "those things" on the prairie and in the past. Diane and her sister had little if any contact with the "folks back home" while growing up. Diane told me:

About a year after I graduated from high school I married a man who was older than me. John was handsome, well travelled, smart, and he was Native, although, like me, he was raised in the city and had little contact with his home reservation. Our first year of marriage was blissful, but later I discovered he had a serious drinking problem when a friend told me she had seen him drinking with some guys in a park near the center of the city. He promised me he would seek help from a local clinic and I believed him. A few months after this confrontation I learned I was pregnant. John was overwhelmed with joy and excitement. Eight months later I gave birth to a beautiful, healthy baby girl, and I named her after my mother. John adored her. Our daughter brought new happiness to our marriage, and for a while brought John and I closer together. But, sadly, John's drinking continued to the point where he would be gone for days. One night he came home drunk and that was when the beatings started. I did my best to defend myself but my bruises and cuts were noticeable. I started wearing heavy makeup when I visited family, but they still could tell what was going on. John eventually lost his job. I thought that would turn him around, but he continued to drink, to beat and curse me, and to stay away from home for days. He always apologized and begged my forgiveness. I foolishly hoped for the best, but it never came. Late one night two Seattle police officers knocked at my door to tell me that John had been in a street fight and was killed by some unknown guy. I collapsed on the doorstep. I was torn up with grief

and anger. I felt so helpless, but I thought about our daughter and I knew I had to be strong.

John's death left Diane without financial resources so she moved in with her sister and found a part-time job. Shortly thereafter, Diane lost her father to a massive heart attack and her mother passed away from surgery complications. For the next year Diane grieved the loss of John, and she and her sister mourned the loss of their parents. During this sad time Diane reflected deeply upon her lost Native heritage.

Diane decided to enroll in a nearby community college to earn her degree. "I was excited about taking classes and earning my degree. My life appeared to be heading in a positive direction."

Just as she was slowly becoming optimistic about her future, Diane started to have very disturbing and confusing dreams:

One night a big black bear appeared in my dreams. He stood tall and straight, arms at his side, and looked at me with no expression before slowly fading away. This dream woke me up. I was frightened, but then again I wasn't. I thought about the bear dream for the next few days. I felt the bear was trying to send me a message, maybe telling me I didn't do enough to stop my husband from drinking and hitting me, but I wasn't certain. For the next week, the bear appeared in my dreams every night, still without expression, doing and saying nothing. He didn't seem to be trying to scare me because he did nothing but look at me. Then one morning I was standing in front of my bathroom mirror getting ready to go to work, and I looked up and saw the reflection of the bear standing a few feet behind me. I was so frightened and alarmed that I screamed. My sister came running and found me shaking and crying. She helped me to the edge of my bed and put her arms around me. When I calmed down, I told her about my dreams and seeing the bear in the mirror standing behind me. My sister then told me she also had been dreaming of a bear and had been hesitant to talk with me because she thought her dreams were a bit crazy. She told me what the bear looked like and how he would just stand there and stare at her. After my sister's description and the vision in the mirror, I decided to confide in my close friends. I knew they would understand and try to help me. One of my friends suggested I see a clinical psychologist, someone she knew and trusted. She thought the counsellor might be able to help me understand my dreams and how I might deal with them. I was hesitant, but I trusted my friend's recommendation and was comforted in part because the counsellor was a woman. The counselor was kind, gentle, a good listener, soft-spoken, not pushy, and I appreciated her approach and style. I waited until our third session to tell her about my dreams. As I told her about the bear I noticed she was looking at me strangely, as if she didn't quite understand what I was telling her. By the time I finished the story our time was up so we made another appointment. I returned to her office a week later excited that she might help me understand my bear dreams and vision. The counselor told me she had given my story and experiences considerable thought. The counsellor told me I had experienced some very difficult times and those experiences would wear down the emotions and psychological strength of most people. She said she had come to the conclusion that I was experiencing a form of post-traumatic stress, which had led me to a state of what she called acute personality disorder. I was furious with her words and assessment of me. I told her I wasn't crazy or emotionally disturbed, that the bear dreams were real. "Why would my sister have them? Was she crazy, too?" I yelled. I told her I never wanted to see her again and stormed out of her office. She followed me and tried to calm me down, but it was useless. A few days later she called and left messages to return her call, but I ignored them.

