How does one integrate medicine, psychiatry, and healing in a rural general practice setting within an Indigenous context? No manuals exist. We wish to share our experience in the hopes that it will lead to further discussion and clarification.

We live in the second largest settlement in Maine -- Bangor, consisting of 30,000 people. Only Portland is larger, though if one combines Auburn and Lewiston, neighboring cities, the two together are larger than Bangor. We work for Wabanaki Public Health and Wellness where we are trying to create a practice style that is life-affirming, relational, and not transactional. We believe that mind and body are not separate and that we need to approach both simultaneously. Therefore, we implemented a group called “Complicated Minds,” providing us with a two-hour block of time to connect with people struggling to negotiate life. One day in Complicated Minds group, we began with a talking circle initiated by the question – in what ways are you suffering? One woman whom LMM had seen earlier in the day struggled to define her suffering. She said she suffered from PTSD. She suffered from a bad relationship. She suffered from chronic pain. She suffered from chemical and environmental sensitivities. Another man, Evan suffered from lack of trust. Catherine suffered from not being able to manage her time. LMM took a turn and said that he suffered from a lack of time to write and to do creative projects. In the second pass of the talking stick, LMM posed the question: how do we explain our suffering to ourselves? What story do we tell ourselves to make sense of our suffering?

Maura’s story was hard to understand at first. She suffered because she had PTSD. That seemed a bit tautological, but then we remembered that people think of PTSD as a “thing” that you have. For us, it’s a delayed process of recovery from trauma; a verb, rather than a noun. For most people who have been taught by our medical system, it is a thing that you get, like a virus or a bacterium. Having PTSD explains much (and nothing). Maura wondered if her accident could explain her suffering or if it was her relationship with her bad boyfriend. Evan wasn’t sure how to explain his suffering. He told a story about how hard it was to get onto the school bus when he started kindergarten. He felt overwhelmingly frightened and didn’t want to get on.

“What did you do?” LMM asked.

“I guess I got on,” he said. “But I’m just slow to do things. I process things slowly.”

Catherine struggled, too. “I guess I just don’t have time management skills. I don’t get lost too often, but I can’t seem to manage time very well. I want it all.”

For the third round of the talking circle, LMM posed the question, what part do we need to radically accept to reduce our suffering. He gave himself as an example. He had needed to accept that part of him who was desperate for love. Maura was new to this way of thinking and struggled again. LMM offered her a suggestion. Maybe she could accept the part of her who’s not perfect? She agreed. Evan would accept the part of him who didn’t trust, who was suspicious, who doubted. Catherine could accept the part of her who couldn’t fit into time.

That led us to a meditation on radical acceptance. LMM suggested that we imagine that the parts of ourselves that wouldn’t ever change and didn’t have to were just fine as they were. His “desperate for love” part would always be there. Maura’s imperfect and in pain part of her would always be there, as would Evan’s distrustful part, and Catherine’s time challenged part. We would never change and were fine as we are. Our weaknesses are secret strengths. The weak things of the world confound the mighty. We didn’t have to change anything. We could be happy just as we are for the rest of our lives.

Next LMM suggested that we forgive those beings whom we have blamed for our misery. We might have blamed parents, school buses, the devil, ex-wives, accidents, and more. Who knows who is responsible? Probably not whom we think? Why not forgive the obvious culprits who probably aren’t responsible?

Always more happens in the clinical encounter than we could ever remember. This is as much as we can remember about that group.

In these kinds of groups, we all must disclose something. We can’t hide behind professionalism and reveal nothing. We try to share those things about which we feel resolved. LMM has had years to find peace with the part of him who chose bad relationships. He could have waited before jumping into a relationship, but he didn’t. Given the distance in time, that part of him is easy to reveal. Everyone has or knows a similar story. We must connect with people on a level of authenticity. By that we mean sharing and relating in a meaningful way. We are the professionals, so our suffering must be more distant. We should have resolved much of what we share. Nevertheless, it is natural for us to have some vulnerability, some weakness. That models for the group members how to be both weak and strong; accessible, yet stable.

