Slouching Towards Bethlehem

Francis Delago is wearing grey slacks and an orange flannel shirt. His feet are bare with long yellowed toenails. He is unshaven. His unwashed hair is matted and oily, thick with grease and debris. He is lying on his back, on top of crumpled sheets, staring at the ceiling. His jaw is clenched, as if he might explode in anger.

"Good morning, Mr. Delago. How are you doing today?"

His eyes are wide and unblinking, as if transfixed by the climax of a horror movie. He remains silent. I begin to wonder if he is catatonic or if he is just refusing to respond.

"I don't want to talk"

Diane Arlow, a third-year Internal Medicine resident, stands in the shadow of the doorway behind me. A patient passes in the hallway behind Arlow on his way to breakfast in the dayroom. Across from the dayroom is the nursing station where earlier this morning a nurse had asked me to do something about Mr. Delago. She told me that he is a 36-year-old male who had his first psychotic break around age 19. He was admitted last week with catatonia after being picked up by the police in an abandoned building. He has been living with his mother and had been stable for ten years until he stopped his medications two months ago when his mother was hospitalized with breast cancer. He has been staying in bed and refusing to eat since admission. "You've got to do something, doc," she said, "You can't let him just lie there and die."

It is December of 1999. I am standing several feet away from Mr. Delago in room 720 of the inpatient psychiatric unit at St Luke's hospital in Bethlehem, Pennsylvania.

"I said, I don't want to talk."

It's a classic opening gambit. He has sacrificed his opportunity to express his point of view or advocate for himself in an attempt take control of the conversation. Refusing to engage is a powerful move.

My first instinct is to honor his request and leave. I can always try again later. But Dr. Arlow's watchful presence causes me to hesitate and stay in the room. Arlow has joined me on rounds today to observe how I interact with patients. This is her first day of a month-long elective rotation in psychiatry.

I sit down on the bed opposite Mr. Delago and consider my next move. Staying in the room of a paranoid patient is risky. I plan my escape route and mentally rehearse running out of the room should he make any sudden moves. Twelve years ago, when I was a second-year resident, I interview a paranoid patient who did not want to talk. Determined to complete my assessment, I stayed in the room and asked the him to talk abut his feelings. He answered by lunging at me and beating me as I yelled out for help. It's the sort of lesson that one never forgets.

I project myself into Mr. Delago's place on the bed and try to sense what he is feeling. The tension in the room is palpable — a fog of paralysis and terror fills the room. I proceed cautiously.

"Well, you've been in the hospital for a week, now. You've been staying in bed all day, not eating, and not taking your medication. I'm becoming concerned because I will not be able to discharge you in your present condition."

His eyes flicker, his lips tighten. I suspect that he is hallucinating.

"I'm not going to take any medications."

"Do you have any particular concerns about the meds?"

"I know what you're trying to do."

"What's that?"

"You're trying to kill me"

He turns his head towards the window. Outside, a sloping ridge rises to the horizon. A slight frost glazes the ground; pine needles and branches are strewn across the hard dirt. Pine trees and holly bush fill the space between outcropping rocks. A single doe is nuzzling the ground as she slowly moves up the hill, snacking on acorns and twigs in the early winter chill. The light from the early morning sun is slanting through the window onto the bed and floor. Dr. Arlow is standing quietly in the doorway. I can hear phones ringing and nurses talking

in the hallway. Occasional laughter is coming from within the nursing station, just enough to cause suspicion among the patients.

I look at the floor, lost in the swirling grey pattern of the linoleum, wondering what to do next. Dr. Arlow is awaiting my next move. As much as I want to help this patient, I also want to impress Dr. Arlow. I want to show her that psychiatry is a valid branch of medicine. I want to demonstrate a perfect intervention with the patient as clearly as a surgeon performing a precise incision. I'm afraid I will make a wrong move or embarrass myself. I consider just leaving the room. I will explain to Dr. Arlow that this patient is too paranoid, that he cannot be reasoned with, that it is best to leave psychotic patients alone. Sound advice, perhaps, but I know something must be done.

I silently rehearse possible responses, trying to imagine how he might respond to each one.

I am not trying to kill you. I want to help you. He won't believe that.

You won't get better unless you take your medications. He will argue that there is nothing wrong with him, he will feel berated, it will come across as condescending.

Why did you stop taking your medication two months ago? This question had been asked many times over the last week. He has refused to answer.

Are you hearing voices? He has heard that question every day from every nurse on every shift. He will deny hearing voices or become argumentative. I might as well ask "are you crazy?"