At that point, I wasn't sure what to do or who to turn to for help. The bear dreams hadn't stopped. One of my friends, who is a member of a tribe in western Washington, suggested I see a traditional Indian healer. I knew very little about Indian healers, but my friend knew a reputable and competent healer. She had been to many of his ceremonies and knew many people he had helped. I thought about this possibility for a few days before I asked my friend to see if the healer was willing to work with me.

He was, so my daughter, my sister, and a few friends headed out to a nearby reservation for a visit with him. He was a kind and gentle man who made us feel very welcome in his home. At the end of our first visit, he set a date for the ceremony. He gave us instructions for preparing our minds and bodies during the week before the healing ceremony. The ceremony would last about a week, he said, so we would need to take time off from work and find someone to care for my daughter. The week went by fast. We followed the healer's instructions closely and arrived back at the reservation prepared. We stayed in the "long house" from early dawn to late in the evening. There was lots of drumming, dancing by small groups of people, singing and chanting, and long periods of silence. The healer was always in the center of the room cloaked in a robe and sitting or lying on blankets on the floor. We sat around him. Several times the image of the bear appeared in the room, just as he did in my dreams – standing there with no expression, his arms at his side, looking directly at us on the floor – and then he would fade away. The healer knew he was there, and at one time invited him to come closer and sit with us. Toward the end of the fourth day the bear appeared again. We all were very tired, so we didn't notice him at first. This time he was standing closer to us. He slowly lifted his arms waist high and opened out his paws to us, as though greeting us and telling us he was friendly – I felt that immediately. The healer stood up and moved toward the bear. They stared at one another for the longest time. Then, the healer held out his hands with his palms up, just like the bear, and the bear smiled! Yes, he actually smiled from ear to ear, and it was such a warm and beaming, friendly smile. Then he faded away. The healer turned to us and said he knew who the bear was and why he had come into our lives: 'He wants to protect you from harm and evil,' the healer said. 'The bear is one of your spirit animals and he has taken on the spirit of your former husband. Your husband has appeared this way in your dreams to ask for your forgiveness for the way he was when he was with us. He's deeply sorry for the pain he caused you and your sister and daughter. He's not begging you to accept his apology, but he hopes you will forgive him. He's not the person he was when he was with us; the spirits of the ancestors have taken him in and helped him with his earthly problems. He is filled with remorse and sadness for the way he treated you. If you and your sister are not willing to accept his forgiveness, he won't come around anymore.'

Diane summarized what happened next:

I could see that the healer had insight and understanding of the bear experiences and vision. I knew it. I looked at my sister and without hesitation we slowly nodded 'yes' to one another. The healer smiled. Yes, we wanted to forgive John and close the circle of sorrow that had spread out so far in our lives. The healer stood and took us by the hands and formed a small circle. Then the bear slowly appeared in the middle of the circle and turned around to face each of us with open paws and smiling face. We drew the circle closer around him. We touched him or blended in with his spirit. I'm not sure what really happened, but at that point I experienced overwhelming joy, love, relief, and freedom – a state of oneness I had never experienced before. It gives me chills just to tell you this. The whole experience was reassuring, because we knew we didn't experience our grieving, sorrow, and fears alone; there were people who cared and spirits looking over us.

After the ceremony was over, we had a wonderful feast at the healer's home. People kept coming into the house with food and gifts of all kinds. We were overwhelmed with their affection and generosity. It was so heart-warming. The next day we sat with the healer, and he reviewed the four days we spent together. When he finished he gave each of us a small beaded pouch and told us to keep it with us at all times for protection and to help us stay in touch with our spiritual guides and ancestors. The weeks and months that followed our healing were filled with peace and happiness. My sister enrolled at the local community college, so we were able to go together. Our friendship network expanded to include lots more Indian people. We were invited to pow-wows, ceremonies, and other get-togethers. The most important thing that happened is that the bear still came into our dreams, but instead of just standing there, he would smile

and bring us great joy. Yes, bear does come in my dreams now, and I truly look forward to the experiences. I know he is protecting us and helping us grow. So, that's the end of my story for now.

