practical matters

New Geographies of Religion and Healing: States of the Field

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Introduction

I take my title from a classic essay by T. J. Hinrichs who, over a decade ago, mapped critical developments in her own field, the history of Chinese medicine.[1] Hinrichs flags, for example, a movement away from an almost exclusive reliance on documentary research to the integration of perspectives and methods from other fields, including a sensibility that privileges "contradictions, ambiguities, resistance, and the marginal spaces of life over system, coherence, and elite versions of culture."[2] Indeed, such an approach is necessary because there are as many ways to interpret and study religion and healing as there are approaches to religious studies.

In one sense, this assertion should come as little surprise. After all, the one can reasonably be

1 T. J. Hinrichs, "New Geographies of Chinese Medicine," *Osiris, 2nd Series* 13 (1998): 295. While attempting to include scholarship from around the world, I will focus some sections of this article on work within the United States. Because of my own work in the study of Chinese medicine and healing traditions in the United States, it may seem a peculiar omission, but this essay will not incorporate resources related to these traditions as these can be found assembled and discussed elsewhere. I refer readers first to the discussions and source materials provided first by Hinrichs, "New Geographies." Second, for treatment of sources related to Western perceptions and interpretations of Chinese healing arts, see Linda L. Barnes, *Needles, Herbs, Gods, and Ghosts: China, Healing, and the West to 1848* (Cambridge: Harvard University Press, 2005). For some of the most current scholarship on the broader topic, see T.J. Hinrichs and Linda L. Barnes, eds. *Chinese Medicine and Healing: An Illustrated History* (Cambridge: Harvard University Press, in press [Spring 2012]), In press (projected publication, Spring 2012).

2 Henrichs, "New Geographies," 295.

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considered a subset of the other and therefore open to interpretation through the full spectrum of its disciplinary methods. Second, there is a natural point of intersection between many, if not most, religious and therapeutic traditions insofar as each addresses, interprets, and constructs responses to the experiences of suffering and affliction.[3] Third, the study of religion and healing permeates the larger discipline. However, because an explicitly defined subfield has been long in the making, it is rare that scholars have the opportunity to get a handle on the full range of fine work that has been accomplished.

I am reminded of a visit I made years ago to the Gold Mountain Buddhist Monastery in San Francisco, California. The meditation hall housed long, low tables with meditation benches. Before each place, a sutra book rested on the table, covered with bright yellow embroidered satin.

Photo courtesy of Linda L. Barnes

After asking permission to lift the fabric, I discovered that the cover of the sutra book read "Medicine Master Buddha Repentance":

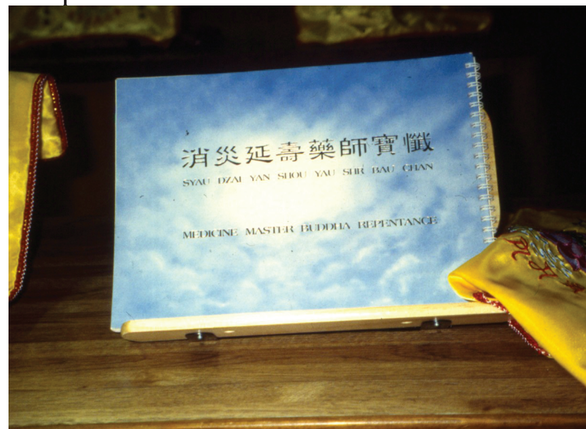

Photo courtesy of Linda L. Barnes

3 We arrived at this formulation independently, but for an eloquent discussion of this point, see Arthur Kleinman. "'Everything That Really Matters': Social Suffering, Subjectivity, and the Remaking of Human Experience in a Disordering World," *Harvard Theological Review* 90, no. 3 (1997): 315-35.

This example has struck me many times as a classic illustration of how matters of healing often lie just beneath the surface of the religious. Lift the cover and there they are. In the following essay, I shall review new geographies of scholarship representing a range of foci and strategies under the rubric of religion and healing. My examples are in no way comprehensive but, rather, suggestive. As I shall show, in addition to the map not being the territory, the territory—such as it is—sometimes seems to call as much for charts to navigate shifting waters as it does for the tools of the surveyor.

Early Days

I begin by reviewing the development of two disciplines in which the study of religion and healing has occurred in significant measure, although along distinct trajectories. Later, I shall examine contributions from several other fields into which, more recently, the topic has migrated. The disciplines in question are Religious Studies and Medical Anthropology, both of which came into being *as* disciplines in their own right at roughly the same time during the 1960s. The disciplines I shall subsequently review include Psychology, Public Health, and Biomedicine.

This is not to say that either Religious Studies or Medical Anthropology actually began during the 1960s. Indeed, considerable prior attention had gone to religious traditions around the world. With European explorations and expansions, beginning in at least the fourteenth century, merchants, diplomats, monastics and priests, and others sent home their observations of other religious worlds. Some of their reports provided exhaustive detail, often accurate but marred by detrimental comparisons with Christianity. For this reason, Hannah Adams's (1755-1831) *Alphabetical Compendium of the Various Sects* (1784), followed by her *A View of Religion* (1791),[4] represented a departure, insofar as both were more evenhanded.

Over the following century, the translation of texts and efforts to compare the history, "original" forms, and traditions of other traditions in light of Biblical perspectives persisted. Scholars like Max Müller (1823-1900) contributed not only to what would become Indian studies but also to the early forms of comparative religion. *Sacred Books of the East*—a fifty-volume work edited by Müller—introduced Western readers to Hindu, Jain, Buddhist, Daoist, Confucian, Muslim, and Zoroastrian texts. Among the translators was the Sinologist James Legge (1815-1897). As Tomoko Masuzawa has noted, the conceptualizations of "religion" that resulted grew directly out of the

4 Hannah Adams. *An Alphabetical Compendium of the Various Sects: Which Have Appeared in the World from the Beginning of the Christian Aera to the Present Day* (Boston: B. Edes & Sons, 1784); Hannah Adams, *A View of Religions: In Two Parts. Part I. Containing an Alphabetical Compendium of the Various Religious Denominations, Which Have Appeared in the World, from the Beginning of the Christian Era to the Present Day. Part II. Containing a Brief Account of the Different Schemes of Religion Now Embraced among Mankind. The Whole Collected from the Best Authors, Ancient and Modern* (Boston: John West Folsom, 1791). For further background, see Gary D. Schmidt, *A Passionate Usefulness: The Life and Literary Labors of Hannah Adams* (Charlottesville: University of Virginia Press, 2004).

nineteenth-century.[5]

Leading early anthropologists included Lewis Henry Morgan (1818-1881), who built relationships with members of the Seneca tribe, studied kinship systems of the Iroquois, met Charles Darwin while in Europe, and developed theories of social evolution that would go on to influence Karl Marx. Edward Burnett Tylor (1832-1917) proposed that cultures could be studied scientifically and that their development could be interpreted as a process of evolution. Likewise, he saw religions as a sequence of progressively more complex forms, with retentions and what he termed "survivals" from earlier versions.[6]

Both fields would eventually claim Sir James George Frazer (1854-1941) as an antecedent, based on his conceptualizations of comparative religion and mythology, analyzed most extensively in *The Golden Bough* (1890). Frazer's version of evolutionary theory posited a progression that began with primitive magic, led to religion, and resulted ultimately in science. Religious Studies and Cultural Anthropology also recognize Karl Marx (1818-1883), Émile Durkheim (1858-1917), Max Weber (1864-1920), and Sigmund Freud (1856-1939) as having provided key interpretive tools to both disciplines.

At the same time, Religious Studies had some of its roots in the study of Biblical literature, as evidenced by the formation in 1910 of the Association of Biblical Instructors in American Colleges and Secondary Schools, which in 1922 became the National Association of Biblical Instructors. It was not until 1963 that the association resolved to change its name and identity to the American Academy of Religion (AAR), whose mission is to promote "reflection upon and understanding of religious traditions, issues, questions, and values" through "excellence in scholarship and teaching in the field of religion."[7] This change came in response to the ways in which the field had changed and grown, and now included the study of world religions, among which Biblical traditions figured. A second leading organization, the Society for the Scientific Study of Religion, was founded in 1949 to support the social scientific study of "of religious institutions and experiences."[8]

Medical Anthropology, organized as such in 1967, came into increasing focus during the mid-1970s to address topics related to "medicine and health." Early practitioners came not only from cultural anthropology, but also from public health, medical sociology, and ethnomedicine. Initially, their discussion involved differentiating between their fields of origin as well as laying out the kinds of medical anthropology already recognized.[9] Following the start of the key journal *Social*

5 See Tomoko Masuzawa, "The Production of 'Religion' and the Task of the Scholar: Russell McCutcheon among the Smiths," *Culture and Religion* 1 (2000):123-30; and *The Invention of World Religions: Or, How European Universalism Was Preserved in the Language of Pluralism* (Chicago: University of Chicago Press, 2005).

6 See, in particular, E. B. Tylor, *Religion in Primitive Culture* (New York: J.P. Putnam's Sons, 1920 [1871]).

7 See http://www.aarweb.org/About_AAR/History/default.asp.

8 See http://www.sssrweb.org/About.cfm.

9 For examples of these early efforts to define the field, see George M. Foster, "Medical Anthropology: Some Contrasts with Medical Sociology," *Medical Anthropology Newsletter (MAN)* 6, no. 1 (1974): 1-6; Virginia Olesen, "Convergences and Divergences: Anthropology and Sociology in Health Care," *MAN* 6, no. 1 (1974): 6-10; Anon., "What Is Medical Anthropology?" *MAN* 6, no. 4 (1975): n.p.; Khwaja A. Hasan, "What Is Medical Anthropology?"

Science & Medicine (1967ff), the original *Medical Anthropology Newsletter* (1968ff) gave way to *Medical Anthropology Quarterly* and was later joined by key journals like *Ethos* (1973), *Culture, Medicine, and Psychiatry* (1977ff), *Medical Anthropology* (1977), *Curare* (1978ff), and *Anthropology & Medicine* (1997), among others.[10]

Yet despite a number of shared origins, the two fields did not generally interact. Religious Studies grew as an overarching, interdisciplinary project that encompassed the many approaches to understanding religious traditions and phenomena. Such approaches included anthropology as an equally overarching discipline, and some religion scholars borrowed extensively from theories developed by contemporary anthropologists who studied religion, among them Claude Lévi-Strauss (1908-2009), Victor Turner (1920-1983), Clifford Geertz (1926-2006), Stanley Tambiah (b. 1929), and Talal Asad. Ironically, some of the work of these anthropologists of religion addressed healing traditions and related rituals and practices. However, that intersection did not translate into a more systemic integration of these areas in Religious Studies. Nor did it generally lead to any significant awareness of Medical Anthropology as a sub-discipline of Cultural Anthropology.