On another day, LMM spent an hour with Ingmar discussing his fears of dying. He was 90 years old with prostate cancer and to his surprise doing better than any of his oncologists thought he possibly could. We explored his ideas about life after death and how he should approach death. This seemed like very appropriate family medicine material, but rarely addressed. When I first met him, he was considering killing himself before dying so as to achieve some control. Now he was embracing some uncertainty even as his prostate cancer markers improved.

My two hats sometimes blur. I do both primary care and psychiatry They are not easy to separate for it is a settler-colonial mindset that makes them so. Two memorable patients appeared one day. One was a 10 year liver transplant survivor with a colostomy bag and dreadful thinness. Recently he had a seizure and no one in the emergency room could determine why. I thought maybe his electrolytes had gone haywire, but not in the blood tests. I wanted to check some vitamin levels since he wouldn’t take vitamins because he’d have to pay for them. Also, he didn’t cook, so his food choices were largely centered around pizza (though he would occasionally fry some eggs). The nutritionist came two or three times to his house to convince him to eat chicken and rice. He ate chicken once. On the day I saw Nick, he was feeling much better and had a good night’s sleep. He wasn’t so worried and therefore his motivation to get blood tests was zero. We had a good talk, though, and he left his lab test requisition form in the waiting room. Oh, well, I said to myself. I’ll catch him next time.

Then I saw a young woman who’s been a success at “curing” her anxiety and panic. She had been on three years of almost every medication known. Nothing helped. I used the ideas of Jeremy Schwartz (see *Brain Lock* and any number of his scientific papers) that she was fine, but she just had a wonky switch in her caudate nucleus. It was up to her to manually force the switch to the off position. She did this by forcibly directing her attention to where she wanted it to go. I also introduced her to Steven Le Doux’s rock band, the Amygdaloids, who sing about anxiety and the brain. (Stephen Le Doux is a neuroscientist at New York University who studies anxiety and the brain and also happens to be a rock star.) We actually didn’t have all that many sessions. Perhaps six total. Her husband joined us for three. We established that pretending she wasn’t anxious (which made her more anxious) actually didn’t work since everyone around her knew she was anxious and pretending not to be anxious. We established that it was better to be publicly anxious and make jokes about it. I also prescribed a dog. Her anxiety skyrocketed after her dog died. Her dog inspired her to leave the house daily to walk in nature and played a major role (as good dogs do) in regulating her emotions. She needed another dog. Her husband was afraid she wouldn’t take care of it. She convinced him otherwise and got a dog. She confronted him with how she took good care of their two children, so why not a dog. Most of her anxiety and panic disappeared after the arrival of the dog. All this occurred as we tapered her off the medicine that wasn’t working anyway. Most humorously, Deborah didn’t actually need to do most of the exercises and experiments I proposed. Just thinking about doing them relieved her anxiety. We designed an anxiety meter for the car since she felt high levels of anxiety riding in the passenger seat. She didn’t have to actually construct and use the meter. Just talking about it with her husband solved that problem. This day she reported that she was off all medications except for 50 mg of sertraline. She was ready to cut that in half also. We talked about the SSRI withdrawal syndrome and how to recognize that, though LMM gave her as many hypnotic suggestions as he could that this wouldn’t happen to her. LMM would see her in one month for 15 minutes for check in and she’ll stop the sertraline all the way. As we both agreed, dogs are much better than drugs, and the dog was doing well. LMM thought that her insurance company should send us a bonus for all the drugs they now wouldn’t have to pay for.