The appearance of the bear in her dreams and in the bathroom mirror startled and mystified Diane. These experiences made little sense to her, although she was sure she wasn't crazy. Motivated by anxiety and a need to understand her experiences, she talked to her friends, which led to the recommendation to see a clinician. Seeking assistance from a clinical psychologist seemed a reasonable approach, although she had little knowledge about the process or what outcomes to expect. Startled by the clinician's assessment, her experience with traditional therapy left her angry and more puzzled. Her decision to see a healer was prompted by her need for answers to the bear's presence in her life and the hope that she could achieve some sense of comfort and resolve.

Diane's clinical experience and the diagnosis she received raises profound questions, as suggested by Pedersen, Crethar, and Carlson (2008). When does a specific psychological diagnosis provide valid explanations? What are the cultural boundaries? Which psychological patterns always appear? Which patterns only sometimes appear? In the case story, did the clinician understand the boundaries between conventional psychological theory and practice and cultural experiences? Did she understand that dreams have unique culturally entwined meanings in other ethnocultural populations? Did the clinician realize that for many of the world's populations the word *magical* does not apply to what they consider normal, everyday experiences?

In Diane's story there was another interpretation that fit more closely with the lifeways and thoughtways of a regional indigenous Native population; the interpretation and correspondent healing ceremony helped her deal with disturbing dreams and experiences. The core feature in Diane's story is the presence of a bear. In the clinical interpretation the bear was symptomatic of magical thinking and acute borderline personality disorder. In the healer's interpretation the bear was viewed as a messenger related to Diane's deceased husband and his need to make amends. In effect, the clinician pathologized the dream content and the traditional healer viewed it as source of strength. To clarify the role of magical thinking in both interpretations, attention will be given in the following section to the construct's meaning and use.

Cultural empathy

When looking through the items represented by the scales described above, one wonders if the clinical psychologist's diagnosis of Diane's emotional and psychological state warranted the personality disorder label. Although she was mourning the deaths of her parents and husband, it was the presence of the bear in her dreams and vision that prompted her to schedule the appointment. Perhaps it was a combination of her life's experiences accompanied by the dreams and vision that prompted the diagnosis. It may be that the clinician relied heavily on what she believed were a combination of "peculiar behavior, magical thinking, and unusual perceptual experiences" to frame her judgment and conclusion" (Horneland, Vaglum, & Larsen, 2002, p. 247). When the shaman assessed her story and dream, however, the interpretation was quite different; in effect, her experiences and dream

were not "pathologized" and viewed as a mental disorder but rather as a symbolic representation of her deceased husband. It's likely that clinicians and counsellors representing various therapeutic orientations and perspectives might have come to a different diagnosis than Diane's clinician. But, it's also likely that shaman from different indigenous tribes would have come to a different interpretation than the healer Diane.

Could Diane's therapist have avoided her seemingly conclusive diagnosis? From a multicultural psychological perspective, yes. The therapist could have been more culturally empathic and considered interpretations lodged in Diane's Native belief systems. Admittedly, Diane didn't know much about her traditional background. Yet, she did recall her parents occasionally discussing her tribal background with her and once in awhile those discussions centered on spirituality, ritual, and traditional healing. Perhaps those discussions influenced her acceptance of the events surrounding the traditional healing ceremony and eventual interpretation of her experiences.