In these developments, the significance of one other figure—Carl G. Jung (1875-1961)—cannot be overlooked. As early as 1939, in an obituary for Edward Sapir, anthropologist Ruth Benedict pointed to the role of Jung's theory of psychological types on Sapir's interest in problems of personality and culture.[11] However, the influence of Freudian psychoanalytic theory in the broader field of anthropology, combined with a general antipathy to generic conceptions of human beings, human nature, and the human mind, led many anthropologists to reject Jung's work. In 1947, for example, Irving Hallowell argued:

> Freud and Jung['s] interest in the psychological significance of myths stems directly from their attempt to deal with them as universal phenomena of the human mind closely related to dreams, and to which the same interpretative principles can be applied as are found valid in the clinic. What they saw convinced them that, throughout humankind, the same basic conflicts and repressions were at work, and that they were represented in the latent content of the myth, as well as in the dreams. This is why it seemed valid to reduce myth content to psychological formulae without reference to the cultural setting in which the narratives were found, or pursuing any investigation of the actual behavior of the people who repeated the stories.[12]

Others criticized what they took to be an uncritical analysis of such categories as the "primi-

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MAN 6, no. 3 (1975): 7-10; Christie W. Kiefer, "Editorial: The Official Medical Anthropology." *MAN* 6.4 (1975): 1-2; Horacio Fabrega, "The Scope of Ethnomedical Science," *Culture, Medicine, and Psychiatry* 1, no. 2 (1977): 201-28; and Anon., "What Is Medical Anthropology?" *MAN* 12, no. 4 (1981): 7-8.

10 See Arthur Kleinman, "Why This New Journal?" *Culture, Medicine, and Psychiatry* 1, no. 1 (1977): 3-7; Alan Harwood, "The Medical Anthropology Quarterly (New Series): Symbol, Tool, and Statement," *Medical Anthropology Quarterly, New Series* 1, no. 1 (1987): 3-5.

11 Ruth Benedict. "Edward Sapir," *American Anthropologist* 41, no. 3 (1939): 465-77. See also Carl G. Jung. *Psychological Types, or, the Psychology of Individuation* (London: Kegan Paul Trench Trubner, 1921).

12 Irving Hallowell, "Myth, Culture, and Personality," *American Anthropologist, New Series* 49, no. 1 (1947): 550.

tive," or human variability.[13] Jung was also charged with *Universalgedanken* (universal thought), and with claiming that archetypal symbols arise from a larger collective unconscious.[14]

And yet it was precisely this universalizing element that appealed to a different audience. It was also Jung's own recourse to multiple disciplines—including anthropology, philosophy, theology, folklore, mythology, and art. He applied these elements to his theories about the integration of conscious and unconscious, and the hypothesis that related symbols originated in the human psyche, generating a variety of traditions that shared common symbols. In turn, considering the psyche to be real, Jung argued that it projected its knowledge outward as gods, giving rise to the various religious traditions.[15] Other researchers took their scholarship in directions that, in some cases, reflected Jung's influence and, in others, provided complementary arguments. The synergies between their respective works conveyed a multi-faceted but mutually reinforcing set of messages about what mattered when studying multiple traditions.

For example, Joseph Campbell (1904-1987) encountered the work of Jung and Freud while on a fellowship in Europe during the late 1920s. During subsequent intensive independent study, he revisited Jung's writings, some of which he would later edit. Campbell's own inquiries into myths, comparative religion, and psychology drew deeply from Jung. Campbell's encounters with Hindu thought also led him to believe that there is an unknowable force that gives rise to all being, within which all being exists, and into which it subsides. Metaphors, myths, and sacred figures all provide vehicles through which to express and experience this force. His work achieved widespread public popularity.[16]

Historian of religion Mircea Eliade met Jung in 1950 and, through subsequent conversations and correspondence, the two discovered shared interests in shamanic traditions, alchemy, world religions, and efforts to discover and study the roots of humanness in the sacred. Eliade posited a duality of sacred and profane, confronting humans with the challenge of rediscovering and reencountering the perennial sacred. He studied and wrote about myths and symbols, shamanism, and other archaic religious phenomena as gateways to understand the sacred in the present.[17]

Huston Smith (b. 1919), a scholar of world religions now in his nineties, was also instrumental

13 Victor Barnouw, "A Psychological Interpretation of a Chippewa Origin Legend," *Journal of American Folklore* 68, no. 267 (1955): 73-85. See also Lois Mednick, "Memorandum on the Use of *Primitive*," *Cultural Anthropology* 1, nos. 5-6 (1960): 441-45.

14 Carlos C. Drake, "Jung and His Critics," *Journal of American Folklore* 80, no. 318 (1967): 321-33.

15 Karen A. Smyers, "Shaman/Scientist: Jungian Insights for the Anthropological Study of Religion," *Ethos* 29, no. 4 (2002): 485.

16 See, for example, Joseph Campbell, *The Hero with a Thousand Faces* (New York: Pantheon Press, 1949), and *The Masks of God*, 4 vols. (New York: Viking Press, 1959-1968). For an example of how Campbell was represented in the media, see the six-part series in which he discussed myth with Public Television's Bill Moyers: *Joseph Campbell on the Power of Myth with Bill Moyers*. 1988 (VHS Format). DVD, NTSC. Perimutter, Alvin H. and Joan Konner, September 21, 2010 (DVD Format).

17 Mircea Eliade, *Shamanism*, (Princeton: Princeton University Press, 2004 [1951]); *The Myth of the Eternal Return*, trans. Willard R. Trask (New York: Pantheon Books, 1954); *Myths, Dreams, and Mysteries: The Encounter between Contemporary Faiths and Archaic Realities*, trans. Philip Mairet (London: Harvill Press, 1960).

in popularizing religious studies, characterizing himself as a universalist. His book *The Religions of Man* (now *The World's Religions*) nourished a widespread resistance to older religious forms in favor of a conviction that something deeper and unified existed beneath the varieties of different religions. The important endeavor, therefore, was to seek commonalities, regardless of how different the traditions appeared to be on the surface. The search for a universal found expression in both scholarly and popular interest in "mysticism," grounded in an underlying expectation that, at that level, all other differences related to specific traditions fell away. Although the very concept of mysticism would eventually come into scholarly disrepute, it added to the vocabulary of what sociologist Wade Clark Roof would term a "generation of seekers," who favored "spirituality" over "religiosity."[18]

Other influences reinforced such convictions, leading some to pursue direct religious experience of a universal through the use of psychedelic drugs such as LSD, psilocybin, and peyote. Perhaps the most widely publicized case of this pursuit involved "The Harvard Project," in which Timothy Leary, Richard Alpert (later known as Ram Dass), Huston Smith, and other academics at Harvard, the Massachusetts Institute of Technology, and Boston University experimented with the effects of these drugs between 1960 and 1962.[19] This initiative was part of a larger counterculture movement that emerged in the 1960s and extending into the 1970s. It sought new freedoms including civil rights, women's rights, gay rights, challenges to medical paternalism, attention to the environment, and protest against the war in Vietnam.[20]

In the midst of these developments, the Immigration and Nationality Act of 1965 equalized immigration opportunities for non-European countries. Gradually, the demographics of the United States changed, providing occasion for the surrounding populations to have more direct engagement with groups from these other parts of the world—groups with other cultural, religious, and therapeutic traditions. Such exchanges grew within the larger phenomenon of globalization.

The emergence within popular culture of what would come to be known as the New Age tapped these different influences, along with a growing self-help movement, transpersonal psychology, its own reading of quantum physics, and a comprehensive application of the term "holism." A pivotal part of this movement lay in its attention to non-biomedical orientations to sickness, suffering, and healing. However, by and large, this interest did not translate back into a related scholarly endeavor within religious studies. Instead, New Age groups, along with new religious movements,

18 Robert C. Fuller, *Alternative Medicine and American Religious Life* (New York: Oxford University Press, 1989). See also Jean-Anne Sutherland, Margaret M. Poloma, and Brian F. Pendleton, "Religion, Spirituality, and Alternative Health Practices: The Baby Boomer and Cold War Cohorts," *Journal of Religion and Health* 42, no. 4 (2003): 315-38.

19 See Don Lattin, *The Harvard Psychedelic Club: How Timothy Leary, Ram Dass, Huston Smith, and Andrew Weil Killed the Fifties and Ushered in a New Age for America* (New York: HarperOne, 2010).

20 For more in-depth discussions of this period, see Jentri Anders, *Beyond Counterculture* (Pullman, WA: Washington State University Press, 1990); Theodore Roszak, *The Making of a Counter Culture: Reflections on the Technocratic Society and Its Youthful Opposition* (Berkeley: University of California Press, 1995); P. Braunstein and Michael William Doyle, eds., *Imagine Nation: The American Counterculture of the 1960s and 70s*. (New York: Routledge, 2001); and E. A. Swingrover, ed., *The Counterculture Reader*, rev. ed. (New York: PearsonLongman, 2003).

garnered that attention and, within that frame of reference, the role of healers and healing traditions was sometimes addressed. More particularly, a movement to pursue alternatives to biomedicine gained sway, resulting in the grassroots popularization of "unconventional" therapies or what would sojourn through the categories of "alternative medicine," "complementary medicine," "complementary and alternative medicine" or "CAM," and eventually "integrative medicine" in the United States.

Paradoxically, a plethora of publications appeared in different religion sources, but in a sufficiently fragmented way that no subfield for the study of religion and healing resulted. To the extent that the discussion of the topic *was* considered, it tended to take biomedicine as a governing frame of reference. Such was generally the case, for example, in the important series "Health/Medicine and the Faith Traditions," begun by religion scholar Martin Marty (b. 1928) in 1982. The series migrated through a number of publishers but, as a whole, continued until 1995.[21] For the most part, however, the religious worldviews frequently addressed were those seen as antithetical to the application of biomedical interventions—generally, Christian Science and Jehovah's Witnesses—a perception that reflected representations of religion and healing in the biomedical literature.

Over time, particularly in the face of post-modern and post-colonial theories, the comparative project in Religious Studies as it had developed into the 1980s came under growing scholarly fire, which paralleled the critiques against universalizing that had originated in Cultural Anthropology. Such critiques represented variations on Hallowell's criticisms of Jung. It became a truism that to engage in post-modern or post-colonial analysis precluded working comparatively. Religion

21 See Martin E. Marty and Kenneth L. Vaux, eds., *Health/Medicine and the Faith Traditions: An Inquiry into Religion and Medicine*, (Philadelphia: Fortress Press, 1982); Martin E. Mart, *Health and Medicine in the Lutheran Tradition: Being Well*, (New York: Crossroad Publishing Company, 1983); Richard A. McCormick, *Health and Medicine in the Catholic Tradition: Tradition in Transition*, (New York: Crossroad, 1984); David M. Feldman. *Health and Medicine in the Jewish Tradition: L'hayyim—to Life* (New York: Crossroad, 1986); E. Brooks Holifield. *Health and Medicine in the Methodist Tradition: Journey toward Wholeness* (New York: Crossroad, 1986); David H. Smith. *Health and Medicine in the Anglican Tradition: Conscience, Community, and Compromise* (New York: Crossroad, 1986); Fazlur Rahman, *Health and Medicine in the Islamic Tradition: Change and Identity* (New York: Crossroad, 1987); Robert Peel. *Health and Medicine in the Christian Science Tradition: Principle, Practice, and Challenge* (New York: Crossroad, 1988); Prakash N. Desai, *Health and Medicine in the Hindu Tradition: Continuity and Cohesion* (New York: Crossroad, 1989); Stanley S. Harakas, *Health and Medicine in the Eastern Orthodox Tradition: Faith, Liturgy, and Wholeness* (New York: Crossroad, 1990); Åke Hultkrantz, *Shamanic Healing and Ritual Drama: Health and Medicine in Native North American Religious Traditions* (New York: Crossroad, 1992); Lester E. Bush, *Health and Medicine among the Latter-Day Saints: Science, Sense, and Scripture* (New York: Crossroad, 1993); Leonard I. Sweet, *Health and Medicine in the Evangelical Tradition: "Not by Might nor Power,"* (Valley Forge, PA: Trinity Press International, 1994); and Graydon F. Snyder, *Health and Medicine in the Anabaptist Tradition: Care in Community* (Valley Forge, PA: Trinity Press International, 1995). During this time, two other related works were also published: Lawrence E. Sullivan, ed., *Healing and Restoring: Health and Medicine in the World's Religious Traditions* (New York: Macmillan, 1989); Ronald L. Numbers, Darrel W. Amundsen, and Martin E. Marty, *Caring and Curing: Health and Medicine in the Western Religious Traditions* (Baltimore: Johns Hopkins University Press, 1997). See also David R. Kinsley, *Health, Healing, and Religion: A Cross-Cultural Perspective* (Upper Saddle River, N.J: Prentice Hall, 1996).

scholar Kimberley Patton describes the experience, some years ago, of presenting her plans for a course in comparative religious studies to a group of religion faculty. One of them spluttered, "But that's like my taking sixteen different birds and hacking out their livers and laying them out in a row! All you end up with is sixteen dead birds!" A colleague, upon hearing the story, said dryly, "How did he know that all the organs were livers?"[22] (Or, for that matter, that all the creatures were birds?)

