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Navajo Medicine and Psychoanalysis

by ROBERT L. BERGMAN, M.D.

Life in western societies has become so fragmented that it seems as if we can never be in touch with all of it at once. Therefore, when we are in trouble and need help, we seek a doctor, lawyer or priest, depending on our problem. The Navajos find this puzzling. Their medicine men blend healing and worship together in a powerful vision of life. A psychiatrist who has worked closely with them for years believes their wisdom may point the way for our own future.

Dr. Robert Bergman is Chief of the Mental Health Program for the Indian Health Service in Window Rock, Arizona.

One day recently, a panicky Navajo Vietnam veteran came to see me in my office in Window Rock, Arizona, where I work as a psychiatrist for the Indian Health Service. He was trembling and had difficulty remaining in his chair. His speech darted from subject to subject as he rushed to explain what he was feeling. In Vietnam he had discovered how murderous he could be and had been horrified. After his return, a quarrel with his father pushed him to the verge of murder again. He ran away to save his father's life, and now he felt as if he were blowing apart.

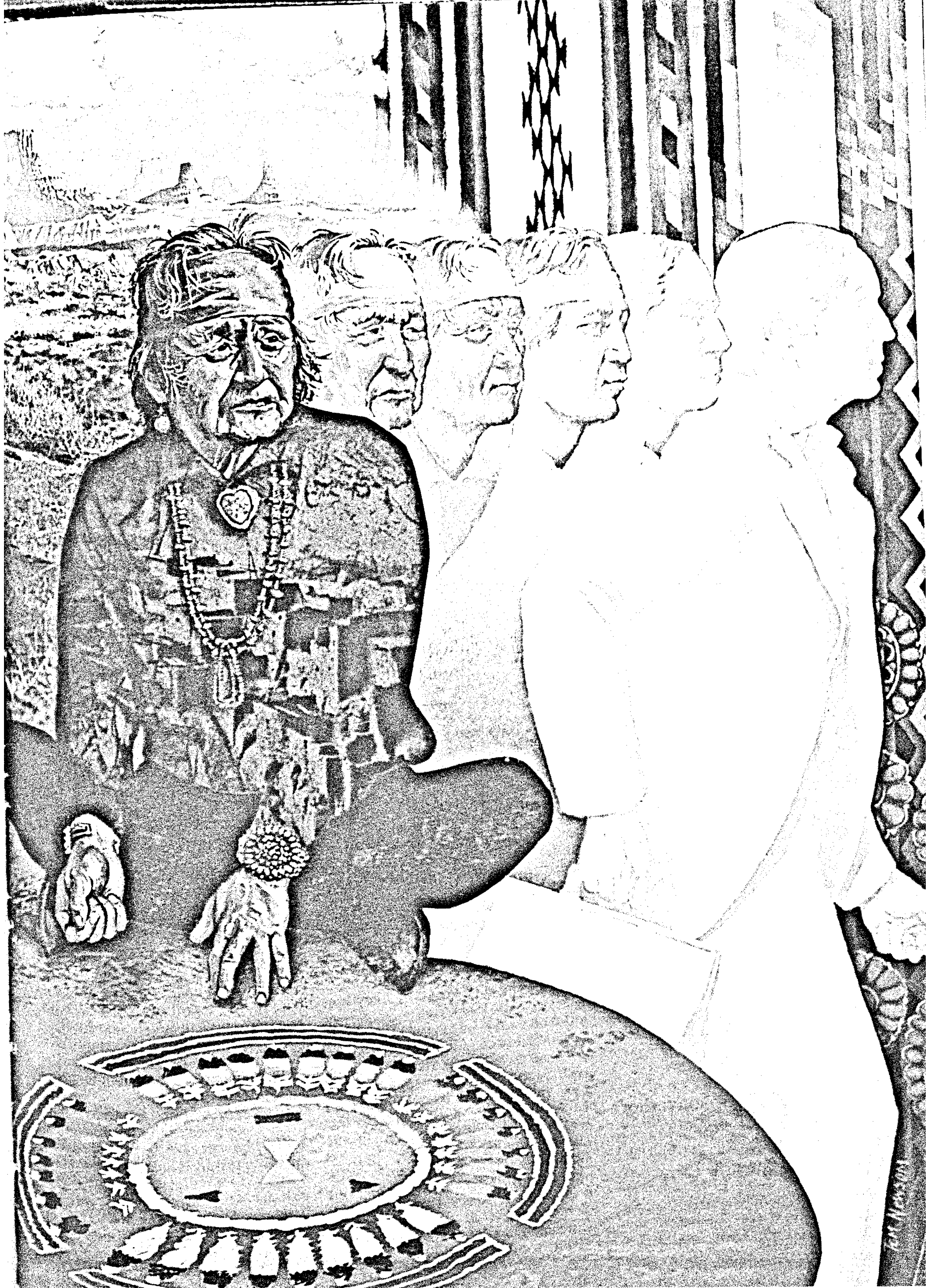
We talked for about an hour. I suggested that he go to our psychiatric unit in the Gallup Indian Medical Center and prescribed some medicine. But I also recommended that he see a medicine man and arrange to have an Enemy Way ceremony as soon as possible. He refused hospitalization, but he did take the medicine and he followed my advice about seeing a medicine man. He went to a hand trembler —a shamanistic diagnostician—who warned him that he was in serious condition. "It's a good thing you went to the doctor," he said. "He understands what's wrong. You should go on taking that medicine, and you should have an Enemy Way sung over you. You should have taken his advice about the hospital." Several weeks or months are required to make all the elaborate preparations to have a nine-night chant, and so it will still be a while before my patient has his, but he is considerably calmer already.

There have been many occasions for this kind of cooperation with medicine men during the seven years I have worked on the Navajo reservation. I learned about the importance of medicine men early in my first year there. As I was following up cases that had been treated previously in off-reservation hospitals, I discovered the record of one woman who had been hospitalized several times as a schizophrenic. A social worker and I set out to track her down to see how she was. We found her father first. He agreed to take us to see her but said that maybe we wouldn't be interested anymore because now she was perfectly well. We said that if she was perfectly well, we were even more interested in seeing her. She was at home taking care of several very active, healthy-looking children and weaving a rug at the same time. After a visit of several hours, we agreed that she was indeed well again.

After various futile kinds of treatment, she told us, she had been referred to a medicine man named Tom Largewhiskers. She and her mother had gone to his camp and asked him to cure her then and there. He agreed to perform a ceremony, but only at her camp. Since she had become ill at home with her family, she would have to be treated at home. The ceremony had been performed two years before we came. During it, the patient said, "I felt my mind come back to me."

The next person I went looking for was Mr. Largewhiskers. When I found him, I asked him to become a consultant to our mental health program. He agreed but said he wasn't sure if we had the same kinds of ideas and would understand each other. "I don't know what you learned from books," he said, "but the most important thing I learned from my grandfathers was there is a part of the mind that we don't really know about and that it is that part that is most important in whether we become sick or remain well." No one knows precisely how old Mr. Largewhiskers is, but he is over 100. I believe that he learned about the unconscious in 1886, seven years before Breuer or Freud published their studies in hysteria.

White people are just learning some of the other important th



known for a long time. When the first men landed on the moon, a magazine writer told him the news and asked if it surprised him. It didn't. "There is nothing so foolish, expensive, or dangerous, that white men won't do it," he said.

Working for the past six years with men like Mr. Largewhiskers, moving rapidly back and forth between two cultures and the systems of healing proper to each and trying to find appropriate roles for mental health people in a receptive but wisely skeptical community has forced me to imagine how the ways of each system could enhance the other. Some things that I like about the Navajo way were abandoned by white people in the past, and other customs are simply different, but in either case, some familiarity with Navajo tradition has helped me to focus my dissatisfaction with the way we organize our work and to see alternatives to our methods that I wouldn't have seen otherwise. I have tried to imagine ways that psychiatrists and psychologists of the future might become more like Navajo medicine men.