Multicultural counsellors emphasize that for one to be effective with clients from different cultural backgrounds, one should be culturally empathic and one's clinical and counselling style should closely resonate with a client's worldview. According to Ridley and Lingle (1996) cultural empathy is "the learned ability of counselors to accurately gain an understanding of the self-experience of clients from other cultures - an understanding informed by counselors' interpretation of cultural data. Cultural empathy also involves the ability of counselors to communicate this understanding effectively, with an attitude of concern for culturally different clients" (p. 32). In essence, Ridley and Lingle (1996) emphasize that cultural empathy is multidimensional, an interpersonal process that does not depend upon client-counsellor similarity and neutrality, and most important, can be learned. The ability to be empathic is both a skill and an art, because it involves the process of understanding and sharing the thoughts and feelings of another; some therapists have an extraordinary gift for empathy, but for most it must be learned. The presence of a client or patient from a culture different from one's own usually complicates the healing process; consequently, adding a cultural dimension pushes the therapist to factor in the nuances of cultural worldviews, and that can be a challenging undertaking.

Counsellors' and therapists' commitment to understanding the cultural contexts and unique cultural characteristics of their clients is essential. For example, to be culturally empathic with American Indian clients, counsellors need to understand the role of magical thinking in Native cultures. Salzman (2001) recommends that counsellors and therapists "respect culture as a necessary psychological defense and design interventions accordingly; promote interventions emphasizing meaning construction at the community level and support the collective (community) and individual construction of meaning that sustains adaptive action; support and assist individuals and communities in the identification of standards and values they identify with that promote adaptive action in current realities; and support and assist communities in cultural recovery through collaborative content analysis of traditional stories" (pp. 189-190).

Returning to Diane's story, there's an indication that her clinician realized her therapeutic style and accompanying diagnoses did not resonate with Diane's thoughts and feelings about the bear dreams and vision.

A positive outcome and the beginning of cultural empathy

Diane's outlook on her life changed in many ways after her experience with traditional healing. She graduated from community college with a high grade point average, as did her sister. Together they enrolled at a four-year college and eventually earned their bachelor's degrees. Diane met a man who is kind, gentle and loving and they married. They now live in Seattle. Diane's daughter worships her stepdad. Diane's sister also met and married a wonderful man, and they now live near Diane and her family.

Many months after the healing ceremony Diane decided to visit her former psychologist to tell her the story of the bear and the healing ceremony. She wasn't sure why but the urge to call her was overwhelming. After listening to Diane's story, the psychologist apologized to Diane for jumping to conclusions and for not being more culturally sensitive. She admitted she needed to learn more about Native ways and to learn from others about different worldviews. Diane let her know the healer would like to meet with her and learn what she did when she worked with people. The psychologist was thrilled with the offer and subsequently spent considerable time with Diane's healer and his family; in fact, they became close friends and colleagues, often collaborating with one another on psychological and spiritual matters.

Summary and conclusions

Folk wisdom, ceremonies, rituals, deeply embedded spiritual beliefs, healing practices, and dreams of animals are major components of the lifeways and thoughtways of countless indigenous populations. Deeply rooted explanations in indigenous populations' worldviews serve to provide meaning about the sacred, and the prophetic qualities of all experiences; the presence of animals in dreams and visions is one area that is filled with profound meaning that often speaks to the nature of one's relationships and foreshadows future outcomes.

To illustrate the point that a clinical psychological diagnosis can be an error in assessment and judgment, a brief case story of an American Indian woman is provided. In the story, Diane recounts her experiences with her late husband and her subsequent bear dreams and vision. Lacking any understanding of her dreams' meaning, she sought the services of a clinical psychologist; after three sessions the clinician diagnosed her with a personality disorder. Aghast at the diagnosis, Diane eventually sought the assistance of a traditional healer; after participation in a healing ceremony, the meaning of the bear's presence was revealed to her and her sister. Since then, her life has been filled with joy and fulfillment.

Perceptual distortions and magical thinking form the major diagnostic themes of a few psychiatric and clinical diagnoses of mental disorders. To guide the article's theme, definitions and descriptions of magical thinking are provided. Brief summaries of measures used to assess mental disorders characterized by perceptual distortions and magical thinking are presented. However, the scales appear to be culture-bound as there is no evidence to indicate they have been administered to indigenous populations; thus the interpretations and outcomes may not be culturally equivalent with their existing psychometric properties scales (Trimble, 2010).

Clinical diagnoses that do not resonate with one's worldview can do more harm than good. To facilitate multicultural understanding and enhance the practice and technique of providing counselling services, practitioners should learn cultural empathy by spending time with clients whose worldviews challenge conventional counselling and clinical approaches. Brief suggestions are provided to promote this perspective and orientation.