How is your mother? I suspect his decompensation is related to his mother's illness. I doubt he would be willing to discuss his mother with me. I'm the guy who's trying to kill him.

I am not coming up with anything. I have no choice but to let all my thoughts dissipate. I continue to sit, staring at the floor, enjoying a respite from the hectic rush of the patients that await me.

As long as Mr. Delago is not getting agitated or asking me to leave, there is little harm or risk in sitting alongside him. Even paranoid patients can feel lonely. Their psychosis is a barrier to human interaction. Just being willing to sit with him sends a message: that I am not afraid of him, that I am willing to sit with him.

With the breakdown of my marriage, I questioned everything I had ever believed. I had pursued a straight path though college, medical school and residency, all the while looking to the future. The long journey over the yellow bricks promised to end in fulfillment, enlightenment, and everlasting peace. By the time I passed my board exams, at age 32, I had finally made it! But I was left with a vague unrest, unable to live in the present after a lifetime of struggling towards the future. Peggy Lee's *Is That All There Is?* became the soundtrack of my life. My doubt was like a 45 rpm record stuck on an automatic turntable with only the briefest respite as the tonearm clicked in the final groove, lifted, and returned to the beginning. I could not find the off switch, nor could I pull the plug. Doubt sang like a refrain, a taunting commentary on to obsessively searched the story of my life, trying to figure out how it all went wrong. *Is that all there is?* I thought I had done everything right. *Is that all there is?* I did well in college. *Is that all there is?* I went to medical school. *Is that all there is?* I got married and had children. *Is that all there is?* I became a doctor. *Is that all there is?* My wife left with the kids. *Is that all there is?* I am lost and alone. *Is this all there is?*

Uncertainty invaded my soul, spread into my perceptions of myself, and radiated outwards. I questioned everything. What is family? Why did I get married? Where did I go wrong, is there free will, what is consciousness, what is life — how do I face the next day? Social interactions seemed pointless. *Hi, how are you today? I'm fine*. Didn't the people passing me in the halls of the hospital know that we are all in mortal danger? Anubis awaits, feather in hand. I

feared that my life had already been measured and that a monster lurked, ready to devour what little I had left.

Lost in a Kung-Fu movie bamboo forest and not knowing which way to turn, I sat still and turned inward. I studied books on meditation and spirituality and religion. I read Neil Donald Walsh's *Conversations with God* and for understanding and grace to reveal itself. Night after night, while wandering the empty fields in the outskirts of Bethlehem, I listened to Carolyn Myss on tape talking about the dark night of the soul in her lecture *Spiritual Madness.* Each night, I felt like I was hearing her words for the first time. I went to the Omega Center in upstate NY to attend a workshop by Michael Harner on Core Shamanism where, while browsing the bookstore, a stranger pulled a book from the shelf and said, "Here, you should read this." It was *The World Is As You Dream It* by John Perkins. I was transfixed by Perkin's account of going deep into the Amazon basin to live with the Shuar Indians where he attended a sacred Ayahuasca ceremony and experienced an epiphany that altered the course of his life. Two weeks later, my sister called to tell my that her friend Wendy was going with a group of eight to Peru to spend two weeks in the Amazon basin with a shaman named Don Augustin Rivas. I was unable to replicate Perkin's epiphany. The jungle was damp and primordial. I already knew how to wallow in the dark. I yearned for the light.

When I returned home, I found an envelope in the mail with no return address. It contained a flyer advertising a weekend workshop on Peruvian Shamanism taking place in an unexpected location less than an hour's drive away into the hills of the Lehigh Valley — New Tripoli, Pennsylvania. It featured two shamans: Ruben Orellano, who had been the head archeologist of Machu Picchu for twenty years, and Dr. Theo Paredes, an anthropologist who lived in Cusco. Both had studied with the Q'ero Indians and had practiced shamanism since childhood. Perhaps the incendiary sun of the Andes would some clarity. I decided to go.

Ruben and Theo sat side by side on the floor as a group of fourteen participants sat in a semicircle around them. Theo sprayed *florida water* — a type of flower-scented perfume from South America — by taking a swig into his mouth then blowing through pursed lips. A perfumed mist spewed forth across the room, followed by a heady scent of alcohol and flower-petals.

Ruben picked up a potato sized gourd by its deer-foot handle and rattled until the entire grew was silent and transfixed. Ruben and Theo sat with eyes closed, listening intently to the swish of the rattle. Ruben began chanting, softly at first, crescendoing into guttural baritone phrase in an unfamiliar language that resonated throughout the room, alternating with a plaintiff tenor line that sounded like question being asked from afar. After fifteen minutes, the chanting stopped. The silence buzzed in my ears. Theo broke the silence and spoke of the ancient traditions of the Andean Q'ero indians, how they experience nature as sacred and view all life as emanating from the sun.

Between sessions, everyone milled about and socialized. I remained sitting, uninterested in the mindless chatter of conversations around me. Theo sat across the room chewing coca leaves and observing the crowd. He was not just from another continent, he was from another world — an uncanny place that exists beyond the mundane. He saw me looking at him and smiled. I went over, sat down next to him, and introduced myself. He reached over, touched my cheek with the back of his hand, and with a thick accent said, "We have a lot to talk about."

Back in the circle, Theo taught tat the main skill of a shaman is the ability to move energy. The physical body is imbued with vibrations that radiate outwards in layers like a matroyshka doll. These layers are given names such as the etheric body, mental body, emotional body and astral body — each with a different quality and function. A shaman is able to sense the energies of the body and identify blockages or irregularities. The energy blocks can then be removed or smoothed out. They see life itself as energy. All disease, whether physical, mental, or emotional, exists on an energetic level. Cure the energy body and the physical body will heal. I did not understand what they were talking about, but as I listened, I began to suspect they were talking about the soul. The soul is rarely mentioned in western medicine. I did not understand much about the soul, but I knew there was an unseen depth to the lives of my patients. Perhaps here was the beginning of an answer.

Eager to learn more, I had joined a tour group on a two week trip led by Ruben and Theo last summer to visit ancient sites in Peru. After flying into Cusco, we embarked on a bus and headed out to the Sacred Valley, also known as the "breadbasket of Peru" as the source of produce that feeds much of the country. Equally important is its "sacred" identity — this valley is home to series of ancient sites that are believed to have been of spiritual significance to the Inca.

As we approached our first destination, known as *The Temple of the Falcon*, Theo narrated the view. He pointed out undulating rows of stone terraces that were built into the sides of the surrounding hills and mountains many centuries ago by the people of the Incan Empire. A seemingly endless series of parallel eight-foot stone walls, built one above the other, follow the contours of side of the mountain. The ground between the walls is flat, resulting in a step-like appearance. Theo described how the Inca were master agrarians, who had developed hundreds of varieties of corn and potatoes. The now popular grain, quinoa, had been extinct until ancient store of seeds were found in the ruins of a granary further down the valley. Theo explained that the terraces were built to provide arable land and that the terraces are considered essential to the success of the Empire - an empire based on farming.

The Temple of Falcon lies high above the town of Pisac. It consists of a several-mile-long path that loops around the crest of a mountainous hill. There is a large arch built of finely carved stonework indicating the entrance of the temple. We passed though the doorway and into a four foot diameter man-made tunnel carved through the rock. After a few yards, the tunnel veered and dimmed into pitch dark. I felt my way forward. My hands alternated between rock wall and empty space, and the occasional feel of the buttocks of the person in from of me. The air was dank and suffocating, I felt short of breath. Just as I began to wonder if I was forever lost in bowels of the mountain, light began to bleed into the tunnel. After a few more yards, the passage ended. I stood up and breathed in the mountain air. The incendiary sun of the Andes blinded me. I stood dazed, eyes closed. I felt a touch on my shoulder.

"Come with me," I squinted towards the voice - it was Theo. He led me away from the group and around the far side of an outcropping of rocks. He stopped and unfurled a plastic bag of Coca. He picked through the bag, scrutinizing each leaf, rejected dozens of them one by one until he collected three perfectly formed specimens. He arranged them into a fan and held it up like a priest praying over a communion wafer. His lips moved silently. He blew on the coca and looked out at the valley beyond. He put the leaves into his mouth and chewed, adding handful after handful of leaves until his cheek bulged. He then pulled from his pocket a ball of *lipta* — a sort of coal briquet that is used to activate the coca. He bit off a small chunk and added it to the wad of cud.

"I have something to tell you. This is very important. You must learn to recognize breathing patterns. Breathing reflects emotions — there is a pattern to fear, there is a pattern to grief, there is a pattern to anger, there is a pattern to anxiety."

Theo spoke intensely with a wild yet somehow calm gaze. I felt like I was smack in the middle of a Carlos Castaneda novel.

"You must learn to regulate your breath. Practice this every day."

He took another pinch of leaves from the bag and placed them into his mouth.

"Practice breathing like this: breath in or a count of seven, hold in for a count of seven, then breath out for a count to seven, and hold out for a count of seven. Repeat this seven times. Do this every day. After a year, we will talk more."

Theo offered me the bag of coca and the lipta. I took a handful of the brittle dried leaves. Stems poked into my tongue as I chewed. The lipta was gray, hard, and airy, like a chunk of volcanic rock. My teeth scraped along the edge of the stone as I tried to bite the rounded edge. A bitter powder flaked off. As I chewed, leaves began to soften and the acrid taste of the lipta blended into the slightly sweet taste of the coca. I walked alongside Theo as we headed back to join the group. I'm in Peru. I'm chewing coca with a master shaman. And he just taught me a basic breathing exercise. *Is that it? Is that all there is?*

My awareness returns to the present moment. I notice that the stream of light coming through the window has moved across the tile floor of room 720. Mr. Delago hasn't budged. He continues to stare out the window. Dr. Arlow is still in the doorway behind me. The patient has not responded to me, and I am beginning to feel tense. I look back at the floor and focus on my breath –- breathe in, two-three-four-five-six-seven, hold in, two-three-four-five-six-seven, breathe out, two-three-four-five-six-seven, hold out, two-three-four-five-six-seven. As I relax, my awareness shifts to another memory.

When I was a third-year resident at Timberlawn Psychiatric Hospital, I had heard that Dr. Blotcky, the Clinical Director of the hospital and the Director of the Child and Adolescent Psychiatry Training Program, had a difficult therapy patient that he wanted to refer to another psychiatrist. Melissa was diagnosed with Schizoaffective disorder, a condition with equal parts psychosis and mood disturbance. She had been hospitalized on the adolescent unit the previous year during which time she with paranoid psychosis, depression, sudden mood swings, self-mutilation, and violent impulses. Prior to admission, she had heard a local news story about a truck driver found lying naked and dead next to his eighteen wheeler on the shoulder of a rural highway. In Melissa's version of the event, his penis had been cut off and stuffed into his mouth. She developed vivid memories of the crime in which she imagined herself as the assailant. She became convinced that she had committed murder. She was only 17 years old, yet she had recently been moved to one of the adult inpatient units due to her lack of response to treatment on the adolescent unit.

Dr. Blotcky, a competent doctor whom I admired and respected, did not typically fail at treatment, yet here he was looking to transfer the care of one of his patients. There are few reasons to justify such a disruption in therapy; Dr. Blotcky was facing a biggie. Melissa had developed increasing homicidal thoughts and was openly expressing her desire to kill Dr. Blotcky. It does not reflect well on the progress of therapy when a patient repeatedly tells you that she wants to kill you.

I offered to take over the therapy of this patient. It was a bold and somewhat shocking offer, coming from an inexperienced resident. This move was seen as audacious by my fellow residents, but I saw it as a safe bet. The worst outcome would be that I fail at therapy just as Dr. Blotcky had — placing me in good company. But if I were able to dodge becoming the target of Melissa's homocidal threats, I would be known as the guy who outdid a Dr. Blotcky.

I was curious what had gone wrong. I was unable to imagine how a patient could feel such anger towards Dr. Blotcky, one the nicest and most likable doctors I had ever met. But psychiatry deals with strange, inconceivable illnesses. With only a couple of years of experience to draw on, there was much I did not know or understand.

During the Intro to Psychotherapy seminars, I had been trained to meet each new patient on the unit before starting therapy. The purpose of this brief visit was to introduce myself and set times and dates for sessions. I arrived on her unit and asked the charge nurse to have Melissa come to the nurses station. The nurse came back with a petite teenager trailing behind her. She was not what I expected; instead of appearing like a murderous maniac, she looked normal. She could blend into any high school class. Her light-brown hair was shoulder length, wavy, and well-styled. She was dressed in designer jeans and a white t-shirt. As she approached, her eyes widened, and she asked "Are you my new therapist?" When I said yes, she blurted "Oh, I like you!", then blushed, grinned and averted her face — both shy and coy, she seemed a perfect example of a typical high-school junior. I offered to meet with her three times a week: Monday, Wednesday, and Friday afternoons at 1:00 for 45 minute sessions. She nodded, then ran off down the hall, calling to her friends, "Hey, you guys! Did you see my new therapist?"

My instructors and supervisors had warned me about such positive patient reactions. The flip side of love is hatred, and when it comes to borderline personality structures, feelings can flip across the spectrum of emotions in an instant. Rather than be pleased that she liked me, I became apprehensive. I pictured the Lost in Space robot — arms flailing, his claw-grips held wide open, a little cerebral weather-vane spinning and lights flashing in his glass-domed head — repeating "Danger, Will Robinson, Danger."

The next day, I arrived on the unit and asked the nurse to summon Melissa for her first therapy session. She came skipping up the hall dressed in a very short ruffled white skirt and a

tight sleeveless top. Her long brown hair was neatly styled and freshly curled. She wore black eye liner, pale purple eye shadow and light red lipstick. We entered one of the therapy rooms on the unit, small but comfortable, furnished with two chairs, a wall clock, a torchiere floor lamp, an end table with dried flowers in a ceramic vase, and boxes of Kleenex on each side of the table.

As I sat down, she hopped onto the chair opposite me. I sat back in my chair and saw that she was sitting with both feet up on the chair, smiling sweetly, and hugging her knees against her chest. She then slowly let her legs fall to each side until both legs were resting against the arms of the chair. I shifted in my chair and caught a glimpse of white cotton panties bulging over a mound of pubic hair, resulting in a reflex sensation of titillation that quickly evaporated as I reminded myself that this is the girl who wants to kill Dr. Blotcky. She maintained her position and kept her legs open the entire session. I I carefully kept my line of sight above the level of her shoulders, alternating my gaze between her eyes and the corners of the room for the entire hour. As she spoke, I began to realize she was just a child. The way she spoke, the thoughts that she revealed, and the feelings she expressed where those of much younger girl. By the end of the session, I saw her as a toddler, naive and hopeful, innocent and vulnerable, eager for attention.

At the next session, she wore jeans. It appeared that she had spent time and care with her hair and make-up in preparation to see me, but at least this time I would not be confronted by her thighs and nether-regions. I decided to ask what had happened with her therapy with Dr. Blotcky.

"He kept insisting that I explore my sexual feelings towards him"

“You had sexual feelings for Dr. Blotcky?” I asked.

“No!”

“How’d you feel about him suggesting that you had these feelings?"

"I felt like killing him."

Over the next several weeks, her initial excitement over having a new therapist wore off and she slipped into a morbid ruminative depression. Each session, she complained of difficulty falling asleep. She approached this subject with an air of secrecy and intrigue, but for days revealed nothing. The sessions became superficial and dull.

She eventually confessed, "The only way I can fall asleep at night is to imagine cutting my arms and covering my entire body with blood. The warmth of blood blanketing my body comforts me so I can finally sleep."

She then became more sullen and withdrawn. She was obstinate and rebellious on the unit and in therapy sessions. Around the fourth week, she stormed into the room for therapy, flung herself onto the chair sideways, folded her arms tight across her chest and tilted her head down, chin on her chest, and barked,

"I don't want to talk."

I paused to give her a chance to explain. After several minutes, I realized that she was not going to talk.

"Therapy time is your time. You're free to do whatever you want."

She tightened her arms around her chest, slumped into the chair, and turned her head towards the wall. A clock was on the wall behind her. It was a large institutional clock with a long thin red hand that flinched every second. As the room settled into motionless silence, the clicking of the red hand marked time like a baton, conducting an ensemble of silence and stillness.

I decided to relinquish any control over the flow of therapy. I allowed my judgments and thoughts to evaporate. There was no one watching, no one to question me, as I allowed Melissa to waste an hour of therapy. The door was locked. I knew that the nurses would not intrude. Within the culture of Timberlawn, therapy time was considered sacred.

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During my years of residency training at Timberlawn Psychiatric Hospital, I had been exposed to a dizzying array of writings from all the masters of psychoanalysis and psychotherapy. Residents were expected to be fluent in the concepts of all the various theories and able to demonstrate how to apply them in practice. Readings were assigned and discussed in small seminar-style classes. Throughout residency, we were expected to maintain a minimum of 10 hours a week of psychotherapy sessions in addition to our regular duties. We video-taped interviews and audio-recorded therapy sessions for supervision where the tapes were played and scrutinized. A typical question might be something like "How would you construct a psychodynamic formulation of this patient's personality structure using Heinz Kohut's model of Self Psychology," or "How does Melanie Klein's concept of splitting of the internalized object apply to this situation," or "Along the lines of Kernberg, how would you interprete this patient's transference and how might your own counter-transference affect what you say?"