The medicine men unite in themselves the three learned professions. We have separated them for centuries, and each—theology, law and medicine—has been further fragmented with nearly fatal results. To understand what it is like not to make our customary distinctions, imagine a society in which there is no difference between a church and a hospital. Many Navajo people find that distinction rather puzzling, and one of the reasons for the considerable success of Pentecostal missionaries among Indians is that these missionaries are quite ready to be both healers and priests. In a Navajo ceremony, there is no way to tell what is healing and what is worship. Everything is both. Moral guidance is also an inextricable element of ceremonial practice. And until quite recently, the medicine men, because of their knowledge, experience and integrity, were called upon to play the leading role in the informal judicial process that settled disputes and dealt with wrongdoers.

"In a Navajo ceremony, there is no way to tell what is healing and what is worship. Everything is both."

We doctors, lawyers and ministers, like the good union men we are, try hard to avoid jurisdictional disputes. Psychiatrists pretend that they make no moral judgments, giving them such misleading labels as *reality testing.* Only old-fashioned or low-status (but high-salaried) ministers openly practice healing. Up-to-date ones call it *pastoral care,* and, in my experience, they become anxious and guilty when they discuss it with a psychiatrist, seemingly fearing that he will think they are taking the bread out of his mouth. We try to hide the role-confusion of judges and doctors in the elaborate ritual called *expert testimony*—a ritual that seems to be increasingly embarrassing to all concerned.

As physicians, the medicine men medicine men, we would rather be scientists and technicians than healer-priests. As a psychiatrist, I am filled with envy by the lovely machinery I see in the hands of my colleagues in radiology or ophthalmology. The bio-chemist-psychiatrists, I suppose, are grappling with some of the hardest scientific-technical problems of medicine, but sooner or later they will succeed in eliminating major mental illnesses, leaving the rest of us with only the universal nuttiness and misery of human life to take care of. How will we do it? Not, I think, as scientists or even as priests of science, but somehow as healers—like the medicine men. I think our successors will be more like Dr. Henry Reilley than Dr. Jonas Salk, or at least they had better be.

Navajo Al Atson, a Vietnam veteran. A Blessing Way ceremony eased his return.

are far ahead of us in the evolution of their role. Until white doctors came along, they set fractures, drained abscesses, treated wounds and did all they could for the physical aspect of illness. They quickly learned that our gadgetry was far better than theirs for this sort of thing and turned over all such matters to the technicians and pharmacists: us. Then they concentrated on what they always considered more important—roughly, what we would call psychotherapy or pastoral care. If we are wise, the same will happen to us sometime in the next 100 years or so. It doesn't seem overoptimistic to predict that in that length of time biologists and technicians—only some of whom are physicians—will fairly easily prevent or cure everything but unhappiness and death. Those two basics should provide enough work for our successors, whoever they turn out to be.

The trouble is that, unlike the

I believe that our shame at not being more rigorously scientific causes us a great deal of trouble already. We are often poor at our nonscientific tasks, partly because we try to remain unconscious of them and therefore do not learn them well. It is well established that psychotherapists influence their patients in accordance with their own set of moral standards, but we rarely discuss those standards. If we do so at all, it is often as surreptitious backroom talk. We leave that sort of thing to the priests, and then we scorn the priests.. When we judge our patients—or more commonly, their parents—we leave the process unexamined because we disguise it so well as reality testing. The old claim that we only hold the mirror up is true if it is also true that we can make all the patient's judgments infallibly and therefore can tell when his reality testing is on or off the mark. One has only to read case reports (of course

they are getting rare these days because they aren't scientific) to have at least a nagging doubt that all psychiatrists see the same reality and therefore can tell how well a patient is testing it.

I do not mean to say that there is any easy answer to the question of how to make moral judgments about our patients, but the problem can only be made worse by ignoring it. Actually, the moral principles traditionally inherent in psychotherapy are rather similar to those of the medicine men, and though surely not a complete moral system, they are in themselves useful and admirable. Thus, it is good for our patients to love and to work. It is good for us to be as helpfully interested in our patients as we can be, regardless of their impulses and actions. It is good for us to meet with our patients for their benefit not ours, except insofar as it is to *our* benefit to work. But, partly because we try to remain unconscious of our values, we seem to be drifting carelessly towards some different ones—namely, that pleasure is better than love or work, and that if the therapist has fun in therapy, it must automatically be good for the patient.

The covering-over of moral issues originates not only from the wish to be scientific, but also from a fear of being unmanly. European religion for some time seems to have been the province of the clergy and women. This trend is only beginning among Indian people. I sometimes take part in a gathering that takes place every Tuesday evening at the home of one of my friends in Gallup, New Mexico. A group of 10 or 15 men get together and beat a drum and sing Indian religious songs just for fun. Among Navajo people there is nothing out of the ordinary about such an evening, but a group of non-Indian men might be looked upon with some disapproval or at least scorn if they were to get together at someone's house to sing hymns just for fun. Traditionally, either men or women can be Navajo ceremonialists, and religious activity is regarded as difficult, important and admirable for anyone. I suspect that one reason for the difference is that Indian religion requires study and effort of everyone. The ceremonialist is the leader, but he is not the performer. In our religions, with only a few exceptions (and these are prospering), the ever-increasing fragmentation of life into professional specialties has left only the clergy active, while everyone else has become a passive member of the audience. Our culture equates passivity and femininity and, therefore, we refer to the kind of damage religion has suffered by such words as "emasculation."

Like the rituals of our religion, the rituals of our medicine have also been damaged. In contrast, the medicine men are taught ritual as much as they are taught anything. There are at least 35 major Navajo ceremonies, each lasting five or nine nights. All of that time is occupied by complex activity prescribed in great detail: sand painting, dances and thousands of lines of poetry. The symbolism of each ceremony is appropriate to the condition of the patient—for example, the removal of the traces of the poisonous influence of the enemy dead in the Enemy Way prescribed for my Vietnam veteran patient. Every line of chanting, every movement and each part of every sand painting must be remembered perfectly by the medicine man. A minister would be in a similar position if he had to conduct a 60 hour service consisting of reciting the entire Bible from memory while playing the organ and making the stained-glass windows of the church.

Atson and his mother, who is a hand trembler—a sort of shamanistic diagnostician.

We psychiatrists also have a ritual, one which is determined by the nature of the case, by our own theoretical or mythological persuasions and by our personalities. We go to the waiting room to greet the patient to show that we are friendly, or wait for him to be sent in to show that we are important. We seat him across a desk from us to show that we are businesslike, across the corner of a desk to be informal or we dispense with the desk to be casual. We say "Hmm" when we like what we are hearing and nothing when we don't. We puff our pipes or furrow our brows to show that our utterances are the result of weighty consideration. Some of us dress in white to show that we are clean, some in suits to show that we are respectable, others in shirtsleeves to show that we are unpretentious. If the case is serious, we resort to an elaborate ceremony called Admission to the Hospital, and we then require another building with many sets and props and a large cast of supporting characters in a variety of costumes.

We should know how important ritual is, but we often deny it or ignore it, and we teach it to our students by the way if at all. The result is unnecessary awkwardness and confusion for the psychiatric resident and his patients, until through experience—usually outside of his awareness—he develops his style. (One way to make such a psychiatrist conscious that he has a ritual would be to have him work without his ritual objects or with the wrong kind—in a lawyer's office or a minister's study, for example.)

Ritual is what gives form to one person's presence with another. In the course of most Navajo ceremonies, there are times when the patient and ceremonialist chant together. A good medicine man quickly achieves a state of harmony with the patient that is so close that the lag between the medicine man's lead and the patient's repetition becomes almost imperceptible. For a lonely, desperate person, the experience seems to be electrifying. Many patients I have shared with medicine men have said that it was during a prayer of this kind that they began to feel better.

I think many therapists today feel so awkward about their rituals that they can scarcely stand to be present with their patients. We don't listen; we diagnose. Scientism is wheeled up to help us out in the form of diagnostic tests—computer scored if possible—and instead of listening we classify.

In the end, it comes down to prescribing. I suspect that the excessive use of prescribed psychotropic drugs results, in part, from inadequate training in being with a suffering person. Prescribe something and he will go away.

Ritual can also be used to keep one's distance from the individual whose fate is being decided. The forms of the law and the courts seem to serve that purpose admirably. Until the advent of tribal courts, disputes in a Navajo community were settled by discussions involving large families of neighbors along with medicine men or other leaders. Discussions were long, but they were not long delayed, and the knowledge of psychology possessed by the medicine man was often what determined a consensual group decision. The formal proceedings of our courts seem to drain the life out of even the most vital matters. Lawyers and judges are called upon to settle interpersonal disputes without training or experience in psychology or therapy. Blame and punishment are decided upon in an antipsychological and an immoral way. Consider a murder trial. If a psychiatrist will testify that the defendant is suffering from a severe mental illness that causes him to be extremely dangerous, he is likely to be free—though still just as dangerous—within a year or two. There are at least two such people now on the Navajo reservation. If the defendant committed his crime under extreme stress such as will never occur again in his life, he will probably be locked up for years. This psychologically illogical result is justified by a concept of justice renounced by most religions many centuries ago—human revenge.

The basic difficulty is the fragmentation of life. One night a group of us were preparing for a Navajo ceremony. The medicine man, who also worked as an interpreter, began talking about his employer. "My boss, Dr. J, knows about anthropology all the way," he said, "but he sure doesn't know about anything else. His car broke down today, and I had to fix it for him. He didn't have any idea what was wrong with it. If we go camping, I'd better be there to put up the tent. He can't do it. That's the difference between an Indian and a white man. An Indian may not know anything all the way, but maybe he does; either way, he sure knows a lot of different things. If he needs a house, he builds one. If his car breaks down, he fixes it. If he wants a horse to ride, he can tell a good one and buy it and train it. An Indian can do all sorts of things for himself, but a white man needs hundreds of other people around to help him."

"The medicine men of our future will constitute a large professional class, with its own customs, values and levels of authority."

Medicine man Billy Sam (above, left) leads a nine-day chant inside his hogan. Below, psychiatrist Bergman demonstrates an oxygen mask for amused Navajos.

By our superspecialized division of labor, we keep almost everyone out of contact with the many realities of life. In any difficulty, minor or severe, we call an expert to take care of it for us, and even though many people are those experts, they only know one kind of crisis and almost always at an emotional distance. Physicians are especially privileged: we are present at birth and death, and we are one of the only groups left who routinely are in touch with joy and grief. It seems to me that the contact with life I had during medical school and internship was the most valuable part of my training as a psychotherapist. Now that internship has been eliminated from the training of most psychiatrists, many psychotherapists will never have the experience of taking responsibility for people in the desperate crises of their lives. I wonder how well therapists without that kind of experience, and whose life before they began their practice was limited to school and home, can empathize with patients who are struggling with real problems in the world of work. No medicine man was ever just a medicine man all his life.

Medicine men begin their training at various ages. Some start in childhood, but many do not begin until middle age. In any case, the training is in the form of an apprenticeship lasting years, and most medicine men are experienced people in early middle age before they are in full practice. They do not perform any ceremony until their teachers de-

clare them ready to do so, but that declaration alone is not enough to establish them in the new role. The community has the final power for that, because the Indian community will not simply accept certification by the teacher. A medicine man is fully accepted after several years of public scrutiny, not only of his practice, but of his life as a whole. Among us, diplomas and board certificates are sometimes enough to outweigh a commonsense judgment of incompetence.

Diplomas and certificates are not quite as necessary among us as they once were. Many mental health programs, including that of the Indian Health Service, now hire and train paraprofessionals. Indian mental health workers are the main strength of our program, and we have found that a well-trained Indian paraprofessional can do many things that a well-trained non-Indian professional cannot. Our paraprofessionals have a familiarity with real life and their own communities that many young professionals lack, but I do not think that paraprofessional positions solve all the problems I have been trying to outline. Medicine men are professionals. What they have that paraprofessionals lack is status and intellectual discipline. It is almost inevitable that paraprofessionals will always be professionals junior grade and, though they may have great practical skill, only rarely do they become masters of any body of theoretical knowledge. Lacking that, they are crippled as planners, teachers and leaders in their fields. Medicine men are in real touch with the life of their community; they are also its intellectual leaders.

The roles of Navajo medicine men, of psychiatrists and of psychologists were not invented by any one in particular, and it is good they were not. They fit into their cultures because they evolved with them. Nevertheless, I have tried to invent a new role to fit into an American culture of the future—a century or more from now. In describing it, I am indulging in science fiction of a wishful rather than a predictive kind in order to be as clear as possible about which way I think we should try to go. A distant goal can establish a direction of movement even if no one has any illusion that we are going to get to that precise point. I do not know whether or not my utopia is possible; a lot of things would have to change to make it so. The changes may not be as positive as those I picture, but, on the other hand, it could be argued that either our future will be a great improvement over the present or we will have no future at all.

The medicine men of our future will constitute a large professional class, with its own customs, values and levels of status and authority. For lack of sufficient imagination to make up an original name, I call its members *therapists*. The essential attribute they will have in common is skill in being with others helpfully: their rituals and mythology will (since this is my imagination) be somewhat like a combination of psychoanalysis and Navajo medicine, the two healing traditions I know best. The two traditions have many similarities, including what seems to me two essentials: a concept of unconscious mental processes, and a coherent, ordered method of establishing intense, helpful relationships. Both traditions provide a framework of concepts and premises within which thoughts, feelings and life experiences can be ordered and examined. Almost all medicine men and many psychoanalysts are able to tolerate the existence of other mythologies, and so will the therapists of the future. They will be less embarrassed than we usually are to notice that a therapist's character is more important in determining his usefulness than is his theoretical persuasion. The beliefs of each therapist will be determined by his experiences in training and in life in general. Though the range of theoretical systems will be wide, they will have in common certain abilities: to relate personality and behavior to past experiences; to discipline observation and relate the data observed; to prescribe helping ritual (e.g., lying on a couch or sitting on a sandpainting); to define the individual's relationship with mankind and nature. The value judgments inherent in the definition of the relationship of man to man and of man to nature will be more explicit than we make them at present and will no longer be obscured by scientism, because we are ashamed of being nonscientific or subjective.

Among the Navajo people, anyone who can find a master therapist willing to accept him as an apprentice can begin training to be a medicine man. Similarly, the therapists will begin their training by finding an apprenticeship, and the decision of who is to be trained by whom will be solely decided by the two people involved. Ordinarily, the process will start in adolescence, but sometimes it will be later. And, though apprenticeship normally will last for the full duration of training, this, too, can be flexible.

The master will decide what tasks an apprentice is ready to perform. At first, they will probably be such things as typing letters, running errands or sweeping out, if there still are such things. All interactions will be used to direct the intellectual and emotional growth of the apprentice. The interaction of student and teacher will combine elements of work supervision, therapy and scholarship. Apprentices will attend school from time to time, but the main structure of their education will be determined by their needs as they arise and become apparent in the apprenticeship. Classes, laboratories and other fixtures of universities will be adjuncts to education, but not its essence. Success in study will be validated by the master, not by the classroom teacher, in order to eliminate the need to study competitively.

By tradition, most facets of Navajo medicine can only be taught in the cold part of the year and, therefore, apprentice medicine men always have other occupations. Similarly, unless the apprentice therapist of the future is already adult and experienced before he begins training, the apprenticeship will last only about six months of each year. During the rest of the year, the apprentice will support himself. Since apprentice therapists will be expected to be particularly capable people, and in order to help them in their development, it will be customary for various organizations to hire them readily. The choice of jobs will be made by teacher and student on the basis of personal needs. Each apprentice will customarily work in many capacities during the years of his training, and they will include as much contact as possi-

ble with dirt and crisis. Two or three kinds of work would almost always be included. For at least one period, an apprentice would be expected to perform some extremely lonely task in a natural setting. One of the advantages the medicine men have is their long experience of nature undiluted. It seems to me that some of the overestimation of the importance of human beings from which we now suffer results from our living so much of the time in cities or on airliners between them that we begin to believe that there really isn't anything but man and his works. The apprentices would do some kind of work in the wilderness, assuming there still is any then.

Another period would be spent working in various capacities among people of another culture. In the earlier stages of training, the work would be simple but, as they become more highly qualified, highly technical work and, finally, therapeutic work in another culture and another language would be expected.

Medicine by this time will be very different from what it is now. Much of what is done now in physical medicine will no longer be needed because of preventive measures, and much physical diagnosis and treatment will be accomplished semiautomatically. Innovations in physical medicine will be made by biological scientists; treatment will be by technicians, and this work will be a third important step in the training of therapists. Most such work will be done by apprentice biological scientists during their work assignments. This will be crucial experience for them, because it will put them in touch with death and other irreducible realities. They will be the ones in closest touch with people in trouble and will handle such terrible tasks as informing relatives of a death.

Work experiences will greatly affect the nature of the apprenticeship itself. Anxieties and issues raised will be worked through in the relationship with the master, and scholarly interests stirred by past experience or future assignments will be pursued in the classroom or independently. Through all modes of instruction, the apprentices will become familiar with as much as possible of the intellectual heritage of mankind, including science and the arts, without the usual scorn of one for the other. Their final and greatest concern will be with what is now organized as psychology, philosophy, theology and law but, in the course of their work assignments, they will also develop a secondary career. It will remain possible throughout apprenticeship that the student or his teacher may decide that he is not suited to being a therapist, and the ability to earn a good living another way will ease the anxiety about that decision, it will keep people from being therapists, even if they come to hate it, because it is all they know, and it will give the therapist a firm footing in the outside world.

At left, Atson's mother uses her own methods to check out a patient in her kitchen. At right, she turns an ear to the white man's way of ferreting out ailments.

As his training progresses, the apprentice will take on increasingly difficult interpersonal tasks. His first experiences will have been formal processes such as structured interviewing for surveys or other research. In his work, especially as a medical technician, he will have had intense contact with patients concerning physical needs, and within the apprenticeship he will have helped patients with concrete problems. He will be involved with his master in group and individual work and will gradually require less and less supervision. At a point determined with reference to the apprentice's development and without reference to time or formal requirements, the master will suggest that the apprenticeship is over. The final decision will be left to patients, however. The new therapist will look for a job. If he can find a community that will accept him and continue to do so for two years, he will have achieved the full status of therapist.

His first job will be in a neighborhood clinic. The community will pay him a good salary, but less than will be available in this future time to someone willing to devote himself single-mindedly to increasing his personal income. In return, he will stay in the clinic or around the community and do what needs to be done. My model for these clinics is something like Kurt Vonnegut's Rosewater Foundation, where the phone was always answered, "How may we help you?" Like Elliot Rosewater, the therapist will be available to talk to anyone who is scared or lonely, or who otherwise feels he needs to talk. Some of these conversations may involve many people, some may be of very long duration and some may occur on a regularly scheduled basis over long periods of time. All will be formed by the therapist's mythos and ethos of healing and justice.

The relationship between a therapist and his clinic and its community will be something like the relationship between a present-day minister and his church and its congregation. The therapist will be hired and paid by the members of the community and will be responsible to them for conducting himself in accordance with the principles of his profession. If the community becomes dissatisfied with the therapist it will fire him, and the position of the therapist will therefore be as insecure as that of a minister. But since the profession and he himself will be respected, firings will not be undertaken lightly. Therapists will be paid by the community as a whole and will not earn individual

"One of the myths of psychiatry and Navajo medicine is that treatment is ineffective without the handing over of money from patient to therapist."

fees from individual patients. One of the myths that I was taught as a psychiatric resident, and one that Navajo medicine men also learn, is that treatment is ineffective without the handing over of money from patient to therapist. Unlike the medicine men, however, I have not collected fees from patients at any time during the last seven years. My patients receive my care as a treaty obligation of the government of the United States. I may be too closely involved or too stupid to see it, but no evidence has been apparent to me that my work was ruined by its being free. As an example of the power of myth, it is worth noting that the mythology of pastoral care is the opposite of psychiatry, and that, as a result, a minister who collected fees from members of his congregation for listening to their troubles would be as suspect as a psychiatrist who didn't.

People will come to depend on therapists for help in solving controversies that are now removed from the community. Much of what now goes to court will stay in the neighborhood. Disputes between large organizations may still be judged formally, and itinerant professional criminals will be brought to formal trial, but personal injuries and local crime will be treated locally if at all possible, and the two goals will be reparation to the injured and prevention of future occurrences. For example, an adolescent who commits an act of vandalism will be expected to repair the damage even if that is very difficult, but he will not be banished from the community into a trade school or any other jail. In fact, jails as we know them will be gone, because only severely dangerous people will be incarcerated, and in a rather different way than at present. If anyone, on the basis of his behavior and the opinion of several therapists, is judged to be a menace to those around him he will be kept in a controlled environment, against his will if need be. However, this condition will be regarded as a misfortune comparable to the chronic diseases of the present, and, as should be the case with the chronically ill now, every effort will be made to make such a person's life as meaningful as possible under the circumstances. He will have fullest possible access to his work and family, and as much privacy and freedom as is safe.

Institutions of this kind and others which I have only vaguely imagined will be conducted by therapists and their apprentices. Therapists will develop their own interests and special skills and will spend part of their time in specialties, such as working in the more formal courts or acting the part of what we now call *advocate* or *ombudsman*. Some will be elected to public office, but all will spend time in the neighborhood clinic. Strong tradition will cause any therapist, no matter how high in status, to continue to treat patients and to maintain contact with the healing relationship that is the essence of his identity.

Among other things, therapists will be asked to take a leading part in worship. Probably, they will be identified with one religion or another. In those days, every religion will be primarily the responsibility of its adherents no matter what their vocation, but religion will be an inseparable part of everything a therapist does. The picture of a therapist I have in mind was partly formed by the requirement that J. D. Salinger's Zooey Glass outlined for a psychoanalyst to help his sister Franny: "He'd have to believe that it was through the grace of God that he'd been inspired to study psychoanalysis in the first place. He'd have to believe that it was through the grace of God that he wasn't run over by a goddam truck before he ever even got his license to practice. He'd have to believe that he has the native intelligence to be able to help his goddam patients at *all*."

Last year, Robert Fulton, a Navajo medicine man, and I traveled together to a famous eastern university where he gave a seminar in the school of public health. One of the main attractions of the trip for Mr. Fulton was a chance to go to the Atlantic Ocean. He is 64, but he has rarely been away from home. On our way East, he explained to me that every part of nature is important in the existence of everything else. A chance to pray at the ocean was something he had always wanted. The ocean, he said, is a giver of life. When the time came, it was a cold, windy day. Mr. Fulton stood on the beach, the waves washing over his moccasins, sprinkling pollen into the water, chanting a prayer for the sea and its creatures.

That evening, a group of us had dinner together at the home of a friend. As we sat down to eat, Mr. Fulton said, "It is my custom to give thanks after a meal, but I know that you do so before it. So I will be happy to follow your way." Our host explained that he did not customarily pray either before or after eating and didn't know any prayers. Mr. Fulton was slightly disapproving and considerably surprised. "How can there be a man without a prayer?" he asked. "Every tree, every blade of grass has its prayer. That's what it means to be alive." It gave us all something to think about. -B