To be effective, multicultural clinicians and counsellors may have to modify conventional approaches and practices. It may take a counsellor considerable time to gather sufficient knowledge of the community and to gain an understanding of the counsellor's role as perceived by the residents (Trimble & Gonzalez, 2008). In the course of that undertaking, mutual awareness can develop, and along with it, trust, an essential component for all human relations. But there is another notable point to be made. Pedersen, Crethar, and Carlson (2008) emphasize that westernized counselling and psychotherapeutic perspectives, which have dominated the field of mental health, must not become the exclusive criteria of "modernized" psychotherapy. It is safe to assume that all indigenous populations developed and maintained sophisticated and elaborate systems or collections of principles, rules, and regulations that guided individuals along the "straight path" (Katz, 1993). For contemporary observers to assume or claim that mental health healing practices are new to indigenous populations would be presumptuous. A good deal can be learned about the effectiveness of these practices and rituals that may expand rather than hinder the development of the mental health professions.

On this note, Sobbotsky (2010) reminds us that "Just as rational thinking helps us to cope with problems in the physical world, magical thinking and magical beliefs come to our aid when we deal with problems in our personal, social, and emotional lives. That is why, despite the popular view, magical thinking and magical beliefs (religion included) go well with common logic and are a useful complement to scientific thinking and rational reasoning" (p. 173).

Acknowledgements

Several colleagues and friends reviewed the manuscript in whole or part. I am truly indebted to Molly E. Trimble, Jeffrey King, Dana Crowley Jack, and Deborah Forgaes for their assistance and advice; Molly provided her usual skillfully worded editorial comments and suggestions through several draft versions and for that I'm extremely grateful in more ways than I can express.

Declaration of interest: The author reports no conflicts of interest. The author alone is responsible for the content and writing of the paper.

Notes on contributor

Joseph E. Trimble, PhD, is a Distinguished University Professor and a Research Associate in the Center for Cross-Cultural Research, Department of Psychology, at Western Washington University. Throughout his thirty-five year career, he has focussed his efforts on promoting psychological and sociocultural mental health research with indigenous populations, especially American Indians and Alaska Natives. He is the editor or author of 18 books and over 100 journal articles and book chapters, and the recipient of 20 fellowships, awards and honors. He teaches courses in culture and personality, applied measurement theory, research ethics and cross-cultural counselling.

Notes

1. The article is an expanded version of an invited keynote lecture with a similar title presented at the 5th Critical Multicultural and Diversity Counselling and Psychotherapy Conference sponsored by the University of Toronto's Ontario Institute for Studies in Education, August 2009.
2. Diane is a pseudonym. The content of the case story is based on a reconstruction of field notes taken by the author during the time of the discussions with Diane.