Each supervisors took a different approach. One of my first supervisors was Dr. Duke, a pleasant, easy-going doctor from east Texas who spoke with a lyrical southern accent. Devoid of guile and pretense, he wore denim shirts and jeans to work and drove a Ford F-150 truck with dual-rear tires. He urged me not to read any of the assigned texts.

"Books will just confuse you. I haven't read any of them, and I do just fine."

One the other extreme, Dr. Marcus had an entire wall of books in his office from floor to ceiling. He had studied every psychotherapeutic text from the classics of Freud and Jung to the current, difficult to comprehend, psychodynamic formulations of Kohut and Kernberg. I was convinced that if anyone understood any of these theories, it was Dr. Marcus.

After three years of being prodded to demonstrate expertise in all the various theories and modes of therapy, my supervisors began to confess that they didn't actually use a specific psychotherapeutic approach method with their patients. They admitted to practicing Eclectic Therapy – picking and choosing different aspects of various methods. Eclecticism allowed therapists to use instinct in guiding their practice style, guided by their own preferences and by the particular needs of each patient. The eclectic approach was criticized by purists as being disorganized, inconsistent, and ultimately meaningless. Therefore many psychiatrists who practiced eclectic therapy avoided describing their style as such. Some of them resorted to using conjugated de-

scriptions such as “interpersonal-psychodynamic therapy.” Despite widespread use, it was considered gauche, or even shameful, to admit eclecticism.

When I was Chief Resident, it was my duty to organize the weekly Chief Resident Lecture Series. For over a year, I tried to recruit Dr. Marcus as a speaker. I approached him every week, begging him to give a lecture on Kohut. Each time, he declined. He never ever explained why.

A common discussion among the Timberlawn Medical staff was the realization that more they practiced therapy, the less they relied on theory. Fitting a patient into a mold helps provide a container and structure for therapy, but it also deforms and limits, can lead to misinterpretations, and induces emotional distance. During a discussion following a tedious lecture on Kohut’s Self Psychology, various members of the medical staff commented that Kohut is difficult to comprehend and that the concepts don’t translate well into therapy. Dr. Rienzi said that patients are nuanced.

“These theories don’t really help. They just force the patient into a pigeon-hole.”

Dr. Brownlee added that he doesn’t bother with theoretical interpretations.

“If you just listen to your patient, they will show you everything you need to know.”

Dr. Marcus said he had studied Kohut for years and concluded,

"The more I learn, the less I know."

Soon after, I started therapy with a new therapy patient, Melissa. After a few weeks of a honeymoon in which she was actively engaged in therapy, she went mute. She entered the room, slouched into her chair, crossed her arms, and stated, “I don’t want to talk.” I tried to imagine what Dr Marcus would say about how to respond to her refusal to talk, and remembered that he had confessed to knowing less and less. I didn’t know what to do, but neither did my supervisors. I told Melissa that she didn’t have to talk, that therapy time belonged to her, that she could spend it however she wanted. Therapy passed in silence for the entire hour. The next day, she started talking. It seemed to work.

I look up and notice the deer disappearing over the top of the ridge. I can sense Dr. Arlow still standing motionless behind me. The slant of the sun has shifted across the bedsheets. Still no

movement or sound from Mr. Delago. The tension in the room seems to have dissipated. Maybe it is Or maybe the shift is internal. I hold out a bit longer, just to see what happens.

"OK, I will take the medication."

"Do you want to go back on the Trilafon, or would you like to try something else?"

“Trilafon's fine"

"I will order it for bedtime starting tonight.”

"Okay. Thanks."

Dr. Arlow steps aside as I leave the room. She hesitates and glances back into the room as I head for the nursing station. As I enter the station, Dr. Arlow jogs up alongside me.

"What the hell just happened in there?"

"He agreed to take his medications."

"But how did you do that?"

"Do what?"

"How did you get him to agree to take his meds?”

For a moment, I am back in Peru, standing next to Theo, looking out at the elaborate rows of terraces covering the side of the mountain at The Temple of the Falcon. Theo points down towards the broad valley below. “They say the Inca built these terraces up here for farming. But look at all that land down there. Why would they build these walls all the way up here just to grow crops? It just doesn’t make any sense.”

A voice interrupts my reverie: “What happened in there? What did you do?” Dr. Arlow is staring at me, her eyes fervent and inquisitive.

I feel the vast intensity of Theo’s gaze. I feel the unfathomable power and mystery of the Andes. I have an opportunity to covey what I know, to explain my experiences and reveal the truth. I look at the clock on the wall of the nursing station and reply,

"I don't know.”