Next came Mary, one of our Complicated Minds group members. Mary liked to see LMM once per week. He wasn’t sure what role he played for Mary but was happy to play it. She had a nurse practitioner who quite independently from LMM prescribed her medications. She had a psychotherapist. She had a case manager whom she never saw. Apparently she scared the nice, young 20-something case manager with her extravagance of emotion and story. She saw LMM weekly and came to Complicated Minds group when her life was not too complicated. Mary told a wonderful story. Instead of giving her the rent money, her roommate (who also had a complicated relationship with her) had announced he was leaving. She was $400 short. She panicked and had an anxiety fit, as she called them. Somewhere in the midst of losing her mind, she remembered to call her mother and negotiate a short term loan for $400 secured on the rent rebate check she had coming by June. The rent was covered. Then she thought of going to the emergency room, as she often did. To her surprise, she found herself saying internally, “Why should I go to the emergency room? What would they do for me? They never do anything for me?” Instead she decided to take an extra clonazepam and take a walk in the woods as she made her way to our office. (The woods are the Bangor City Forest.) By the time she got to the office she was feeling much better. When she entered the office, she said, “I don’t want to say a lot about my problem. I solved it. I’m better. I want you to do some of that guided imagery with me to relax me the rest of the way so I can go home and go to sleep. Tell me to go home and go to sleep after we’re done.” LMM did just what she wanted including a bedtime coyote story at the end. He was happy that Mary had found an alternative to going to the emergency room.

The next day, LMM spoke with a woman from Houlton, Maine, who had a mass in her lung. She was terrified as her father died of lung cancer and she had been a long-term smoker, though having quit for over 10 years. She wanted help managing her anxiety. LMM did guided imagery with her about visualizing a positive future. The rationale was simple and parallel to Blaise Pascal’s explanation for why he believed in God. Either we can influence our future or we can’t. If we can’t, then pretending that we can will still decrease our anxiety. If we can, then we should do so. Either way, when worry crosses our path like a cloud blocking the sun, we should take that moment as an opportunity to visualize the future we wish, to see ourselves in the future where we want to be. I did that visualization with Betty which she found quite helpful.

We subscribe to the Many Worlds Theory of Quantum Physics as explained by Max Tegmark of MIT. In this explanatory story of the Universe, everything that could happen does happen somewhere. There are parallel universes in which Betty has cancer and there are those in which she doesn’t. From the eagle’s eye view (the perspective of the quantum wave function which contains everything, it really doesn’t matter because both possibilities exist in some probabilistic fashion. But from the frog in the pond’s eye view, it does matter, because as one little frog in one little pond, I only have one memory stream. Even if I can enter extraordinary states of consciousness occasionally and catch glimpses of other parallel selves, I don’t have their memory stream. Therefore, for the particular version of me that I call me, I have a preference for what happens. If it’s probabilistic, I want to increase the likelihood that my memory stream goes in the direction of no cancer. Therefore, according to aboriginal elders I have known, the best way to get to the future you want is to visualize already being there. So LMM taught Betty to visualize hearing that the tumor was benign and unimportant each time she began to worry that she might have cancer. Instead of visualizing a terrible death, she could visualize how happy and relieved she was to learn that it was a benign tumor, perhaps an innocent granuloma. We’re not saying this is easy. We attempt these techniques when we find ourselves worrying and some days, they’re easier than other days. Of course we’re not perfect at this form of visualizing. But it’s worth the effort. And, as we tell our skeptical friends, so what if it doesn’t work. At least we’ve reduced our anxiety which can’t be all bad.

Betty called LMM because her daughter had just finished an internal medicine residency and had looked into her mother’s surgical pathology report which had shown, exactly as we visualized, a benign granuloma, the kind that could have resulted from a cancerous tumor transforming itself into a benign tumor. Many don’t realize how often this happens, because of the stigma placed upon cancer. Once upon a time, LMM did a computer model for the growth of colon cancer from polyps. An important part of the model was the rate at which colon cancer cells reverted back to normal cells. Betty’s daughter had decided she had tuberculosis and that was the explanation for the granuloma. Her mother had worked as a nurse at a tuberculosis hospital forty years earlier. There was her simplistic explanation which we all want. We don’t like complexity.

LMM asked Betty how she felt. “I feel great,” she said.

“No problems? No fevers? No chills? No night sweats? No coughing?”

“Nothing,” Betty said, adding that she had been diagnosed with COPD, which scared her into exercising. She had raised her percent pulmonary function into the high 90’s even though her chest X-ray hadn’t changed and was hiking high into the mountains at altitudes that could be daunting for anyone. Still she worried about dying of COPD.

“Betty,” LMM asked, “what does your doctor say?”

“That I’m in great shape, and I don’t even qualify any more for the diagnosis of COPD.”

“So why do you let that X-ray shape how you think?” LMM asked. “Haven’t you seen the studies showing that X-rays rarely correlate with much? It’s how you use the cytokines that counts, not whether or not you have them.”

Betty’s daughter had arranged for a complicated four-month course of anti-tuberculosis drugs, many of which had tremendous side effects. Betty decided to refuse. We supported that decision. “You’re not sick,” LMM said. “Your TB skin tests are negative. You have rebuilt your lung capacity to fabulous levels. You know the symptoms of TB and would call immediately.” Betty agreed and that ended the discussion. We would continue our work together in a month to investigate the nature of this thing that she called “depression”.

On Easter Sunday one of our favorite young men called because his voices were out of control. Edward was presented to us as having severe paranoid schizophrenia, though, we wouldn’t have said that. Calling someone a paranoid schizophrenic is quite pejorative. People thought Edward was hopeless, which we also resist.

At Wabanaki we don’t practice medicine as a business to make money. We practice medicine because it is a calling. We have a concierge practice for the poor unlike some of our colleagues who do a concierge practice for the wealthy.

Edward had two beings who tortured him. He said they said they were Ascended Masters. One was Jesus and the other was a famous Tibetan with whom we were not familiar. They were there to torture Edward because he was Hitler in his last life, and he needed to suffer. They told him to kill his parents so he would go to prison for life where they could really torment him. They told him they would really torment him when he died and they would have complete control over him.

We reduced his risperidone because Edward wasn’t feeling anything, and he was still suffering terribly from the ascended masters despite a high dose of medication. He was still suffering equally but said that his good days were much brighter on the lower dose and that he could think again. Reducing the dose didn’t increase any of his symptoms at all. Plus, he had more good days on the lower dose.

Nevertheless, this was a bad day. He hadn’t really slept all night. He was angry because he thought no one believed him about the ascended masters. He was convinced they were who they said they were. We responded that we did believe Edward but we didn’t believe what the beings were telling him because they contradicted everything our teachers and elders told us about the nature of the universe. We assured him that we accepted him and his interpretation of his experience and that we could do that without believing what the beings told him because they appeared to us to lie. We shared with Edward that our spirit helpers and contacts and all our living teachers taught that higher beings are full of compassion and love and that they don’t torture mortals. In our visions of Edward’s infestations, we had seen tar babies as in the Uncle Remus stories. They were stuck to Edward and he needed to cultivate spiritual turpentine to get them lose. That consisted of love and compassion as we had previously said. He had replied that he couldn’t love these beings or feel anything positive for them.

When we explored further with Edward what was going on, it turned out that his parents (with whom he lived in the basement) were having a dinner party that evening and he wasn’t allowed to leave the basement because he had embarrassed them the last time, they had a dinner party. “That’s sort of invalidating,” Barbara responded. Apparently, during the last dinner party, he had tried to get his mother’s attention and she had ignored him until he went outside and made faces through the window, which angered her because her guests saw her son acting crazy. We also learned that he had just had a bad experience contacting a Peruvian “shaman” who had charged him the equivalent of two weeks’ worth of food and the encounter was ineffective. He was lonely and had no alternatives for a place to go that evening since he was out of money. Friends had invited him to meet them at the pub, but he couldn’t afford to do so. Barbara insisted that he eat some oatmeal and try to get some sleep. He did and two hours called us back. Things were better but not yet out of the woods.

We realized this was why people preferred medications. They believed the medications would prevent phone calls on Easter Sunday, which they actually don’t, but instead, many of the people end up in hospital or emergency. It’s both harder and easier to do concierge medicine with people who have had severe psychiatric diagnoses. It’s harder because one has to be available sometimes when it’s inconvenient. It’s easier because they actually improve. Edward found ways to be around friends that evening and felt better.

On the next day, we encountered Michael’s crisis. LMM saw Mike every other week for an hour. He’d known him for years. Mike was 57 years old and lived in a trailer park at the edge of town. The park lies next to an abandoned quarry and many of the trailers have been condemned as not habitable. Mike was always available to help his neighbors sort out their electric wires, plumbing, and belongings.

Mike was the black sheep in a family of successes, mostly in construction and real estate. For as long as Mike could remember, he was being told that he was no good. We suspected a learning disability that was unrecognized, untreated, and interfered with his academic success. To compensate, we suspected that he became even more rebellious than many teens – those were the days of James Dean and to be an anti-hero was more desirable than to be a “goody-two-shoes”. Eventually Mike fell into drinking and spent a lot of years drunk. However, when we met him, he was over 10 years sober and still the black sheep of the family. He was in and out of the psychiatric hospital every year. Typically they would load him up with medications and he’d slowly stop taking them. Someone had given him a diagnosis of bipolar disorder (though like the great majority of our patients, he had received every diagnosis in the DSM including schizophrenia and schizo-affective disorder) and that had stuck in his mind and on the disability application which had been approved finally when he and I met. Disability was a double-edged sword for Mike. It paid his bills but also made him feel permanently defective – crazy and unable to better himself. It also played into his family’s view of him as a mental defective.

Mike was always looking for jobs in which he could be paid under the table, though many of the jobs he would like can’t do that. He made us wish disability were more flexible, expanding and contracting his stipend as he was able to work or not. The thinking behind disability is flawed. People are not static. Whatever their problem is, it waxes and wanes in severity, making them more or less able to work on any given day. We believe they should be rewarded for working by being allowed to keep a percentage of the money they earn and not have all their disability benefits removed (sometimes permanently) if they have a good month. However, government policy rarely rides on common sense psychology (what we sometimes call folk psychology), however obvious its lessons are, and disability is no exception. We struggled with opposing the labeling of Mike.

Mike had one hospitalization since we knew him. It happened on his birthday when he thought no one called him. It turned out his family did call him several times but his answering machine wasn’t showing messages properly. He later got a new phone. However, that night he called us planning to kill himself by taking all the pills that he had stopped taking some months earlier without telling us. We wouldn’t have berated him for stopping his pills anyway, but he didn’t know that. We’ve learned that berating and humiliating people is rarely an effective way to help them and we don’t tend to criticize their decisions but rather to puzzle over the consequences and determine what we can learn together. Mike forced himself into the uncomfortable position of having to call the police to come get him because he couldn’t guarantee his safety. When the police came, he tried to taunt them (rather ineffectively with a wooden stick) into thinking he had a gun so they would shoot him. They didn’t and finally he agreed to go to the emergency room. Somehow between the emergency room and the psychiatric hospital, he was arrested and shackled. He arrived at the psychiatric hospital in leg irons and handcuffs. What he hadn’t told anyone (I told the police and they didn’t pass it on) is that he had taken 100 lamotrigine tablets. By the time he reached the hospital, he was a bit delirious and confused about why he was in leg irons and handcuffs and when the handcuffs were removed, he got scared and took a punch at an attendant, knocking him to the ground. The hospital gave him haloperidol and lorazepam. He slept for over 48 hours and felt much better when he awoke. They discharged him on a number of medications that he gradually discontinued.

For several months, Mike did quite well without medications. His ex-wife gave him custody of their 16 year old son as she was unable to manage him and Mike coached his son from failing high school to a “B” average. However, on that day we got the call that he couldn’t come to our appointment because he had no ride and he was afraid the police were out to get him and take him to a state hospital in Connecticut for permanent commitment based upon what he had done before and during his previous hospital. LMM had an hour available when Mike was supposed to appear, so he told him to stay put and he’d come see him at his house. Mike’s son was home, so Mike asked LMM to meet him at the picnic table by the gas station on the road out of town. He did.

Mike was very afraid. He hid any time police drove by. He had gone into the gas station to buy a coffee and had abandoned it because two police came into the store. He was sure that he was doomed to be committed to the Connecticut State Hospital for what he had done and that the police were looking from him. Reassurance and logic were only mildly effective. LMM searched for triggers and learned that family members had been particularly humiliating toward him during the previous few days. He said he was two different people. When his son was in the trailer, he felt fine and behaved normally. When his son left, he turned into a raving lunatic. He feared he needed to go back to the psychiatric hospital.

“You need to sleep,” LMM told him. He knew the hospital had just given him a shot of haloperidol and lorazepam and he’d slept for 48 hours, and they’d discharge him on a bunch of medications that he’d slowly stop taking. That had happened over and over for years. “What if I give you the same medicines they’d give you at the hospital?” he said. “We could make you sleep the night and see you tomorrow and see how you’re doing.”

“You can give me those same medicines?” he asked. “A shot?”

“Or pills,” LMM said. They’ll work either way.

“Pills,” he said. Pills it would be.

Barbara drove to the drug store to pick up his pills (haloperidol, 5 mg and lorazepam, 2 mg) and bring them to him. She also gave him a water and a bag of chocolate Easter eggs that we were trying not to eat. He was to take two of each pill and sleep. He did. Jump to tomorrow ….

Mike came to the office. He was a bit groggy but much better. He took the medicine and slept soundly. His fears had disappeared. He was going to take the full dose for one more night and then cut back to one tablet of each for the next nights and return on Friday. LMM had previously learned that this was how medication is used in India, as a short-term means of crisis management and not for long periods of time. This is because India can’t afford these medications. However, this approach has worked well for us when people aren’t already on medications. It’s been our observation that the crises come anyway, regardless of whether or not people are on medications. Typically they are hospitalized during crises and all their medications are changed because “the meds just weren’t working”. This is how people get to sample all the known psychiatric medications. We have a colleague at West Virginia University who waits one week before changing medications. He finds that he almost never has to change medication because the structure and the safety of the hospital is enough to resolve the crisis. We have also observed that rarely do most contemporary psychiatrists inquire about the precipitants of the crisis. In Mike’s case, we spoke more about how his family humiliated him. We felt sad for his life with them. We were sure he had been quite obnoxious in his day and probably upset them enormously, but LMM maintained that this bravado that he had displayed as a teenager was a cover-up for his learning disabilities and his discomfort at having trouble in school when everyone else in his family did well without difficulty. Saving face is hugely important at all ages. The benefit of keeping Mike outside the hospital was that he didn’t have to save face to his family. They would never know about his crisis.

Mary came for her individual appointment. She reported that she had been having great difficulty in her life during the past week and had missed group and didn’t want to talk about her problems any more. She was bored of hearing herself and surmised that she made mountains out of molehills – that being her greatest problem. The problems that were stressing her were actually quite small and not worthy of discussion. She requested that LMM do a guided imagery for her and help her chill out even more since she really wanted to get a good night’s sleep. She wanted him to tell her a story at the end of the session so that she could feel like she’d been read a bed time story. She wanted a story about a strong woman.

Guided imagery was never easy with Mary because she frequently interrupted with another story, and today was no exception. She did, however, relax visibly as we proceeded. She was beginning to agree that her problems – whatever they were – were not so daunting as she had imagined. LM gave her the image of breathing out her problems on each exhale and sending them out the door and down the street to the library where they could enter books and become part of other worlds. He told her an old favorite strong woman story, that of the Gatherer, which is told in full in one of my earlier books. This story is about a young woman who saves her village from sneak attack only to be taken captive by the enemy and returned to their villages many days march away. The War Chief wants to torture her for thwarting his plans but the Head Chief refuses him for a year. During this time she is adopted by an older couple who have lost a child in battle and eats a sacred herb from home and becomes pregnant and gives birth to a magical child who came from that herb and is actually the chief of the plant people become human. He can walk and talk from birth and will become full grown in 2 weeks. He has come to rescue her and allow her to escape and return to her own people. She does, and her child appears and makes a covenant with her that plants will present one of their own to treat any affliction that humans develop. The story paralleled Linda’s life in many ways. She was delighted with it and happily trundled home to take her medications and go to sleep for the night.

The next day, I taught first year graduate students in clinical psychology. We were exploring what it means to be a psychologist, including the ethics of psychology. We were using art as a means of self-reflection, but that was curtailed by the Dean because art is not evidence-based. The Dean also told LM that she was bored to tears. Art brings feelings to awareness that might not otherwise surface. The students were not initially comfortable with art which is good because it showed them how their future clients might feel about psychotherapy. Nevertheless, art is suspicious. All good totalitarian regimes have tried unsuccessfully to quash it because it keeps the spirit of resistance alive. Art allows us to recognize parts of ourselves that are often healing. Art serves well the self-reflection process.

We understand this suspicion of art, for it seems messy. Psychology has made the cognitive turn. We are training rational beings who can do evidence based practice. Cognitive therapy is the ultimate rational enterprise. We suffer because we think incorrectly. Change how we think and we will suffer less. We have some respect for this perspective but come at it from a narrative direction. We believe we think what we think because of the roles we play in the stories we live and that live through us. We perform the roles of the characters into which we have been inducted.

Artist Amy Stein writes that all portraits are self-portraits. All writing may be autobiographical! All art may externalize our internal processes. We began the first semester with Amy Stein’s self-portrait process. She uses charcoal and geometry to teach physicians that anyone can draw. Amy does for drawing what Rita Charon does for writing. Rita (head of the Narrative Medicine program at Columbia) teaches that anyone can write and that everyone is a poet. Amy uses charcoal – what she calls a forgiving medium – and some basic geometrical principles surrounding the shape of the human face, to show physicians that anyone can draw. We learned Amy’s technique in a restaurant in Santa Fe where we proceeded to draw a face in the midst of Amy’s invectives about a writer who had given a talk on “writer’s block” at the conference we were both attending. Amy was born in Brooklyn and had worked hard to support herself with her painting. Her art is glorious and hangs from the walls of many Santa Fe institutions, including La Fonda, the historical landmark hotel where we sat. Amy was raving about how that writer would have overcome her block sooner if she hadn’t had a rich husband to support and coddle her. Amy might have been right, but we’ll never know. Certainly that writer would never be as productive as Amy. Almost absent-mindedly, aside from the main topic of conversation, Amy taught us her technique and we’ve been using it ever since. For LM, who could previously barely draw a stick figure, knowing that he could draw a face that was at least recognizable as resembling a human being in the world was exhilarating. It challenged all that he had been taught– that he couldn’t draw which is why he became a scientist. He could draw! Not only that, with enough time, he could draw well. Malcolm Gladwell (Outliers) says it takes 10,000 hours to learn how to do something well. His hour per month of art with the students fell far short of that mark, but it was a dramatic beginning, and opened the door to much deeper levels of communication than we had before art.

Instead of art, we watched a movie. I suppose the message here is that passive watching is more acceptable than active doing. This Israeli movie, *Walk on Water*, was an investigation into the level at which we are culpable and responsible for correcting the misdeeds of our ancestors. It stimulated interesting discussion but less “from the heart” than art did.

 We will see if art can make a return into psychology. Interestingly, the textbooks we found on using art in therapy and in personal growth and professional development were largely published by the American Psychological Association. Ironic! We made a proposal for art to return. In the new syllabus, labeled it self-reflection.

 Next came Adam’s day. We first met Adam in February when his father brought him to see us after he had driven himself into psychosis with excess drugs, particularly crystal meth and cocaine on top of a heavy diet of alcohol and marijuana. Adam was clearly in more than one dimension, what we ordinarily call psychotic. He was refusing to take medication and only wanted natural substances. We suggested Empower Plus, a supplement championed by True Hope in Lethbridge, Alberta, and well-studied for conditions such as bipolar disorder. Adam was initially open to taking Empower Plus, but friends convinced him that he should get his vitamins from food only and not from supplements, so he stopped. He had seemed to be doing better when he was taking the Empower Plus and Fish Oil, but when he stopped both, he began to spiral downhill. He stopped coming to our group and stopped seeing us. Two weeks later he was in the hospital. We had visited him there and saw him on the day he was discharged. He continued to refuse supplements or medication. By the end of the day, he had run out into the forest in retaliation to his mother who had been pestering him to behave well. He spent the night in the forest prompting six dog teams and a helicopter to look for him. Eventually he presented himself at a local house and was taken to hospital, where he stayed for almost four weeks. When we saw him, he was on 20 mg of olanzapine, an antipsychotic medication which he didn’t want to take.

 What stood out about Adam? He had a twin sister. He didn’t want to be controlled by his mother. His mother wanted him to stop taking drugs and *straighten up.* She had gone through his father’s drug problems and five years of Adam’s drug problems. She was done with tolerance and was angry. However, it was clear that the more she pushed, the more Adam sought ways to rebel and to get back at her. Sometimes revenge is also self-destructive as it was for Adam, who took revenge by wandering off into the forest.

 Here we were after almost four weeks in the hospital. Interestingly, no one had called us back from the hospital or talked to us, despite how many times we had called. This was consistent with how the hospital deals with community physicians. Ignore them! LM did get to speak to a medical student once when Adam was first admitted, but that was after calling and asking to talk to the attending physician. At least the hospital was consistent in letting LM know his place.

 Adam didn’t want to take any medication. He didn’t want to take nutritional supplements. He didn’t want to take fish oil. He did want to take marijuana, though, which enraged his mother. Adam had been discharged on 20 mg of olanzapine, which is a large dose. It was easy to imagine reducing it to 15 mg without any adverse effects, but we had to begin the process of developing an early warning system to alert us if Adam was deteriorating if we continued to reduce his dosage. Unfortunately, only his family was present to be his early warning system. I like to get at least a few friends as well as family. Adam wasn’t willing to bring any of his friends into this meeting. We reviewed what would constitute evidence for deterioration. Adam suggested that he could be considered deteriorating if he stopped eating, exercising, doing yoga, or got confused enough to not be able to function. His mother agreed if he went back to turning off all the electricity everywhere in the house; that would count.

 The hospital had referred Adam for partial hospitalization, which he wouldn’t attend. Nor would he attend the various groups that we offered except that he did come to Complicated Minds, though he didn’t say much. Adam’s mother was angry that he wouldn’t go to partial hospitalization. She poked at him and poked at him. We could see how enraged Adam was. He didn’t like being poked. His mother was strident. She had suffered enough. Her position could work, but her delivery probably wouldn’t.

 LM told a story about coming to terms with his son’s thoughts of suicide. He had to embrace all possibilities to not be triggered by his son. When he did that, he was more able to respond in a helpful way. He suggested to mother that radical acceptance was needed. We need to embrace the people in our life whether they change or not. She could set limits about what behavior she would tolerate, and she could love Adam whether he complied with her demands. However, if he didn’t comply with her demands, he would have consequences, such as not being able to live with her. We suggested she begin to think about where he could live if he couldn’t live with her.

 She had trouble relating to this. She just wanted Adam to do the right thing. We suggested to her that Adam wasn’t necessarily going to do the right thing. He was going to do whatever he wished, ultimately, regardless of what she wanted.

 Adam’s sister had some words. She thought Adam knew what he needed and that he would figure it out. She agreed that her mother’s stridency was counter-productive. What were we to do? We suggested that we would just have to see how things unfolded. We made appointments for the future. Adam assured his mother that he would think carefully about what he wanted and make good choices, though I was not so reassured.

 These are days in which we are integrating general practice, psychiatry, and healing. As readers can see, it is messy and not always successful, but we are always respecting the people we serve, believing them, working within their belief systems, and doing what we can to reduce the suffering which we encounter.