References

- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders*, 4th Edition, Text Revision. Washington, DC: American Psychiatric Association.
- Ayan, S.J., & Calliess, I.T. (2005, March 24). Actions deemed odd, psychotic or even barbaric by one culture may be perfectly acceptable to another. *Scientific American Mind*, 1-3.
- Bohus, M., Limberger, M.F., Frank, U., Chapman, A.L., Kuhler, T., & Stieglitz, R.-D. (2005). Psychometric properties of the Borderline Symptom List (BSL). *Psychopathology*, 40, 126-132.
- Brown, M.F. (1993). *Thinking about magic*. Westport, CT: Greenwood Press.
- Bolton, D., Dearsley, P., Madronal-Luque, R., & Baron-Cohen, S. (2002). Magical thinking in childhood and adolescence: Development and relation to obsessive compulsion. *British Journal of Developmental Psychology*, 20, 479-494.
- Chapman, L.J., & Chapman, J.P. (1980). Scales for rating psychotic and psychotic-like experiences as continua. *Schizophrenia Bulletin*, 6, 476-489.
- Chapman, L.J., & Chapman, J.P. (1987). The search for symptoms predictive of schizophrenia. *Schizophrenia Bulletin*, 13(3), 497-503.
- De Mijolla-Mellor, M. (2005). Magical thinking. *International Dictionary of Psychoanalysis. Encyclopedia.com*. <http://www.encyclopedia.com/doc/1G2-3435300847.html>
- Eckblad, M., & Chapman, L.J. (1983). Magical ideation as an indicator of schizotypy. *Journal of Consulting and Clinical Psychology*, 51(2), 215-225.
- Frazer, J.G. (1996). *The Golden Bough: A study in magic and religion* (3rd ed.). London: Macmillan.
- Freud, S. (1946). *Totem and taboo: Resemblances between the mental lives of savages and neurotics*, translation by A. A. Brill. New York: Vintage Books.
- Freud, S. (1938). *The basic writings of Sigmund Freud*, translation by A. A. Brill. New York: Random House-Modern Library.
- Glucklich, A. (1997). *The end of magic*. London: Oxford University Press.
- Horneland, M., Vaglum, P., & Larsen, T.K. (2002). The prevalence of DSM-III-R 'prodromal' symptoms of schizophrenia in non-psychotic psychiatric outpatients. *Nordic Journal of Psychiatry*, 56, 247-251.
- Katz, R. (1993). *The straight path: A story of healing and transformation in Fiji*. Reading, MA: Addison-Wesley.
- Nemeroff, C., & Rozin, P. (2000). The makings of the magical mind: The nature and function of sympathetic magical thinking. In K. Rosengren, C. Johnson, & P. Harris (Eds.), *Imagining the impossible: The development of magical, scientific, and religious thinking in contemporary society* (pp. 1-34). New York: Cambridge University Press.
- Pedersen, P., Crethar, H., & Carlson, J. (2008). *Inclusive cultural empathy: Making relationships central in counseling and psychotherapy*. Washington D.C.: American Psychological Association.
- Raine, A. (1991). The SPQ: A scale for the assessment of schizotypal personality based on DSM-III-R criteria. *Schizophrenia Bulletin*, 17(4), 555-564.

- Rawlings, D., Claridge, G., & Freeman, J.L. (2001). Principal components analysis of the Schizotypal Personality Scale (STA) and the Borderline Personality Scale (STB). *Personality and Individual Differences, 31*, 409-419.
- Ridley, C., & Lingle, D.W. (1996). Cultural empathy in multicultural counseling: A multidimensional process model. In P. Pedersen, J. Draguns, W. Lonner, & J. Trimble (Eds.), *Counseling across cultures* (4th ed., pp. 21-46). Thousand Oaks, CA: Sage.
- Rosengren, K., Johnson, C., & Harris, P. (Eds.) (2000). *Imagining the impossible: Magical, scientific, and religious thinking in children*. New York: Cambridge University Press.
- Sulzman, M. (2001). Cultural trauma and recovery: Perspectives from terror management theory. *Trauma, Violence, & Abuse, 2*, 172-191.
- Serban, G. (1982). *The tyranny of magical thinking*. New York: Dutton.
- Shweder, R.A. (1977). Likeness and likelihood in everyday thought: Magical thinking in judgments about personality. *Current Anthropology, 18*, 637-658.
- Stevens, P. (2001). Magical thinking in complementary and alternative medicine. *Skeptical Inquirer*, November/December.
- Subbotsky, E.V. (2010). *Magic and the mind: Mechanisms, functions, and development of magical thinking and behavior*. New York: Oxford University Press.
- Trimble, J.E. (2010). Cultural measurement equivalence. In C. S. Clauss-Ehlers (Ed.), *Encyclopedia of cross-cultural school psychology* (pp. 316-318). New York: Springer.
- Trimble, J.E., & Gonzalez, J. (2008). Cultural considerations and perspectives for providing psychological counseling for Native American Indians. In P. Pedersen, J. Draguns, W. Lonner, & J. Trimble (Eds.), *Counseling across cultures* (6th ed., pp. 93-111). Thousand Oaks, CA: Sage.
- Zusne, L., & Jones, W.H. (1989). *Anomalistic psychology: A study of magical thinking* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum.