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The Navajo Healing Project

The articles in this issue represent some of the first fruits of the Navajo Healing Project, a collaborative work by a group of Navajo and non-Navajo researchers dedicated to understanding the nature of the therapeutic process in contemporary Navajo religious healing. Life in Navajoland today proves the outdatedness of any simple dichotomy between tradition and modernity/postmodernity. Many of those who explicitly define themselves as traditional Navajos do so in full awareness of the contemporary context in which that identity takes on meaning, while at the same time the anomalies of modern life are often taken very much in stride by even elderly, monolingual Navajo people. One of the most striking ways in which this complexity is evident is in the large area of Navajo life in which religion and spirituality are intimately entwined with health care and healing. Indeed, healing is the central theme of Navajo religion, while the sacred is the central element in Navajo medicine. Just as Navajos orient themselves geographically within a territory defined by four sacred mountains aligned with the four cardinal points, today they orient themselves medically in a field of vital interaction among four modes of healing: conventional biomedicine, Traditional Navajo healing, Native American Church (NAC) healing, and Navajo Christian faith healing.

The Navajo, or Diné, are speakers of an Athabaskan language, and their contemporary homeland is located geographically in the "four-corners" region where New Mexico, Arizona, Utah, and Colorado meet. The reservation is an institution of the U.S. federal government, its boundaries established by an imposed treaty in 1868 as the condition for the Navajos' release from captivity at Bosque Redondo, near Fort Sumner in eastern New Mexico. The collective trauma of the Long Walk, their forced march into captivity following military defeat at the hands of the infamous Kit Carson, is critical to contemporary Navajos' identity as a people.

According to the 1990 census, the population of the Navajo Nation was 155,276, of which 96 percent was American Indian. Although precise figures are not available, as many as another 50,000 Navajos, for a total population of roughly 200,000, may live in various other regions of the United States, many maintaining close ties to their homeland. Given the size and geographical expanse of Navajoland, it is not surprising that there exists a degree of regional cultural variation among Navajos, though this may have become less salient as more paved roads have decreased isolation over the past 20 years.

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Navajo society is traditionally organized around a system of exogamous matrilineal clans, with traditional subsistence based on a combination of farming (primarily corn) and livestock raising (primarily sheep). In the 20th century, these activities have been supplemented by wage labor, first in railroad construction and mining of coal and uranium, and more recently in service occupations in the federal Bureau of Indian Affairs, the federal Indian Health Service, and the Navajo tribal government. In general, though Navajos remain an economically poor people, their land, resources, population, and cultural/linguistic base place them as relatively well off in comparison with many other American Indian tribes.

Taken together, the four modes of healing identified above are the principal components of the "health care system" (Janzen 1978; Kleinman 1980; Leslie 1978, 1980; Rubel 1979) in contemporary Navajoland (Diné Bikéyah). We suggest that this health care system can be conceptualized with reference to the cardinal points by means of which traditional Navajo thinking is oriented, and represented in contemporary Navajo style with east, the direction of the sunrise, at the top (Figure 1; see also Figure 2 in Begay and Maryboy, this issue). For primarily logistical and pragmatic reasons, the Navajo Healing Project has not focused on biomedical healing as experienced by Navajos in the hospitals and clinics of the Indian Health Service or in private institutions, whether on or off the reservation. Indeed, restricting our attention to the principal modes of religious healing emphasizes that in Navajo society the roles of what in much social science research are called "conventional" and "alternative" healing often appear to be reversed, with biomedical healing taking on the character of the alternative. Never ignored and seldom rejected, it remains in the background of discourse, appearing in the words of religious healers mostly in response to our direct requests for comparisons with their own practice, and in the words of their patients as a form of treatment often sought concurrently with religious healing.

There are three principal varieties of contemporary Navajo religious healing. Traditional healing is that of the *hataałii,* who performs intricate chants and sandpaintings, and of the diagnostician who works by methods such as hand-trembling, crystal-gazing, or coal-gazing. NAC healing is that of the road man, who prays at his earthen altar or fireplace and administers sacramental peyote. Christian faith healing is that of the independent Navajo Pentecostal preacher, with his revival meetings and laying on of hands, and of the Catholic Charismatic prayer group, with its communal integration of Navajo and Roman Catholic practices. All of these forms are available on the Navajo reservation, and it is worth emphasizing that Navajos typically distinguish among them as representing three identifiably distinct religious traditions—that is, they are in principle not solely etic categories, the boundaries of which are presumed by analysis but ignored in everyday life. The most vivid recent evidence of this was a ceremony broadcast by the tribal radio station during the drought of 1996, the public symbolism of which highlighted a chanter, a road man, and a minister taking turns offering prayer for rain. This being said, it is nevertheless the case that, in practice, the three traditions appear to allow varying degrees of eclecticism among their adherents (the least being among conservative Traditionalists and fundamentalist Christians, the most among adherents of the NAC and Roman Catholics). It is also the case, particularly among patients, but in many cases healers as well (see Begay and Maryboy, this issue), that individual

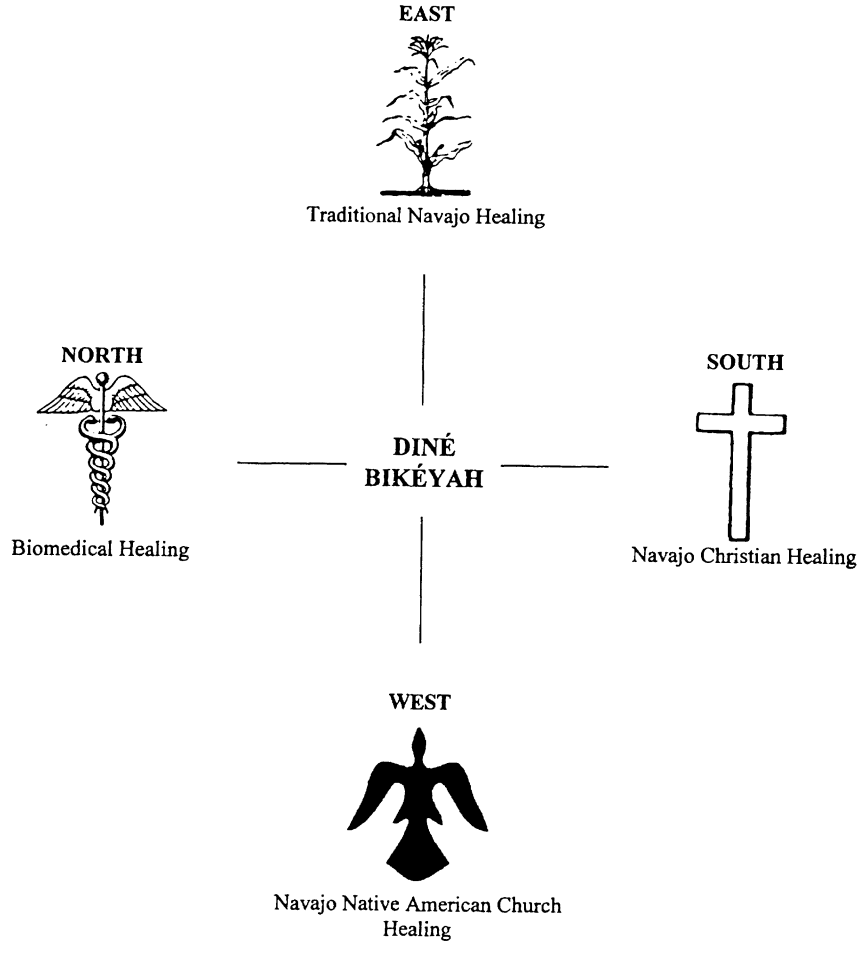

FIGURE 1
The Health Care System in Contemporary Navajo Society.
(Source: Navajo Healing Project, Case Western Reserve University.)

Navajos synthesize elements of all three traditions in their experience and that a diversity of allegiances and affiliations can often be found within families.

Two principal motives guided development of the Navajo Healing Project. One of these was intellectual and academic, that is, to contribute to a cross-cultural theory of healing of the kind called for decades ago by the psychiatrist Jerome Frank (Frank and Frank 1991). Religious healing is an important aspect of health care in many cultures, and defining the efficacy of religious healing is an enduring problem in anthropology (Bourguignon 1976; Csordas 1994a; Dow 1986; Finkler 1994; Kiev 1964; Kleinman 1980; Laderman and Roseman 1996; Moerman 1979; Ness and Wintrob 1981; Numbers and Amundsen 1986; Sullivan 1989). It has become commonplace to observe that efficacy is contingent on the nature of problems addressed by different forms of healing, how those problems are defined in cultural practice, and what counts in cultural terms as their successful resolution. Given this set of contingencies, it has been argued on the one hand that ritual healing is invariably and necessarily effective due to the manner in which it defines its goals (Kleinman and Sung 1979), and on the other that it necessarily fails insofar as it is a treatment more of lifestyle rather than of symptoms (Pattison et al. 1973). Between these positions is a disturbing lack of analytic specificity and a repertoire of unsubstantiated hypotheses about how healing works (Csordas and Kleinman 1996; Csordas and Lewton 1998).

The second motive was to produce knowledge that could be circulated back into the Navajo community in a way that could enhance health care providers' understanding of their Navajo patients, as well as enrich Navajos' understanding of their own society—not to teach them about their own traditions or to parrot back what they already knew, but to provide a different perspective than that easily obtained by a cultural insider. Producing and disseminating this kind of knowledge is an increasing priority of cultural and health-related research in American Indian communities. Too often, research is experienced by community members as a kind of extractive industry akin to mining, in which indigenous resources are taken away and only minimal compensation returned for the financial enrichment and career enhancement of researchers. A project on the scale of the Navajo Healing Project has a particular responsibility both to the Navajo community (to share the fruits of its work), and to the research community (to provide an exception to the often negative perception of the research enterprise on Indian reservations).

The conjunction of these two motives led to a project that was unique in a variety of ways from any previous study of Navajo healing. First, instead of adopting the small-scale model of the solo ethnographer working with one or two healer informants, I undertook to make our work reservation-wide, with four teams of ethnographic researchers situated respectively in the eastern, southern, western, and northern regions of Navajoland. The project's geographical scope allowed for assessment of regional diversity and variation in healing practice. Second, instead of focusing on a single kind of religious healing, we are working to understand healing as a cultural system in contemporary Navajo society. Thus, the project deals equally with the three principal forms of healing in Navajoland, whereas much previous work has been restricted to one healing form (or even to one healer); among Navajos, Christian healing in particular has been virtually neglected. The three forms of healing are in lively interaction with each other and with conventional biomedical care. Third, whereas most previous studies have focused primarily on

the knowledge and practice of healers, our work pays equal attention to the suffering and transformation of patients. Such a focus is essential to avoid the tendency to fall back on "black box" mechanisms such as suggestion, catharsis, placebo, or trance to account for the effects of healing ritual. Fourth, we have come to conceive of therapeutic process not as a function strictly of ritual action within particular healing events, but as an element of life course and developmental trajectory that transcends those events. Such a conception allows for recognition of incremental changes that may or may not be integrated into a patient's experience over the course of time. Fifth, and perhaps most importantly, we aim to create a dialogue between Navajo and non-Navajo ways of knowing, so that we can produce not a brute translation of Navajo experience into academic discourse but, instead, an intertwining or braiding of the two ways of thinking and knowing. Each year from 1993 to 1996, the authors of the articles presented here, along with other Navajo and non-Navajo members of the project staff, gathered for a weekend to share our insights. This volume is intended to bring the results of those collective reflections to a broader audience of Indian and non-Indian scholars and thinkers. Each article is contributed by one of the research teams and reflects that team's own interest and experience, as well as the common research methods used and the collaborative framework of the project.

Methods

Ethnographic work with healers and patients was carried out by four teams, each consisting of an ethnographer and an interpreter assigned to a particular region of the Navajo reservation. In addition to the ethnographic work, a formal psychiatric diagnostic interview was conducted with each patient by a team composed of a clinician experienced in treating Navajos and an interpreter trained in social work or mental health services. The importance of the interpreters in our work is a testimony to the contemporary linguistic viability of the Navajo Nation; indeed, 58 percent of healers and 38 percent of patients who participated in the Navajo Healing Project chose to be interviewed exclusively in the Navajo language (see Tables 1 and 2). The team approach was invaluable in that recruiting and interviewing in the vast expanse of Navajoland can be both physically and emotionally exhausting for a solo researcher. Moreover, even when interviews were conducted in English, having at least one Navajo researcher present was a critical aspect to establishing a level of comfort in the culturally alien and often mistrusted research enterprise.

Healers were identified through networks familiar to the interpreter member of each field team and approached on the basis of an assessment of their standing in the community. Contacts were made with the leadership of the Diné Spiritual and Cultural Association, the NAC of Navajoland and NAC of North America, and the Navajo Christian community, the latter providing an extensive contact list of pastors and evangelists who were likely to have experience in the healing ministry. A series of visits was made to each participant for purposes of describing the project, obtaining consent, and conducting interviews that would build on one another and allow time for reflection in between. Following cultural standards of respect, in the first interview visit each team invited the healer to offer whatever type of elaboration he or she chose. More focused questions, filling out themes that did not emerge in the initial encounter, were reserved for subsequent visits. Each participant had

TABLE 1
Healer Demographics ($N = 95$)

	Traditional		NAC		Christian		Total	
	N	%	*N*	%	*N*	%	*N*	%
Age								
≤ 19	0	0.0	0	0.0	0	0.0	0	0.0
20–29	1	3.3	0	0.0	0	0.0	1	1.1
30–39	4	12.5	3	9.1	7	23.3	14	14.7
40–49	2	6.3	7	21.2	7	23.3	16	16.8
50–59	4	12.5	7	21.2	11	36.7	22	23.2
60–69	13	40.6	12	36.4	4	13.3	29	30.5
70–79	4	12.5	2	6.1	0	0.0	6	6.3
80–89	0	0.0	2	6.1	1	3.3	3	3.2
≥ 90	1	3.1	0	0.0	0	0.0	1	1.1
None reported	3	9.4	0	0.0	0	0.0	3	3.2
Gender								
Male	25	78.1	32	97.0	24	80.0	81	85.3
Female	7	21.9	1	3.0	6	20.0	14	14.7
Marital Status								
Single	4	12.5	1	3.0	3	10.0	8	8.4
Married	17	53.1	29	87.9	27	90.0	73	76.8
Widowed	3	9.4	1	3.0	0	0.0	4	4.2
Separated	1	3.1	1	3.0	0	0.0	2	2.1
Divorced	3	9.4	1	3.0	0	0.0	4	4.2
Live with partner	2	6.3	0	0.0	0	0.0	2	2.1
None reported	2	6.3	0	0.0	0	0.0	2	2.1
Education								
Grades 0–5	18	56.3	11	33.3	8	26.7	37	38.9
Grades 6–8	1	3.1	5	15.2	4	13.3	10	10.5
Grades 9–12	3	9.4	5	15.2	1	3.3	9	9.5
High school graduate	3	9.4	5	15.2	3	10.0	11	11.6
1–2 yrs. college	2	6.3	3	9.1	4	13.3	9	9.5
2–3 yrs. college	0	0.0	0	0.0	3	10.0	3	3.2
College graduate	2	6.3	4	12.1	7	23.3	13	13.7
None reported	3	9.4	0	0.0	0	0.0	3	3.2
Occupation								
Rancher/farmer	6	18.8	2	6.1	0	0.0	8	8.4
Unskilled labor	3	9.4	9	27.3	6	20.0	18	18.9
Skilled labor	2	6.3	4	12.1	6	20.0	12	12.6
Chanter/road man/minister	4	12.5	1	3.0	8	26.7	13	13.7
Craftsperson	1	3.1	3	9.1	0	0.0	4	4.2
Government*/professional	5	15.6	9	27.3	4	13.3	18	18.9

*Either federal, state, tribal, or chapter government occupations.

Table 1 (Cont'd.)
Healer Demographics ($N = 95$)

	Traditional		NAC		Christian		Total	
	N	%	*N*	%	*N*	%	*N*	%
Homemaker	1	3.1	0	0.0	0	0.0	1	1.1
Student	1	3.1	0	0.0	1	3.3	2	2.1
Other	1	3.1	2	6.1	1	3.3	4	4.2
None reported	8	25.0	3	9.1	4	13.3	15	15.8
Language of Interview								
Navajo	24	75.0	24	72.7	7	23.3	55	57.9
English	3	9.4	7	21.2	18	60.0	28	29.5
Navajo and English	5	15.6	2	6.1	5	16.7	12	12.6

the option to choose whether or not the sessions would be audiotaped, since there are individual variations in attitudes toward potential adverse spiritual consequences of inscribing a person's voice or image. Whether or not interviews were taped, each interview was augmented by detailed ethnographic notes. The interviews covered the healers' demographic characteristics, initiation and training, and methods of practice, as well as aspects of the social organization of healing with respect to kinship links between patients and healers, healers' interactions with other healers, and their attitudes toward and interactions with conventional health care providers. Wherever possible in these interviews, healers were asked to cite specific examples and cases from their experience.

From among the healers interviewed, several representing each form of healing were invited to participate further, as the teams followed patients who came to them for healing. Healers were recruited on the basis of their degree of engagement in the first phase of the project and on their level of comfort in providing access to patients, as well as the team's assessment of their level of respect and acknowledged expertise within the community. Additional patients were recruited from the networks of the interpreter member of each team, whereupon the healer chosen by the patient and his or her family was also asked to participate, though without the full set of interviews conducted with other healers. Patients were required to be at least 18 years of age.

The researchers attended the healing event or events conducted for each patient, documenting the types of events, procedures, purposes of the healing and issues addressed, and number of participants and their relation to the patient. Although recording of healing events was not permitted in the vast majority of cases, field notes included detailed reconstructions. As soon as possible following the healing ritual, each patient was interviewed following the Interpersonal Process Recall (IPR) method as described by Elliott (1984, 1986; Elliott et al. 1985; Elliott and Shapiro 1988) for use in psychotherapy process research, adapted for the study of North American Christian religious healing (Csordas 1988, 1994a), and readapted for use with Navajo patients in ritual healing. The method is designed to assess therapeutic impact by asking the patient to identify the most significant event

TABLE 2
Patient Demographics ($N = 84$)

	Traditional		NAC		Christian		Total	
	N	%	*N*	%	*N*	%	*N*	%
Age								
≤ 19	2	6.1	1	4.8	2	6.7	5	6.0
20–29	3	9.1	7	33.3	3	10.0	13	15.5
30–39	8	24.2	3	14.3	4	13.3	15	17.9
40–49	4	12.1	3	14.3	3	10.0	10	11.9
50–59	5	15.2	3	14.3	8	26.7	16	19.0
60–69	7	21.2	4	19.0	4	13.3	15	17.9
70–79	4	12.1	0	0.0	5	16.7	9	10.7
80–89	0	0.0	0	0.0	1	3.3	1	1.2
≥ 90	0	0.0	0	0.0	0	0.0	0	0.0
None reported	0	0.0	0	0.0	0	0.0	0	0.0
Gender								
Male	17	51.5	9	42.9	8	26.7	34	40.5
Female	16	48.5	12	57.1	22	73.3	50	59.5
Marital Status								
Single	5	15.2	7	33.3	4	13.3	16	19.0
Married	22	66.7	9	42.9	19	63.3	50	59.5
Widowed	1	3.0	0	0.0	3	10.0	4	4.8
Separated	1	3.0	1	4.8	1	3.3	3	3.6
Divorced	0	0.0	2	9.5	3	10.0	5	6.0
Live with partner	3	9.1	2	9.5	0	0.0	5	6.0
None reported	1	3.0	0	0.0	0	0.0	1	1.2
Education								
Grades 0–5	10	30.3	6	28.6	9	30.0	25	29.8
Grades 6–8	3	9.1	0	0.0	1	3.3	4	4.8
Grades 9–12	6	18.2	2	9.5	4	13.3	12	14.3
High school graduate	0	0.0	1	4.8	5	16.7	6	7.1
1–2 yrs. college	7	21.2	3	14.3	3	10.0	13	15.5
2–3 yrs. college	2	6.1	6	28.6	3	10.0	11	13.1
College graduate	5	15.2	3	14.3	4	13.3	12	14.3
None reported	0	0.0	0	0.0	1	3.3	1	1.2
Occupation								
Rancher/farmer	3	9.1	4	19.0	1	3.3	8	9.5
Unskilled labor	6	18.2	5	23.8	5	16.7	16	19.0
Skilled labor	1	3.0	2	9.5	4	13.3	7	8.3
Chanter/road man/minister	1	3.0	1	4.8	1	3.3	3	3.6
Craftsperson	1	3.0	1	4.8	3	10.0	5	6.0
Government*/professional	8	24.2	2	9.5	5	16.7	15	17.9

*Either federal, state, tribal, or chapter government occupations.

Table 2 (Cont'd.)
Patient Demographics ($N = 84$)

	Traditional		NAC		Christian		Total	
	N	%	*N*	%	*N*	%	*N*	%
Homemaker	2	6.1	1	4.8	2	6.7	5	6.0
Student	2	6.1	2	9.5	3	10.0	7	8.3
Other	2	6.1	1	4.8	0	0.0	3	3.6
None reported	7	21.2	2	9.5	6	20.0	15	17.9
Language of Interview								
Navajo	13	39.4	8	38.1	11	36.7	32	38.1
English	14	42.4	13	61.9	17	56.7	44	52.4
Navajo and English	6	18.2	0	0.0	2	6.7	8	9.5

within a session, and then eliciting an audiotaped experiential commentary about that event. At least three months after the session observed, patients were re-interviewed to determine whether the event had retained its previous salience, whether changes had taken place in the problem originally addressed, what other life issues may have intervened, and what other therapeutic measures may have been undertaken. Finally, healers were interviewed using the IPR method to elicit accounts of the session, its typicality or atypicality, and its therapeutic effect on the patient.

In addition, a series of interviews was conducted with each patient, typically in their homes. These included the Description of Illness in Navajo Experience (DINE), an interview in Navajo and English developed by Thomas J. Csordas and Martha Austin for use in a study of the experience of Navajo cancer patients (Csordas 1989, 1994b; Csordas and Garrity 1994), and elements of the Context of Illness Experience Interview (CIEI) developed by Janis Jenkins for the cross-cultural study of psychiatric illness (1997). The following topics were addressed: demographics, family history and interpersonal environment, typical daily activity, acculturation, work history, medical history, attitudes toward illness and health, explanatory model of the current illness, religious background, and experience with religious healing, including sessions prior to the one observed. Finally, a separate team composed of a trained clinician and an interpreter administered a standard psychiatric research diagnostic instrument, the Structured Clinical Interview for *Diagnostic and Statistical Manual 3rd Revised Edition* (DSM–IIIR) and *Diagnostic and Statistical Manual 4th Revised Edition* (DSM–IV) (SCID), to each patient. This instrument was chosen because of its flexibility in allowing for probes, rephrasing, and a conversational style. These are important features for use with a culturally distinct population unaccustomed to highly structured interview formats.[1]

Outline of Contributions

Two foci of the Navajo Healing Project were the interactions among the three forms of religious healing and the nature of the therapeutic process in each healing form. With respect to the first focus, what all three have in common is a shared

criterion of success: Navajo healers typically say that in caring for patients one "must talk to them so they understand." This emphasis is in accord with the often observed preeminence of language and thought in Navajo culture. However, the ways in which the goal of understanding is approached in the three healing forms are differentiated by distinct philosophies and therapeutic principles (Csordas 1999:11, in press). As already noted, in everyday practice the three forms allow for varying degrees of eclecticism, and Navajos often have recourse to all three forms with little or no sense of contradiction. With respect to the second focus, we are formulating the experience of each participant according to a four-part model of therapeutic process that specifies a person's disposition toward his or her problem and its resolution, the person's experience of the sacred within the healing process, the elaboration of alternatives with respect to emotion, thought, and behavior, and the actualization of change attributed to the healing process as it is integrated into the person's life (Csordas 1988, 1994a). Each of the articles in this volume elaborates in some way on these two primary research foci.

Elizabeth Lewton and Victoria Bydone, the project's western region ethnographic team (based in Tuba City, Arizona), present an overview of the three principal religious healing traditions that coexist in Navajoland. Against the historical background of colonial repression and dislocation that color much of Navajo experience, they discuss how each tradition addresses issues of identity for contemporary Navajos and suggest that in this respect each can be understood with reference to notions of harmony and beauty expressed in the Navajo synthetic principle of *są'ah naagháí bik'eh hózhǫ́*. This general discussion is brought to a specific and personal level in the article by David Begay and Nancy Maryboy, the project's northern region ethnographic team (based in Tsaile, Arizona). They present the story of a woman they refer to as Asdzáán Jobaa'ii, or Woman of Compassion, who embodies the synthesis of the three spiritual options. In her experience as both healer and patient, not only Traditional, NAC, and Christian elements, but also conventional biomedical treatment, become part of a spiritual outlook in which, as she puts it, "the whole universe is my cathedral."

The article by John Garrity of the southern region ethnographic team (based in Gallup, New Mexico) takes exception to an exclusive focus on the Navajo ethos of beauty and harmony, suggesting the importance of an equally strong ethos of power in Navajo culture. Garrity highlights a commonality between the relatively new NAC and Christian healing traditions in their attention to alcohol abuse and suggests that their appeal in this respect stems from the manner in which they mobilize the underlying ethos of power. Whereas Garrity finds a commonality between NAC and Christian healing in their concern with alcohol, the eastern region ethnographic team of Derek Milne and Wilson Howard (based in Shiprock, New Mexico) find commonalities with respect to ritual diagnosis in Traditional and NAC practice. They emphasize that diagnosis is not merely the identification of a problem, but a critical element of therapeutic process, and demonstrate this point in terms of the manner in which distress is narrativized in a case study of interaction between a diagnostician and a patient. The final article, representing the work of the reservation-wide clinical interviewing team, is by psychiatrist Michael Storck, clinical psychologist Milton Strauss, and myself. Here, the question of diagnosis becomes one of the relevance of Euro-American diagnostic categories in Navajo experience, since beyond the obvious medical problems presented by patients, it is

widely understood that emotional problems, mental disorders, and the effects of life crises are also submitted to religious healing. Discussion of the existential circumstances of patients with "depression" in each of the healing traditions displays our intent not to reduce these problems to Euro-American psychiatric categories, but simply to ask how they would be defined if they were being treated in psychiatric terms in order to facilitate comparative analysis as well as education of health care professionals who treat Navajos.

Each set of authors brings its own style of engagement with the vast literature on Navajo society, religion, and healing (see Csordas and Lewton 1998 for a review of some of the more recent literature on Navajo healing). Yet neither singly nor together can the articles be read either as a contribution to the rich literature on Navajo social organization, to the many detailed discussions of Navajo myth and ceremony, or to the wealth of Navajo life history. It is our hope, instead, that they contribute to an account of healing that hovers between the immediacy of individual experience and the complexity of social life in the contemporary Navajo setting. We intend them to be tools for thinking of the Navajo Nation, not as an isolated segment within a cosmopolitan complex society, but as a complex society in its own right, with a variety of options for living and healing. One of the themes of our ongoing work is to define what on the one hand makes these options distinct and what on the other hand they share as elements of a common Navajo existence. Finally, the articles also suggest a way of thinking about healing as a multiplex process that includes not only cure or relief from symptoms, but also the negotiation of cultural and personal identity, the interplay between spiritual and medical realities, the search for meaning through diagnosis and narrative, and the struggle for power as a means to achieve a life characterized by respect, balance, and harmony.

NOTE

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1. A second phase of fieldwork is currently underway under continued funding from NIMH, in which we are reinterviewing a selected group of healers in greater depth, reinterviewing patients in order to add a longitudinal dimension to our understanding of the therapeutic process, and deepening our analysis of linguistic processes in both healing events and interview encounters.

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