Core Comparative Categories in Medical Anthropology

Despite its resistance to universalizing, anthropology was also invested in comparative studies and in arriving at theories that might help to illuminate cultural phenomena and dynamics. Its own comparative project, which favored understanding the general through the particular, took two other broad directions. The first involved the application of a set of analytical methods to particular settings. Structuralism, which originated in France, is one such example, although in no way the only one. It came out of Ferdinand de Saussure's theories of linguistics and related theories of signs and symbols. It arose in the 1950s and gained full momentum in the '60s, influencing the humanities and social sciences. Theorists who applied structural analysis to their ethnographic work sought to identify deep structures of thought underlying cultural forms. It was these structures that provided the comparative frames.

A second approach involved the development of categories that could be applied analytically to different traditions. The challenge in so doing entails determining whether there are even analogous phenomena. For example, might the shaman of other cultures, who had perhaps undergone what—in biomedical settings—could have been construed as a psychiatric breakdown, be the equivalent of the psychotherapist for that other culture? Insofar as both were socially sanctioned healers, upon what bases should one draw comparisons? What is the meaning, in this connection, of different forms of religious healing?[23]

In medical anthropology, this project resulted in the formulation of key concepts between the 1970s and '80s. One force driving these early inquiries involved an interest in developing methods with which to compare therapeutic traditions and in determining whether their respective classifications of illness experience and related responses were commensurate. Among the most influential of these categories have been Explanatory Models, Biomedicine, Idioms of Distress, Culture Bound Syndromes, Illness Behaviors/Roles, Health-Seeking Behavior, and Efficacy. I review them here because they are transferrable and thus important for religious studies scholars to

22 Kimberley C. Patton, "Juggling Torches: Why We Still Need Comparative Religion," in A Magic Stil Dwells: Comparative Religion in a Postmodern Age, eds. Kimberley C. Patton and Benjamen C. Ray (Berkeley: University of California Press, 2000), 153-71

23 Jerome D. Frank, *Persuasion and Healing: A Comparative Study of Psychotherapy* (Baltimore: Johns Hopkins Press, 1961); A. S. Heber et al., "Dissociation in Alternative Healers and Traditional Therapists: A Comparative Study," *American Journal of Psychotherapy* 43, no. 4 (1989): 562-74

consider when exploring issues related to religion and healing.

In general, an explanatory model[24] provides an explanation for how or why something has happened or how it works. Arthur Kleinman (b. 1941) advocated that the concept be applied to understandings of illness held by patients, practitioners, and others, recognizing that each party might hold correspondingly different models. Gradually, the generic term "medicine," applied uncritically to the dominant system, gave way to "biomedicine," in recognition that it, too, comprises a cultural system.[25]

It had become clear that one could not take for granted that the illness categories and diagnoses constructed by one system correspond to those of another system. If they do, in what ways? How do different groups experience and express suffering and sickness in ways that are recognizable and acceptable to others in the group? How do they manifest these experiences and what do they do about them? What, that is, are the varied *idioms of distress*?[26]

24 For early formulations, see Editor, "Culture and Illness: A Question of Models," *Culture, Medicine, and Psychiatry* 1, no. 3 (1977): 229-31; Dan Blumhagen, "On the Nature of Explanatory Models," *Culture, Medicine, and Psychiatry* 5, no. 4 (1981): 337-40; Allan Young, "The Anthropologies of Illness and Sickness," *Annual Review of Anthropology* 11 (1982): 257-85. For examples of its application, see Louis M. Guimera, "Witchcraft Illness in the Evuzok Nosological System," *Culture, Medicine, and Psychiatry* 2, no. 4 (1978): 373-96; George M. Foster, "Humoral Traces in United States Folk Medicine," *MAN* 10, no. 2 (1979): 17-20; Karen L. Ito, "Illness as Retribution: A Cultural Form of Self Analysis among Urban Hawaiian Women," *Culture, Medicine, and Psychiatry* 6, no. 4 (1982): 385-403; and Sam Migliore, "Evil Eye or Delusions: On the 'Consistency' of Folk Models," *Medical Anthropology Quarterly* 14, no. 2 (1983): 4-9. For a more recent application, see Mitchell Weiss, "Explanatory Model Interview Catalogue (Emic): Framework for Comparative Study of Illness," *Transcultural Psychiatry* 34 (1997): 235-63.

25 See, for example, Robert A. Hahn and Arthur Kleinman, "Biomedical Practice and Anthropological Theory: Frameworks and Directions," *Annual Review of Anthropology* 12 (1983): 305-33.

26 See, for example, Mark Nichter, "Idioms of Distress: Alternatives in the Expression of Psychosocial Distress: A Case Study from South India," *Culture, Medicine, and Psychiatry* 5, no. 4 (1981): 379-408; Claire D. F. Parsons, "Idioms of Distress: Kinship and Sickness among the People of the Kingdom of Tonga," *Culture, Medicine, and Psychiatry* 8, no. 1 (1984):71-93; Claire D. F. Parsons and Pat Wakeley, "Idioms of Distress: Somatic Responses to Distress in Everyday Life," *Culture, Medicine, and Psychiatry* 15, no. 1 (1991): 111-32; Richard Rechtman, "Stories of Trauma and Idioms of Distress: From Cultural Narratives to Clinical Assessment," *Transcultural Psychiatry* 37, no. 3 (2000): 403-15; and Raymond Massé, "Between Structural Violence and Idioms of Distress: The Case of Social Suffering in the French Caribbean," *Anthropology in Action* 14, no. 3 (2007): 6-17.

More recently, *Culture, Medicine, and Psychiatry* published an issue devoted to the topic: Devon E. Hinton and Roberto Lewis-Fernández, "Idioms of Distress among Trauma Survivors: Subtypes and Clinical Utility," *Culture, Medicine, and Psychiatry* 34, no. 2 (2010): 209-18; Roberto Lewis-Fernández et al., "Association of Trauma-Related Disorders and Dissociation with Our Idioms of Distress among Latino Psychiatric Outpatients," *Culture, Medicine, and Psychiatry* 34, no. 2 (2010): 219-43; Devon E. Hinton et al., "Khyâl Attacks: A Key Idiom of Distress among Traumatized Cambodia Refugees," *Culture, Medicine and Psychiatry* 34, no. 2 (2010): 244-78; Duncan Pedersen, Hanna Kienzler, and Jeffrey Gamarra, "Llaki and Nakary: Idioms of Distress and Suffering among the Highland Quechua in the Peruvian Andes," *Culture, Medicine and Psychiatry* 34, no. 2: 279-300; T. de Joop and Ria Reis, "Kiyang-Yang, a West-African Postwar Idiom of Distress," *Culture, Medicine, and Psychiatry* 34, no. 2 (2010): 301-21; Brandon A. Kohrt and Daniel J. Hruschka, "Nepali Concepts of Psychological Trauma: The Roles of Idioms of Distress, Ethnopsychology, and Ethnophysiology in Alleviating Suffering and Preventing Stigma," *Culture, Medicine, and Psychiatry* 34, no. 2 (2010): 322-52; Mark Nichter, "Idioms of Distress Revisited," *Culture, Medicine, and*

It was recognized that different cultures (as well as diverse groups within those cultures) might favor ways to express suffering and sickness that do not necessarily align. A well-known example involved efforts to determine whether depression is experienced cross-culturally. For example, Arthur Kleinman's work on depression in Mainland China argued that somatized expressions were sometimes more culturally acceptable than emotional articulations of distress.[27] As his later work demonstrated, such expressions can include the impact of social suffering relayed through bodily or affective symptoms.[28] Sometimes illness categories appeared not to overlap at all. Such cases seem to occur only within a single culture as a "culture-bound syndrome."[29]

The broad consensus has been that in addition to representing what biomedicine would characterize as biologically-based experiences and related expressions, different forms of sickness also encompass learned, culturally-grounded *illness behaviors* and *illness roles*. Such behaviors can include ways in which one does (or does not) express pain. They are the culturally learned performances of suffering. Illness roles are learned, as part of a larger process of enculturation into a cultural identity.[30]

In response to a constellation of symptoms and illness experiences, people often define their

Psychiatry 34, no. 2 (2010): 401-16.

27 Arthur Kleinman, "Depression, Somatization, and the New Cross-Cultural Psychiatry," *Social Science and Medicine* 11 (1977): 3-10; "Neurasthenia and Depression: A Study of Somatization and Culture in China," *Culture, Medicine, and Psychiatry* 6, no. 2 (1982):117-189; *Social Origins of Distress and Disease: Depression and Neurasthenia in Modern China* (New Haven: Yale University Press, 1986).

28 See Arthur Kleinman. "'Everything That Really Matters:' Social Suffering, Subjectivity, and the Remaking of Human Experience in a Disordering World," *Harvard Theological Review,* 90 (1997): 315- 335.

29 A range of authors explored the topic for over a decade, particularly in the journal *Culture, Medicine, and Psychiatry*. See, for example: Editor, "Three Faces of Culture-Bound Syndromes: Their Implications for Cross-Cultural Research," *Culture, Medicine and Psychiatry* 2, no. 3 (1978): 207-08; John Carr, "Ethno-Behaviorism and the Culture-Bound Syndromes: The Case of Amok," *Culture, Medicine, and Psychiatry* 2, no. 3 (1978): 269-93; Raymond L. M. Lee, "Structure and Anti-Structure in the Culture-Bound Syndromes: The Malay Case," *Culture, Medicine, and Psychiatry* 5, no. 3 (1981): 233-48; Cheryl Ritenbaugh, "Obesity as a Culture-Bound Syndrome," *Culture, Medicine, and Psychiatry* 6, no. 4 (1982): 347-61; Unni Wikan, "Illness from Fright or Soul Loss: A North Balinese Culture-Bound Syndrome?" *Culture, Medicine, and Psychiatry* 13, no. 1 (1989): 25-50; Raymond Prince and Françoise Tcheng-Laroche, "Culture-Bound Syndromes and International Disease Classifications," *Culture, Medicine, and Psychiatry* 11, no. 1 (1987): 3-19; and Margaret Lock, "DSM-III as a Culture-Bound Construct: Commentary on Culture-Bound Syndromes and International Disease Classifications," *Culture, Medicine, and Psychiatry* 11, no. 1 (1987): 35-42. See also Ronald C. Simons and Charles C. Hughes, eds., *The Culture-Bound Syndromes*, (Boston: D. Reidel, 1985).

30 For early examples of this discussion, see Raymond Neutra, Jerrold E. Levy, and Dennis Parker, "Cultural Expectations Versus Reality in Navajo Seizure Patterns and Sick Roles," *Culture, Medicine, and Psychiatry* 1, no. 3 (1977): 255-75; Horacio Fabrega, "Group Differences in the Structure of Illness," *Culture, Medicine, and Psychiatry* 1, no. 4 (1980): 379-94; David Locker, *Symptoms and Illness: The Cognitive Organization of Disorder* (New York: Tavistock, 1981); Mark Nichter, "Negotiation of the Illness Experience: Ayurvedic Therapy and the Psychosocial Dimension of Illness," *Culture, Medicine, and Psychiatry* 5, no. 1 (1981): 5-24; Charles W. Lidz, Alan Meisel, and Mark Munetz, "Chronic Disease: The Sick Role and Informed Consent," *Culture, Medicine, and Psychiatry* 9, no. 3 (1985): 241-55; Shuji Tonai et al., "Illness Behavior of Housewives in a Rural Area in Japan: A Health Diary Study," *Culture, Medicine, and Psychiatry* 13, no. 4 (1989): 405-17.

problem in complex ways, each of which may require an intervention in order to restore balance and/or health. The formulation of the problem and its various parts also falls within particular cultural frames, as do the related therapeutic resources that different groups associate with each part. The steps people take to pursue health and the remedies in which they invest personal and collective energies and resources were gathered into the category of *health-seeking behaviors.* Moreover, in choosing which therapeutic strategies they will select, individuals and groups engage in a process of *health decision making*.[31]

Early discussions of this decision process took for granted a rationality of a type familiar to Western academics.[32] However, such assumptions soon gave rise to counter-theories positing multiple rationalities. Such theories sought to identify a more complex set of variables playing a role in the choices people made. In part, health decision making was related to different concepts of *personhood* and of the *self*; in part, choices involved complex circumstances that had to be weighed against each other, with priorities changing alignment depending on the nature of the circumstances.[33]

31 Noel J. Chrisman, "American Patterns of Health-Care-Seeking Behavior," in *The American Dimension: Cultural Myths and Social Realities*, eds. W. Arens and Susan P. Montague (Port Washington, NY: Alfred Publishing Company, 1976), 206-17; "The Health Seeking Process: An Approach to the Natural History of Illness," *Culture, Medicine, and Psychiatry* 1, no. 4 (1977): 351-78; Arthur Kleinman, "Lessons from a Clinical Approach to Medical Anthropological Research," *MAN* 8, no. 4 (1977): 11-15; Arthur E. Hippler, "On Stein and Kleinman, and the Crucial Issues in Medical Anthropology," *MAN* 9, no. 1 (1977): 18-19; Tsung-Yi Lin et al., "Ethnicity and Patterns of Help-Seeking," *Culture, Medicine, and Psychiatry* 2, no. 1 (1978): 3-13; Noel J. Chrisman. "The Health Seeking Process: An Approach to the Natural History of Illness." *Culture, Medicine, and Psychiatry* 1, no. 4 (1980): 351-77; Kaja Finkler, "A Comparative Study of Health Seekers: Or, Why Do Some People Go to Doctors Rather Than to Spiritualist Healers?" *Medical Anthropology* 5, no. 4 (1981): 383-424; Carol Shepherd McClain, "Patient Decision Making: The Case of Delivery Method after a Previous Cesarean Section," *Culture, Medicine, and Psychiatry* 11, no. 4 (1987): 495-508.

32 Allan Young. "When Rational Men Fall Sick: An Inquiry into Some Assumptions Made by Medical Anthropologists." *Culture, Medicine and Psychiatry* 5.4 (1981): 317-35; "Rational Men and the Explanatory Model Approach." *Culture, Medicine and Psychiatry* 6.1 (1982): 57-71.

33 Arthur S. Einstein and Margaret M. Holmes, "The Limits of Rational Decision Making: Anthropological and Psychological Perspectives," *Culture, Medicine, and Psychiatry* 5, no. 4 (1981): 340-44; Robert A. Hahn, "On the Rational Distribution of Rationality," *Culture, Medicine, and Psychiatry* 5, no. 4 (1981): 344-47; Richard A. Shweder, "Rationality 'Goes without Saying,'" *Culture, Medicine, and Psychiatry* 5, no. 4 (1981): 348-58; Byron J. Good, "Rationality 'Goes without Saying,'" *Culture, Medicine, and Psychiatry* 5, no. 4 (1981): 358-62; Howard F. Stein, "Rationality 'Goes without Saying,'" *Culture, Medicine, and Psychiatry* 5, no. 4 (1981): 363-70; E. Valentine Daniel, "Rationality 'Goes without Saying,'" *Culture, Medicine, and Psychiatry* 5, no. 4 (1981): 370-73. About a decade later, the topic continued to receive attention: Susan C. Weller, Trenton R. Ruebush, and Robert E. Klein, "Predicting Treatment-Seeking Behavior in Guatemala: A Comparison of the Health Services Research and Decision-Theoretic Approaches," *Medical Anthropology Quarterly* 11, no. 2 (1997): 224-45; Cheryl Mattingly, "In Search of the Good: Narrative Reasoning in Clinical Practice," *Medical Anthropology Quarterly* 12, no. 3 (1998): 273-97; Linda M. Hunt, "Moral Reasoning and the Meaning of Cancer: Causal Explanations of Oncologists and Patients in Southern Mexico," *Medical Anthropology Quarterly* 12, no. 3 (1998): 298-318; Linda C. Garro, "On the Rationality of Decision-Making Studies. Part 1: Decision Models of Treatment Choice," *Medical Anthropology Quarterly* 12, no. 3 (1998): 319-40; "On the Rationality of Decision-Making Studies. Part 2: Divergent Rationalities," *Medical Anthropology Quarterly* 12, no. 3 (1998): 341-55; Linda M. Hunt and Cheryl Mattingly, "Diverse Rationalities and Multiple Realities in Illness

Perhaps one of the primary questions shaping the field involved the matter of how to gauge when healing has happened. What transformation in what domain counts as a sufficient and effective outcome? Who decides, and based on what? Each variation on affliction has corresponding varieties of efficacy, further framed by the different therapeutic systems. A given problem could be formulated as requiring multiple kinds of intervention in order to address the situation as a whole. Each intervention would then have corresponding versions of efficacy. The more amorphous outcome would entail how these discrete outcomes would have to add up in order for the practitioner, the person, and the group to agree that healing had fully occurred.[34]

Moreover, each culture of medicine and healing recognizes different types of practitioners who have varying degrees of legitimacy and authority. Anthropologists have studied the different processes by which individuals are called, or choose, to become healers, such as dreams, visions, spirit journeys, pivotal illness experiences, and family traditions. Related processes for ‘‘traditional’’ or ‘‘folk’’ healers have often examined individual narratives as illustrative case studies. Other work has explored the processes by which legitimacy is conferred upon individual practitioners.[35]

These multiple variables serve as a powerful reminder that, just as it is a major challenge to arrive at an inclusive definition of religion, so is it difficult to define healing in any way that encompasses the many varieties. Nonetheless, comparative categories—understood as necessarily porous and intersecting—enable us to get a richer understanding of the variations spanning particular concepts.

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and Healing," *Medical Anthropology Quarterly* 12.3 (1998): 267-72.

34 For key early discussions of efficacy, see Erica Bourguignon, "The Effectiveness of Religious Healing Movements: A Review of Recent Literature. Transcultural Psychiatric Research," *Overviews* 13 (1970): 5-21; Allan Young, "Order, Analogy, and Efficacy in Ethiopian Medical Divination," *Culture, Medicine, and Psychiatry* 1, no. 2 (1977): 183-99; Emily M. Ahern, "The Problem of Efficacy: Strong and Weak Illocutionary Acts," *MAN* 14, no. 1 (1979): 1-17; Kaja Finkler, "Non-Medical Treatments and Their Outcomes," *Culture, Medicine, and Psychiatry* 4, no. 3 (1980): 271-310; "Non-Medical Treatments and Their Outcomes," *Culture, Medicine, and Psychiatry* 5, no. 1 (1981): 65-103; Arthur Kleinman and James L. Gale, "Patients Treated by Physicians and Folk Healers: A Comparative Outcome Study in Taiwan," *Culture, Medicine, and Psychiatry* 6.4 (1982): 405-23. For more recent approaches to the discussion, see Robert Anderson, "The Efficacy of Ethnomedicine: Research Methods in Trouble," In *Anthropological Approaches to the Study of Ethnomedicine*, ed. Mark Nichter (Philadelphia: Gordon and Breach Science Publishers, 1992), 3-17; Kris Heggenhougen, "Perceptions of Efficacy and the Use of Traditional Medicine, with Examples from Tanzania," *Curare* 20, no. 1 (1997): 5-13; François Jullien, *The Propensity of Things: Toward a History of Efficacy in China*, trans. Janet Lloyd (New York: Zone Books, 1995); Lars-Christer Hydén, "The Rhetoric of Recovery and Change," *Culture, Medicine, and Psychiatry* 19 (1995): 73-90; Arthur Kleinman and Don Seeman, "The Politics of Moral Practice in Psychotherapy and Religious Healing," *Contributions to Indian Sociology, New Series* 32 (1998): 237-52; James B. Waldram, "The Efficacy of Traditional Medicine: Current Theoretical and Methodological Issues," *Medical Anthropology Quarterly* 14, no. 4 (2000): 603-25; Linda L. Barnes, "American Acupuncture and Efficacy: Meanings and Their Points of Insertion", *Medical Anthropology Quarterly* 19, no. 3 (2005): 239-266.

35 As illustrations and for reviews of related literature, see Linda L. Barnes, "Practitioner Decisions to Engage in Chinese Medicine: Cultural Messages under the Skin," *Medical Anthropology* 28, no. 2 (2009): 141-65; Linda L. Barnes, "The Acupuncture Wars: The Professionalizing of Acupuncture in the United States—a View from Massachusetts," *Medical Anthropology* 22 (2003): 261-301.

Ultimate Human Possibility	Frequently religious frames of reference, referring to the ultimate possibility to which a person can aspire (e.g. salvation, awakening, sagehood, immortality, freedom from rebirth), frequently understood to happen following death. Such frames of reference, if present, often relativize death.
Suffering & Affliction	The larger, existentially based explanations for why beings suffer. A given tradition may provide more than one explanation.
Personhood/Self	Models of personhood, that can include ways of conceptualizing embodiment; the capacities for thought, feeling, sensitivity; self-in-relationship; and whatever vital force is thought to animate the person; in some cases, may include a soul, or souls. To know the different facets of personhood is to know all the ways a person can become ill.
Illness	Related to specific episodes or courses of sickness. Can be conceptualized as a subset of the larger category of Suffering. It encompasses the categories: - *Explanatory Models* - *Idioms of Distress* - *Culture Bound Syndromes* - *Illness Behaviors/Roles* - *Illness Experience & Illness Narratives* Also involves social forms of suffering, and related social-structural factors.
Healers	The socially sanctioned persons recognized as having the abilities and/or training to address specific facets of illness and/or suffering.
Health-Seeking Behavior	Includes *Health Decision Making*
Interventions	The spectrum of interventions available, addressing different facets of the problem. *Biomedicine* provides one set of such interventions, but is relativized as only one cultural system of medicine.
Efficacy	The forms of change that are recognized and valued in relation to how the various causes and aspects of a given illness are explained

This chart lays out factors involved in the different healthworlds, providing a number of broad comparative categories.

And yet they are not sufficient when examining religion and healing. Perhaps the variable least attended to in medical anthropology, yet of primary concern in religious studies, is Healing in relation to some ultimate frame of reference. Paradigms of Healing—with a capital "H"—refer to understandings of ultimate human possibility. Healing, here, represents a tradition's deepest hopes and promises. It may be a way of talking about a person's relation to a highest reality, whether known as God, Yahweh, Allah, Atman, Nirvana, Obatalá, kamis, Tian, or other names, although it does not necessarily involve such a reality. It may take the form of enlightenment, salvation, a place in Heaven, life in a World to Come, Paradise, Nirvana, freedom from cycles of rebirth, immortality, sagehood, venerated ancestral status, remaining alive in human memory, or something else not related to any particular tradition.

Healing thus conceptualized relativizes everything else about human life. It provides a frame of reference within which someone may interpret all other experiences, including the meaning of health in this lifetime. The influence of such visions of ultimate possibility are often read back into how people conduct their lives, leading them to try to live in ways that will bring about this kind of Healing. This frame of reference is reflected in the formulations of personhood and self. That is, some aspect or part of a human being is structured in such a way as to make ultimate healing possible although not inevitable.

Many traditions and related systems of healing represent some aspects of Healing as occurring after death. Death, therefore, becomes a transition, marking a change of state. Conversely, biomedicine is a tradition with no way of talking about what follows death, since the demise of the body represents the end of biomedical intervention. As a result, death can only represent failure and is often experienced as such by biomedical clinicians.

A second variable includes the range of explanations for Suffering and Affliction. Arthur Kleinman and Don Seeman note that "the problem of suffering is everywhere, in one way or another, at the heart of religious experience."[36] "Suffering" writ large may be assigned multiple explanations, not only between traditions but also within a single tradition. Specific experiences then become embodied expressions of these often more cosmic explanations. Just as Healing is directly related to Suffering—Healing overcomes Suffering—so healing, in its different forms, addresses the particularities of individual episodes of suffering. Religions, Clifford Geertz argues, make suffering "sufferable."[37] Their various approaches to ritual healing posit that the specific episode of suffering is relative and finite, as is the individual act of healing, where Healing, understood as ultimate, is not. This relativity is part of what renders suffering sufferable. Meanings of efficacy are formulated in relation to these understandings of Healing and healing.

Paradigms of Suffering and Affliction represent explanations for why suffering and affliction happen. Many traditions, for example, explain Suffering as the fruits of earlier actions, whether as a sign of judgment, punishment, and/or testing. The explanation may reiterate core narratives of a

36 Arthur Kleinman and Don Seeman, "The Politics of Moral Practice in Psychotherapy and Religious Healing," *Contributions to Indian Sociology, New Series* 32 (1998): 244.

37 Clifford Geertz, *The Interpretation of Cultures* (New York: Basic Books 1973), 104.

tradition: some early individuals behaved in a forbidden way, as a result of which all subsequent humans suffer. Within the trajectories of Buddhism, the very nature of reality is characterized as impermanent. The human desire to hold on to things is routinely frustrated, causing suffering. Consequently, Suffering constitutes a fundamental human experience, until one learns how to disengage from its causes. Generally, paradigms of Suffering and Affliction are offset by paradigms of Healing. The former attempt to explain why we suffer; the latter offer possible responses and ultimate alternatives.

Such paradigms may frame how each party interprets specific experiences: "Am I being punished?" "Am I being tested?" "Am I to learn something from this?" In such instances, Suffering may function as the impetus for seeking transformation. On the other hand, actual experience may lead individuals to reject a paradigm as inadequate to account for a particular reality, and to struggle to find some other reason for why that reality is happening. In such cases, the person is still searching for a paradigm sufficient to the experience. Some of these paradigms may be experienced as punitive. If a family is told, for example, that God doesn't give them more to bear than they can handle, it is hard not to think, "If we were weaker, would our beloved family member not be living with this disability? Would they still be alive?" The sacred may be represented as indifferent or punishing. Yet the paradox of many traditions is that the sacred is represented as both merciful or loving and as a force of judgment that is sometimes terrifying. The challenge may involve navigation through such paradoxes.[38]

As Patton's work has so richly argued, the renewed comparative project in religious studies requires avoiding the formulation of facile equivalents and, instead, striving for an exploration into the religious implications of a theme—in this case, healing—that has held profound significance in the different religious worlds. The comparative frame presented here is intended to be both sufficiently specific and yet open enough to accommodate a wide, interdisciplinary inquiry. Such an inquiry requires the researcher to reflect on the meaning of the particular theme from within his or her discipline, as well as on the multiple meanings that theme may hold "*within* particular religious traditions, ethical trajectories, social histories, or research methods."[39]

38 The preceding six paragraphs draw directly from Linda L. Barnes, "Introduction, *Teaching Religion and Healing*, eds. Linda L. Barnes and Ines Talamántez (New York: Oxford University Press, 2006), 3-26. See that chapter for a more in-depth discussion.

39 Paul Waldau and Kimberley Patton, "Introduction," in *A Communion of Subjects: Animals in Religion, Science, and Ethics*, eds. Paul Waldau and Kimberley Patton (New York: Columbia University Press, 2006), 13. Both in its content and its methods, Patton's work has been pivotal in the renewal of the comparative project in Religious Studies. She builds complex comparative evidence, drawing on both cultural and historical resources, identifying both structural commonalities and key differences in ways that are significantly transferable to the study of religion and healing. See Kimberley C. Patton and Benjamin C. Ray, eds. *A Magic Still Dwells: Comparative Religion in the Postmodern Age* (Berkeley: University of California Press, 2000); Kimberley C. Patton and John Stratton Hawley, eds. *Holy Tears: Weeping in the Religious Imagination* (Princeton: Princeton University Press, 2005); Kimberley C. Patton, *The Sea Can Wash Away All Evils: Modern Marine Pollution and the Ancient Cathartic Ocean* (New York: Columbia University Press, 2006); and Kimberley C. Patton, *Religion of the Gods: Ritual, Paradox, and Reflexivity* (New York: Oxford University Press, 2009).

Through Other Theories

Categories, in themselves, involve a theoretical step of classification. But that is only a step toward broader understanding, which requires the use of additional analytical tools. Four of these theoretical orientations have been especially significant, and they intersect deeply with concerns in Religious Studies: Meaning-Centered analysis; the Cultural Phenomenology of Healing and related theories of embodiment; Interpretive Anthropology; and the Anthropology of Experience.

Meaning-Centered Analysis

In the course of examining different conceptualizations of illness, medical anthropologists became increasingly aware that, unlike biomedical disease classifications, illness categories in other cultural systems are not necessarily discrete or separate. In a now classic essay, Byron Good and MaryJo DelVecchio Good provide a formulation of what would become known as "meaning-centered" analysis. They argue, "[*T*]*he meaning of medical discourse is constituted in relationship to socially constructed illness realities.*" To interpret the illness narratives and experiences in other settings, one confronts the challenge of cultural meanings, which may be conveyed through metaphors, symbols, and processes. Indeed, a meaning-centered approach, versus a disease-centered model, allows a network of symbols to function as the site of one's inquiry.[40]

One can apply meaning-centered analysis to conceptualizations of the self and related understandings of illness. Marina Roseman, for example, discusses a permeable personhood among the Temiar rain forest dwellers. This personhood comprises multiple potentially detachable selves, which—if separated from the person—can cause illness and require ritual restoration. Paul Farmer, in studying *move san*—a widespread somatically experienced disorder in Haiti—found that people explained it as having been caused by emotional distress, and he characterized it as a disorder of experience. Likewise, a group's encounter with a new affliction may be positioned within an existing explanatory model, as Farmer found with HIV/AIDS in Haiti where it was gradually linked with etiologies related to sorcery and the sending of sickness. Working with Navajo people, Thomas Csordas found that cancer was commonly attributed to someone's being struck by lightening. Among Yucatec Maya women, Anne Woodrick observed, it is not the heart, the brain, or another inner organ that grieves; rather it is the soul, because love resides in the soul. Hence, it is the soul that requires healing.[41]

40 Byron J. Good and MaryJo DelVecchio Good, "Toward a Meaning-Centered Analysis of Popular Illness Categories: 'Fright Illness' and 'Heart Distress' in Iran," in *Cultural Conceptions of Mental Health and Therapy*, eds. A. J. Maarsella and G. M. White (Boston: D. Reidel Publishing Company, 1982), 141-66.

41 For illustrations of a meaning-centered approach applied to topics in religion and healing, see Byron Good, "The Heart of What's the Matter: The Semantics of Illness in Iran," *Culture, Medicine, and Psychiatry* 3, no. 1 (1977): 73-94; Arthur Kleinman, "Sickness as Cultural Semantics: Issues for Anthropological Medicine and Psychiatry," in *Toward New Definitions of Health Psychosocial Dimension*, eds. Paul I. Ahmed and George V. Coelho (New York: Plenum Press, 1979), 53-66; Arthur Kleinman, "The Meaning Context of Illness and Care: Reflections on a Central

Probably one of the most widely known examples of meaning-centered medical anthropology is Arthur Kleinman's book *The Illness Narratives: Suffering, Healing, and the Human Condition*, in which Kleinman argues that biomedical physicians all too quickly lose sight of the patient's explanatory model, as well as the lived experience of the illness, in the process of translating that narrative into a diagnosis grounded in the course of a disease.[42] Although written especially for doctors, the book also illustrates more broadly the unintended conflicts between core paradigms and their related stories, and the related erasure of meaning from what becomes, instead, a "case."

The Cultural Phenomenology in Anthropologies of Healing

The second prominent theoretical orientation is provided by Phenomenology and related analyses of embodiment. Four figures in particular have influenced this area in medical anthropology: Alfred Irving Hallowell (1892-1974), Alfred Schütz (1899–1959), Maurice Merleau-Ponty (1908-1961), and Thomas J. Csordas (b. 1952). Of the four, medical anthropologist Tom Csordas has dedicated much of his work to the study of religion and healing, making his work of seminal importance for this field.

Irving Hallowell (who also went by the name "Pete") had studied with Frank Speck (1881-1950), an early ethnographer of different Native American tribes in the United States, and with Franz Boas (1858-1942), with whom Speck had also studied. Both influenced his focus on addressing the particularities of specific groups rather than arriving at grand, more abstract theories. In his obituary for Hallowell, Melford Spiro pointed to Hallowell's contributions to the understanding of connections between environment and personality, or self. In the case of the former, he identified the pivotal role played by perception, cognitive orientations, and the related assigning of meanings, all of them deriving from the cultural systems of symbols at work in a group. An environment, that is, is culturally constituted. But so is a self.[43]

> In sum, many years before the current "emic" or "phenomenological" approaches become fashionable, Hallowell insisted that the objective constructs of culture and of personality are in themselves inadequate to explain the human social order. An adequate explanation requires, as he saw it, the notion of a phenomenologically conceived psychological field

Theme in the Anthropology of Medicine," in *Sciences and Cultures: Anthropological and Historical Studies of the Sciences*, eds. Everett Mendelsohn and Yehuda Elkana. Vol. 5 (Dordrecht: D. Reidel, 1981), 161-76; Paul Farmer, "Bad Blood, Spoiled Milk: Bodily Fluids as Moral Barometers in Rural Haiti," *American Ethnologist* 15, no. 1 (1988): 62-83; Thomas J. Csordas, "The Sore That Does Not Heal: Cause and Concept in the Navajo Experience of Cancer," *Journal of Anthropological Research* 45, no. 4 (1989): 457-85; Paul Farmer, "Sending Sickness: Sorcery, Politics, and Changing Concepts of AIDS in Rural Haiti," *Medical Anthropology Quarterly* 4, no. 1 (1990): 6-27; Marina Roseman, "Head, Heart, Odor, and Shadow: The Structure of the Self, the Emotional World, and Ritual Performance among Senoi Temiar," *Ethos* 18, no. 3 (1990): 227-50; Frederick R. Bloom, "Searching for Meaning in Everyday Life: Gay Men Negotiating Selves in the HIV Spectrum," *Ethos* 25, no. 4 (1997): 454-79.

42 Arthur Kleinman, *The Illness Narratives: Suffering, Healing, and the Human Condition*, (New York: Basic Books, 1988).

43 Melford Spiro, "Obituary: Alfred Irving Hallowell," *American Anthropologist* 78, no. 3 (2009): 608-11.

> consisting of culturally constituted selves in interaction with a culturally constituted behavioral environment.[44]

By including the perspectives of the self, or the individual, he expanded the understanding of cultural categories to go beyond those commonly used by the observer, and to employ those used by a people themselves. While it may now seem commonplace to balance between etic and emic perspectives, at the time this was a key contribution to the interpretation of the lifeworlds of others. It required a commitment to understanding the "outlook of the self in its behavioral environment."[45] By foregrounding this dimension, Hallowell contributed directly to the significance assigned, in medical anthropology, to "the culturally situated understandings individuals bring to the occurrence of illness, and how these cultural knowledge resources are used in evaluating illness and in deciding what should be done."[46]

Alfred Schütz, an Austrian lawyer exposed to philosophers and phenomenologists while still in Europe, came to the United States in 1939. Also a part-time academic, he integrated phenomenology and sociology. His intellectual heritage traced back to Max Weber, by way of Edmund Husserl (1859–1938); Husserl inspired in Schütz an ongoing interest in the phenomenology of the consciousness of inner time, which Husserl himself owed to Weber's influence. That is, how do individuals take the mass of their experiences and arrange them according to a sense of inner time—that which has happened, is happening, and will happen (or not)—while also assigning meanings to such events?

Schütz suggested that we inhabit a life-world with three degrees of engagement with others, whom he classified as Consociates, Contemporaries, Predecessors, and Successors. Consociates share the same time and have physical/spatial access to one another's bodies. Contemporaries live during the same time (or within overlapping periods), but do not have spatial access to each other. Predecessors and Successors, by virtue of living either in the past or the future, share neither the same time nor any spatial access to one another's physical selves. Each kind of relationship is structured by its position in the individual's sense of inner time. But those relationships lead to the challenge of intersubjective understanding.

This process of reflection on the facets of one's life-world generates layers of meaning over time, which combine with choices and actions in the person's social world. There, one composes a self that plays different roles, each one calling for reflective engagement in thought and action. The resulting different provinces of meaning are not mutually exclusive; rather, they are permeable, allowing the person to move between and within multiple realities that Schütz characterized as the structures of the life-world, which exists within a larger social world.[47] He argued that the goal of

44 Ibid., 610.

45 A. Irving Hallowell, *Culture and Experience* (Philadelphia: University of Philadelphia, 1955), 89.

46 Linda C. Garro, "Hallowell's Challenge: Explanations of Illness and Cross-Cultural Research," *Anthropological Theory* 2, no. 1 (2002): 81. See Garro's full essay for her discussion of Hallowell's work in connection with medical anthropology (77-97). See also Dennison Nash, "Hallowell in American Anthropology," *Ethos* 5, no. 1 (1977): 3-12.

47 Alfred Schütz, *The Phenomenology of the Social World* (Evanston, IL: Northwestern University Press, 1967);

the social sciences "is to obtain organized knowledge of social reality . . . the sum total of objects and occurrences within the social cultural world as experienced by the common-sense thinking of men living their daily lives among their fellow-men, connected with them in manifold relations of interaction. It is the world of cultural objects and social institutions."[48] This interpretation of the self, on connections between the subjective experience of the world and the relationship between different subjectivities—or persons—and how one reflects upon and gives meaning to these experiences carried over into the work of anthropologists looking to apply phenomenological analysis to their own interpretive work.[49]

Merleau-Ponty attended to analyzing the world of actual lived experience rather than "experience" as an abstraction. The nature of lived experience required thinking through the role of the senses, the perceptions, and the body as necessary and inescapable components. Therefore, he argued, it is not possible either to separate the mind from the body or to prioritize the one over the other. Instead, the discussion of consciousness must thus include sensory perceptions. Moreover, none of the senses operates in isolation; rather, it is in their complementary exchange—particularly in the service of action or some project—that an "I" emerges which, in turn, perceives, remembers, pays attention, and makes choices. It is an embodied subjectivity.

Embodiment, he suggests, is the way we know, express, and act in the world. His work thus also provides a theory of behavior. It makes for a body/subject, which is different from a mind/subject, but without eliminating awareness or reflection. Rather, the body, consciousness, and the world represent an interconnected, mutually informing network of perception.[50] Sociologist John O'Neill would go on to join Merleau-Ponty's work with that of Schütz in order to integrate the theory of the lived body and perception with the notion of the common-sense knowledge of the world.[51]

Collected Papers. Vol. 1, The Problem of Social Reality. (The Hague: Martinus Nijhoff, 1971); Alfred Schütz and Thomas Luckmann, *The Structures of the Life World*, trans. Richard M. Zaner and H. Tristram Engelhardt (Evanston, IL: Northwestern University Press, 1973); Alfred Schütz, *Life Forms and Meaning Structure*, trans. Helmut Wagner (Boston: Routledge, 1982); Alfred Schütz. "The Phenomenology of the Social World." *Contemporary Sociological Theory*. Eds. Calhoun, Craig, et al. Blackwell Readers in Sociology. Malden, MA: Blackwell Publishing, 2002. 32-41. See also Michael Barber, "Alfred Schutz," *Stanford Encyclopedia of Philosophy*, eds., Edward N. Zalta, Uri Nodelman, and Colin Allen (Stanford, CA: Stanford University, 2010), http://plato.stanford.edu/entries/schutz/.

48 Alfred Schütz, "Concept and Theory Formation in the Social Sciences," *Journal of Philosophy* 51, no. 9 (1954): 257-273.

49 See, for example, Helmut R. Wagner, "Toward an Anthropology of the Life-World: Alfred Schutz's Quest for the Ontological Justification of the Phenomenological Undertaking," *Human Studies* 6, no. 3 (1983): 239-46.

50 Maurice Merleau-Ponty, *Phenomenology of Perception*, trans. Colin Smith (New York: Humanities Press, 1962); *The Structure of Behavior*, trans. Alden L. Fisher (Boston: Beacon Press, 1963); *The Primacy of Perception, and Other Essays on Phenomenological Psychology* (Evanston, IL: Northwestern University Press, 1964); *Sense and Non-Sense*, trans. Hubert L. Dreyfus and Patricia Allen Dreyfus (Evanston, IL: Northwestern University Press, 1964); *The Visible and the Invisible*, trans. Alphonso Lingis (Evanston, IL: Northwestern University Press, 1968).

51 John O'Neill, *Perception, Expression and History: The Social Phenomenology of Maurice Merleau-Ponty* (Evanston, IL: Northwestern University Press, 1970); *The Communicative Body: Studies in Communicative Philosophy, Politics, and Sociology,* (Evanston, IL.: Northwestern University Press, 1989). See also Bernhard Leistle, "Some Notes on

Finally, Csordas, who builds on the work of these other phenomenologists, is one of the few anthropologists of religion who resists the general practice of reducing religion to an expression of other political, economic, sociological, or psychological forces. He has focused, instead, on the application of phenomenological theory to religious experience and theories of religion.[52]

For example, Csordas focuses not on ritual or clinical aspects of healing but rather on participants' experience of religious healing. He analyzes their accounts of the outcomes of the process in order to develop minimal criteria for efficacy. He considers the participants' orientation both toward and within the healing system, the meanings they assign to their experience, and how they navigate their way through their choices. He affirms the perspectives of the subjects, thereby reversing the ways in which they have routinely been marginalized by academic interpretation (much, I would suggest, as patient narratives have been undermined by translation into a diagnosis and a case).

In this undertaking, he emphasizes conceptions of embodiment. One of his primary contributions has been to propose that embodiment function as a core paradigm for the field of anthropology as a whole and that we integrate theories of embodiment into the discussion and theorizing of religion.[53] In the American Academy of Religion, this aim has taken form through the Body and Religion program unit, which "brings together scholars working with different methodologies who address body as a fundamental category of analysis in the study of religion."[54]

Through Traditions

Understanding Other Lifeworlds in Social and Cultural Anthropology," *Curare* 30, no. 2-3 (2007): 163-76, 286-87.

52 Thomas J. Csordas, "Elements of Charismatic Persuasion and Healing," *Medical Anthropology Quarterly* 2, no. 2 (1988): 121-42; *The Sacred Self: A Cultural Phenomenology of Charismatic Healing* (Berkeley: University of California Press, 1997); Thomas J. Csordas and Elizabeth Lewton, "Practice, Performance, and Experience in Ritual Healing," *Transcultural Psychiatry* 35, no. 4 (1998): 435-512; Jack Katz and Thomas J. Csordas, "Phenomenological Ethnography in Sociology and Anthropology," *Ethnography* 4, no. 3 (2003): 275-88.; Thomas J. Csordas, "Global Religion and the Re-Enchantment of the World," *Anthropological Theory* 7, no. 3 (2007): 295–314.

53 Thomas J. Csordas, "Embodiment as a Paradigm for Anthropology," *Ethos* 18 (1990): 5-47; "Somatic Modes of Attention," *Cultural Anthropology* 8, no. 2 (1993): 135-56; Thomas J. Csordas., ed., *Embodiment and Experience: The Existential Ground of Culture and Self* (New York: Cambridge University Press, 1994); Thomas J. Csordas, "The Body as Representation and Being-in-the-World," In *Embodiment and Experience: The Existential Ground of Culture and Self*, ed. Thomas J. Csordas (London: Cambridge University Press, 1994), 1-23; Thomas J. Csordas, *Body/Meaning/Healing* (New York: Palgrave Macmillan, 2002) (a collection of many of his earlier essays); and "Asymptote of the Ineffable: Embodiment, Alterity, and the Theory of Religion," *Current Anthropology* 45, no. 2 (2004): 163-84. See also Thomas Ots, "Phenomenology of the Body: The Subject-Object Problem in Psychosomatic Medicine and the Role of Traditional Medical Systems Herein," in *Anthropologies of Medicine: A Colloquium on West European and North American Perspectives*, eds. Beatrix Pfleiderer and Giles Bibeau (Braunschweig, Germany: Vieweg, 1991); Patricia Benner, ed., *Interpretive Phenomenology: Embodiment, Caring, and Ethics in Health and Illness* (Thousand Oaks, CA: Sage, 1994).

54 http://www.aarweb.org/Meetings/Annual_Meeting/Program_Units/PUinformation.asp?PUNum=AARPU188 (Accessed 12/2/2010).

As is the case in the larger discipline of Religious Studies, one can engage in the study of religion and healing through the portal of the different traditions, bearing in mind that the boundaries between them function frequently as artificial constructs that assist in the formation of identities and, in the scholarly world, in the exploration of social phenomena. In the following section, I will review examples of work in the field that illustrates how a tradition-based approach lends itself to the application of multiple methods and foci. I intend the examples to be suggestive and by no means comprehensive.

Greek Religions: The Cult of Asklepios

The healing cult of Asklepios affords us a good historical example. For a long time, histories of science and of medicine, as disciplines, constructed their accounts as a series of pivotal discoveries made by great men, within an even greater march toward progress. More recently, however, the two fields have gravitated instead toward looking at broader cultural and social trends and the contexts within which various forms of change occur. They have examined how related kinds of knowledge have developed. This orientation is evident, for example, in a study of the cult of Asklepios, which flourished alongside the increasing influence of Hippocratic practitioners who habitually turned away difficult chronic cases. At the same time, the government of Athens supported the entry of the cult into the city as part of its effort to expand its medical, political, and religious influence.

Alexia Petsalis-Diomidis focuses, instead, on the healing pilgrimage narrative of orator Aelius Aristides, who writes of his visions, the physical challenges, and the nature of the journey itself. She contextualizes his account in relation to her own fieldwork in Pergamon at the sanctuary of Asklepios, pointing to the architecture, offerings, and records of rituals. The cult illustrates, too, the inseparability of veneration, ritual, health seeking, and health through a communal practice.

But what did people in that lifeworld mean by "health," and what different interventions were required to acquire and maintain it? What was the usual life course, and how did it differ for men and for women? In part, the answer would depend on the nature of the illnesses of the day. What was the spectrum of options through which to address afflictions? What did this mean for women, for athletes, for people with disabilities, for practitioners of different types? Might one construe the votive symbols—miniature body parts—to represent not only the target of the healing, but also a representation of the experience of fragmentation brought on by illness?[55]

55 Bronwen L. Wickkiser, *Asklepios, Medicine, and the Politics of Healing in Fifth-Century Greece: Between Craft and Cult* (Baltimore: Johns Hopkins Press, 2008); Alexia Petsalis-Diomidis, *Truly Beyond Wonders: Aelius Aristides and the Cult of Asklepios* (New York: Oxford University Press, 2010); Michael T. Compton, "The Union of Religion and Health in Ancient Asklepieia," *Journal of Religion and Health* 37, no. 4 (1998): 301-12; Helen King, ed., *Health in Antiquity* (New York: Routledge, 2005); Jessica Hughes, "Fragmentation as Metaphor in the Classical Healing Sanctuary," *Social History of Medicine* 21, no. 2 (2008): 217-36. For discussion rooted in a biomedical frame, see Marek H. Dominiczak, "The Temple and the Plane Tree: Rationality and Cult at the Beginnings of Western Medicine," *Clinical Chemistry and Laboratory Medicine* 39, no. 10 (2001): 997-1000; and James E. Bailey, "Asklepios: Ancient

Hindu Illustrations

That therapeutic practices associated with a deeply pluralistic religious world would be equally pluralistic is not surprising. How one describes the scope and nature of those practices can vary greatly. Much in line with a history-of-religions approach deriving from the nineteenth century and prioritizing sacred texts over lived practice, one can lead off with a focus on versions of elite medical practice directly linked to Vedic texts. From this orientation, one might begin with Ayurvedic medicine and end with practices related to gods and goddesses, with astrology and the use of gemstones arrayed along the way. One might look for ways to make Ayurvedic practices look "scientific" along the lines of the biomedical. Or one could try to establish direct parallels with temple healing, on the one hand, and mental health clinics on the other. Or, to go in a different direction, one could begin with lived practice—home-based devotional *puja* to household shrines, for example, along with how what people wear, eat, and do is informed by a larger healthworld that does not preclude Ayurvedic practice but does not start out with it either.[56]

Frequently, traditions of gods characterize the divine as both afflicting and healing. In some cases, the same god does both, sometimes becoming identified with a particular sickness. For example, Sitala—the goddess associated with smallpox throughout India, although particularly in the north—can both bring the disease as well as cure it. In nineteenth-century Punjab, for example, her efficacy was linked to multiple factors, among them the coordination of variolation, or inoculation, with nourishment and cooling practices among the agrarian lower classes who turned to her shrines. Yet the specifics of variolation practices changed, over time, as did the involvement of the British colonial officials, in the course of which the role of the goddess underwent related changes in relation to the kinds of inoculation that were distributed and the ways in which this was done. The extent to which the officials collaborated with some forms of local healing in local dispensaries, even as they rejected others, challenges binary polarities such as colonizer/colonized or indigenous/western. More recently, as smallpox has been eradicated, the goddess's connection

Hero of Medical Caring," *Annals of Internal Medicine* 124, no. 2 (1995): 257-63. See also Margaret Trawick Egnor, "The Changed Mother or What the Smallpox Goddess Did When There Was No More Smallpox," in *Contributions to Asian Studies*, eds. Daniel E. Valentine and Judy F. Pugh. Vol. 18. (Leiden: E.J. Brill, 1984), 24-45. For a study on the medicalization of the hair of women devotees of a South Indian goddess, see Lucinda Ramberg, "Magical Hair as Dirt: Ecstatic Bodies and Postcolonial Reform in South India," *Culture, Medicine, and Psychiatry* 33 (2009): 501-22.

56 See, for example, Prakash N. Desai, *Health and Medicine in the Hindu Tradition: Continuity and Cohesion* (New York: Crossroad, 1989); "Health, Faith Traditions, and South Asian Indians in North America," in *Religion and Healing in America*, eds. Linda L. Barnes and Susan S. Sered (New York: Oxford University Press, 2005), 423-37; Hari Sharma et al., "Utilization of Ayurveda in Health Care: An Approach for Prevention, Health Promotion, and Treatment of Disease. Part 1—Ayurveda, the Science of Life," *Journal of Alternative and Complementary Medicine* 13, no. 9 (2007): 1011–19; "Utilization of Ayurveda in Health Care: An Approach for Prevention, Health Promotion, and Treatment of Disease. Part 2—Ayurveda in Primary Health Care," *Journal of Alternative and Complementary Medicine* 13, no. 10 (2007): 1135-50; R. Raguram et al., "Traditional Community Resources for Mental Health: A Report of Temple Healing from India," *British Medical Journal* 325 (2002): 38-40. For an illustration of the last example, see Vasudha Narayanan, "Shanti: Peace for the Mind, Body, and Soul," in *Teaching Religion and Healing*, eds. Linda Barnes and Ines Talamantez (New York: Oxford University Press, 2006), 61-82.

with sickness does not disappear; rather, she may become associated with a different one. Such illustrations point to the importance of reflection on theological dimensions of the goddess. But they also remind us to attend to the fluctuating constructions of those dimensions, which change in response to the parties involved, and to surrounding historical and cultural particularities.[57]

The gods in their various avatars reside in particular places and do not worry unduly about preserving the boundaries between traditions. Consequently, devotees identifying with Hindu, Christian, and Muslim communities may resort to each other's shrines, particularly when in need of healing. Their respective saints are seen as holders of sacred power that derives, on the one hand, from their connection with a specific deity. On the other, that power is not limited by one tradition, making it possible for them to lend their assistance to anyone who seeks it. It is possible for anyone to turn to the healing Mother in a Christian basilica and the infant Jesus in his shrine—or for Brahmin Hindu priests as well as Muslims to worship at the shrine of the god Babon Gaji, a Muslim during his lifetime (Gaji=Ghazi=Muslim warrior-monk), when searching for a cure for affliction.[58]

Socially assigned roles may undergo change as groups seek to reposition themselves to more advantageous social locations. One example involves the conversion of Dalits ("Untouchables") to Christianity, Islam, Sikhism, and Buddhism with the expectation that their lot will improve. They find, however, that they are not necessarily made welcome in these other larger communities, even as they lose legal protections afforded to them while they remain Hindu. Caste distinctions tend to remain in other forms in these other traditions, thereby reassigning the ex-Dalits to roles paralleling their old ones. Other groups, also defined religiously, may seek new identities linking them to healing. For example, the Aghori of north India, long known for their extreme asceticism and engagement with highly polluting sites and substances, have more recently shifted from stigmatizing substances to the healing of stigmatizing diseases, for which they employ a combination of their own version of Ayurveda, biomedicine, and ritual practices.[59]

Sickness is attributed to "natural" and "non-natural" causes, the meanings of both being contingent on context. In some instances there is no clear dividing line between the two. For example, in addition to recognizing the influence of environmental factors of different kinds and of internal imbalances, human relationships of different kinds may figure in causing illness. Ill will, anger, and unresolved conflict, for example, are regularly associated with sickness. Such tensions arise

57 See Lauren Minsky, "Pursuing Protection from Disease: The Making of Smallpox Prophylactic Practice in Colonial Punjab," *Bulletin of the History of Medicine* 83, no. 1 (2009): 164-90; and Projit Bihari Mukharji, "Structuring Plurality: Locality, Caste, Class, and Ethnicity in Nineteenth-Century Bengali Dispensaries," *Health & History* 9, no. 1 (2009): 80-105.

58 See Vasudha Narayanan, "Sacred Land, Common Ground, Contested Territory: The Healing Mother of Velankanni Basilica and the Infant Jesus Shrine in Bangalore," *Journal of Hindu-Christian Studies* 17 (2004): 20-32; Projit B. Mukharji, "Babon Gaji's Many Pasts: The Adventures of a Historian in a Counter-Archive," *Contemporary South Asia* 18, no. 1 (2010): 89-104.

59 Janet A. Contursi, "Political Theology: Text and Practice in a Dalit Panther Community," *Journal of Asian Studies* 52 (1993): 320-39; Vatsala Vedantam, "Still Untouchable," *Christian Century* 119, no. 13 (2002): 25-27; Ron Barrett, *Aghor Medicine: Pollution, Death, and Healing in North India* (Berkeley: University of California Press, 2008).

not only among the living but also between the living and the dead. The unhappy dead routinely play a part in causing illness, reminding us of the many ways in which they are viewed as remaining among the living, the relationship requiring ongoing attention.[60]

Buddhist Variations

The different religious traditions have historical, regional, and transnational variations, which take certain common variables and transmute them. For example, the Buddha's early advocacy of medical practice as an expression of compassion has led not only to the integration of Buddhist interpretive frames with local therapeutic practices; the Buddha himself appears as the Medicine Buddha, who not only has his own temples but also resides in the temples of other deities in mainland China as well as throughout the Chinese diaspora. Early Daoist temples in Northern California, for example, reserve the alcove on the far left of the altar for this Buddha. As teacher of the Dharma, he provides the remedy for human suffering.[61]

But common human experiences, like pregnancy, childbirth, and postpartum experience, also live within different religious worlds, which may permeate how such experiences are addressed, albeit as an unaddressed environment. In some cases, the commitments of the religious world inform the factors that the different parties must consider, particularly when systems interact—like, for example, during encounters between Tibetan medicine and religious culture and biomedicine. How, for example, do researchers address the ethical dimensions of securing informed consent when biomedical research mandates views of personhood—the individual, independent, choice-making agent, who must be informed of all possible risks and benefits—that do not align with other conceptualizations of self? How is prenatal care conceptualized, and what is viewed as a good birth? What changes does Tibetan medicine undergo, in the course of such interactions? For example, if herbal medicines are commonly compounded in formulas or mixed and shaped into pills, how must the biomedical research standard of the clinically controlled, randomized, double-blind study be modified in order not to distort the nature of the medicine? The alternative is to test a single ingredient, which is not how herbal ingredients are used in actual practice.[62]

60 Alison M. Spiro, "Najar or Bhut—Evil Eye or Ghost Affliction: Gujarati Views About Illness Causation," *Anthropology & Medicine* 12, no. 1 (2005): 61-73.

61 Raoul Birnbaum, *The Healing Buddha*, rev. ed. (Boston: Shambhala Publications, 2003). For a more popular account, see David Crow, *In Search of the Medicine Buddha: A Himalayan Journey* (New York: Tarcher, 2001).

62 Vincanne Adams et al., "Informed Consent in Cross-Cultural Perspective: Clinical Research in the Tibetan Autonomous Region, Prc," *Culture, Medicine, and Psychiatry* 31 (2007): 445-72; Andrea S. Wiley, "Increasing Use of Prenatal Care in Ladakh (India): The Roles of Ecological and Cultural Factors," *Social Science & Medicine* 55 (2002): 1089-102; Sarah Pinto, "Pregnancy and Childbirth in Tibetan Culture," in *Buddhist Women across Cultures: Realizations*, ed. Karma Lekshe Tsomo (Albany: SUNY Press, 1999), 159-68; Vincanne Adams et al., "Having a 'Safe Delivery': Conflicting Views from Tibet," *Health Care for Women International* 26 (2005): 821-51; Carrie Tudor et al., "Preliminary Progress Report: Randomized Double-Blind Trial of Zhi Byed 11, a Tibetan Traditional Medicine, Versus Misoprostol to Prevent Postpartum Hemorrhage in Lhasa, Tibet," *International Journal of Gynecology and Obstetrics* 94, supplement 2 (2006): S145-S46

Because Tibetan Buddhism has migrated throughout the world after the forced exile of Tibetans into India, the medicine tradition has had to find ways to sustain itself in different cultural environments. Likewise, for Tibetans living under Chinese governance in Tibet, facets ruled "superstitious" by the government have been suppressed or have had to go underground. In some cases, this results in modifications to existing diagnostic categories. For example, *rlung* (pronounced "loong")—the Tibetan term for wind or air, a vital life force—can become imbalanced. Such imbalance leads to dizziness, high blood pressure, heart palpitations, dysphoria, and, ultimately, insanity. Multiple factors can trigger the imbalance; to these factors have been added the tensions resulting from the politics of autonomy, independence, and human rights.[63] Abroad, in a country like the United States, when non-Tibetans convert to Tibetan Buddhism, they are likely to focus selectively on aspects of the tradition that appear to address their own concerns. Such selections can range from the biomedicalizing of practices like meditation to a focus on how Buddhist practice can address emotional ills.[64]

Jewish Healing Traditions

The tools from the history of religion are well employed to develop both broad and detailed analyses of medicine and healing within Jewish worlds. These can include studies related to episodes of affliction and healing occurring in the Hebrew Bible, overlapping with rabbinic commentaries and theological interpretation. They extend to encompass historical illustrations of Jewish engagement in surrounding medical cultures, as well as responses to other spheres of religious healing, including even the saints' shrines of other groups. They also entail collective healing in response to the great traumas of World War II. Overviews of the contemporary scenario in the United States and much of the available literature tend to focus on practices and commentaries that have grown out of Eastern European Ashkenazic heritage and experience, although Sephardic influences growing from the Iberian peninsula are sometimes touched on. Yet one can also consider the history of a more global formulation of healing, *tikkun olam*. The term, which has come to mean the charge to mend the brokenness of the created world through social justice, has migrated historically through a series of meanings, illustrating the fluidness of a term that compels the religious imagination over time.[65]

63 Craig R. Janes, "The Transformations of Tibetan Medicine," *Medical Anthropology Quarterly, New Series* 9, no. 1 (1995): 6-39. See also Eric Jacobson, "Panic Attack in a Context of Comorbid Anxiety and Depression in a Tibetan Refugee," *Culture, Medicine, and Psychiatry* 26 (2002): 259-79.

64 Bruce M. Sullivan, Bill Wiist, and Heidi Wayment, "The Buddhist Health Study: Meditations on Love and Compassion as Features of Religious Practice," *Crosscurrents* 60, no. 2 (2010): 185-207; for a related critique, see Wakoh Shannon Hickey, "Meditation as Medicine: A Critique," *Crosscurrents* 60, no. 2 (2010): 168-84; Daniel Goleman, ed., *Healing Emotions: Conversations with the Dalai Lama on Mindfulness, Emotions, and Health* (Boston: Shambhala, 1997).

65 Laura J. Praglin, "The Jewish Healing Tradition in Historical Perspective," *Reconstructionist* 63, no. 2 (1999): 6-15; Gerald J. Grudzen and Richard W. Bullet, *Medical Theory About the Body and the Soul in the Middle Ages: The First*

The ordering of life happens through the application of *halakha*—from *halakh* ("to go" or "to walk"), thereby suggesting "the way to go" or the path. Practically, it occurs through the implementation of the 613 commandments, or *mitzvot,* in the *Torah*, the Five Books of Moses. More broadly, it represents a way for humans to transform themselves into holiness through the acts of daily life. As such, it has invited—indeed required—commentary over time, including that of Moses ben Maimon, or Maimonides (1135-1204), a physician-philosopher. Among these acts are those related to medical decision making, which poses ongoing challenges in the face of emerging therapeutic technologies.[66] The *mitzvot* also shape how one relates to those who are sick, including the obligation to visit and comfort them, and to pray with them and on their behalf. Likewise, they provide guidance regarding care for the dying and the process of mourning.[67]

The preceding approaches tend to be prescriptive; although they may include case illustrations, their purpose is to provide more general guidance without necessarily specifying a branch of Judaism. Yet both historical and anthropological methods support the study of a particular branch—say, Hassidic Jews but from different cultural groups—or a role that emerges within a specific cultural

Western Medical Curriculum at Monte Cassino (Lewiston, NY: Edwin Mellen Press, 2007); Ephraim Shoham-Steiner, "Jews and Healing at Medieval Saints' Shrines: Participation, Polemics, and Shared Cultures," *Harvard Theological Review* 103, no. 1 (2010): 111-29; Ronald H. Isaacs, *Judaism, Medicine, and Healing* (Northvale, NJ: Jason Aronson, 1998); David M. Feldman, *Health and Medicine in the Jewish Tradition: L'hayyim—to Life* (New York: Crossroad, 1986); Emil L. Fackenheim, *To Mend the World: Foundations of Post-Holocaust Jewish Thought* (Bloomington: Indiana University Press, 1994); Gilbert S. Rosenthal, "*Tikkun Ha-Olam*: The Metamorphosis of a Concept," *Journal of Religion* 85, no. 2 (2005): 214-40; Eduardo Rauch, "Redeeming the Holy Sparks: Evil, Healing, and the Soul of the World," in *the Parabola Book of Healing*, eds. Bill Moyers, Lawrence E. Sullivan, and Anatole Broyard (New York: Continuum Publishing Company, 1994), 37-44.

66 As an introduction, see J. David Bleich. *Judaism and Healing: Halakhic Perspectives* (Hoboken, NJ: Ktav Pub. House, 2002 [1981]); Benjamin Freedman, *Duty and Healing: Foundations of a Jewish Bioethic* (New York: Routledge, 1999); Fred Rosner, "Payment for Healing on the Sabbath," *Journal of Halacha and Contemporary Society* 40 (2000): 59-67.

67 Barbara A. Olevitch, *Life Is a Treasure: the Jewish Way of Coping With Illness* (Brooklyn, N.Y.: Targum Press, 2010); National Center for Jewish Healing, *Guide Me Along the Way: A Jewish Spiritual Companion for Surgery* (New York, N.Y.: National Center for Jewish Healing, 2001); Joseph B. Meszler, *Facing Illness, Finding God: How Judaism Can Help You and Caregivers Cope When Body or Spirit Fail*, (Woodstock, VT: Jewish Lights Publishing, 2010); Miriam Dansky, *To Comfort, to Cure: Patients and their Families Talk About the Healing Power of Bikur Cholim* (Southfield, MI: Targum Press, 2006); Bat Tova Zwebner and Chana Shofnos, *The Healing Visit: Insights into the Mitzvah of Bikur Cholim* (Southfield, MI: Targum Press, 1989); Samuel Chiel and Henry Dreher, *For Thou Art With Me: The Healing Power of Psalms* (Emmaus, Pa.: Daybreak, 2000); Simkha Y. Weintraub, ed., *Healing of Soul, Healing of Body: Spiritual Leaders Unfold the Strength & Solace in Psalms* (Woodstock, Vt.: Jewish Lights Pub., 1994); Chai Lifeline, *Healing and Deliverance: A Collection of Psalms and Prayers in Times of Illness* (New York: Chai Lifeline, 1993); Hirshel Jaffe and H. Leonard Poller, eds., *Gates of Healing: A Message of Comfort and Hope* (New York: Central Conference of American Rabbis, 5749, 1988); Hara E. Person, ed., *The Mitzvah of Healing: An Anthology of Jewish Texts, Meditations, Essays, Personal Stories, and Rituals* (New York: UAHC, 2003); Amy Eilberg, *Jewish Principles of Care for the Dying* (New York: The National Center for Jewish Healing, 2001); Rabbi Herbert A. Yoskowitz, ed., *The Kaddish Minyan: From Pain to Healing: Twenty Personal Stories*, 2nd ed. (Austin, TX: Eakin Press, 2003); Anne Brener, *Mourning & Mitzvah: A Guided Journal For Walking the Mourner's Path through Grief to Healing: With Over 60 Guided Exercises*, 2nd ed. (Woodstock, VT.: Jewish Lights Pub., 2001 [1993]); Earl A. Grollman, *Living With Loss, Healing With Hope: A Jewish Perspective* (Boston: Beacon Press, 2000).

group. They lend themselves to cases where a Jewish group has incorporated strategies from other sources, whether deriving from practices like psychoanalysis or Facilitated Communication. They encompass, as well, local versions of older illness categories, such as demon affliction.[68]

In the United States, the broader countercultural interest in Eastern religions, meditation, and mysticism that gained ground during the 1960s and beyond filtered into American Judaism, contributing to a larger social phenomenon—the Jewish Renewal Movement. Although importing influences from other traditions, many of these changes were often formulated as a return to long-neglected Jewish texts or practices and as a healing transformation of American Jewish life, as well as a resistance to certain older cultural forms. Rather than viewing rabbinic figures as the sole arbiters of the tradition, men—and particularly women—elected to engage in Jewish learning at a far more sophisticated level that also addressed their alternative concerns.[69]

On the one hand, related inquiries sparked a new interest in Kabbalah, an esoteric branch of rabbinic Judaism that proposes to provide access to the inner meanings of the Hebrew Bible and related commentaries. In scholarly circles, this interest has translated into studies of individual Kabbalistic figures and communities. In more popular circles, however, it has generated sources

68 See, for example, Simon Dein, *Religion and Healing Among the Lubavitch Community in Stamford Hill, North London: A Case Study of Hasidism* (Lewiston: E. Mellen Press, 2004); Simon Dein, “The Power of Words: Healing Narratives among Lubavitcher Hasidim,” *Medical Anthropology Quarterly* 16, no. 1 (2002): 41-63.; Gil Daryn, “Moroccan Hassidism: The Chavrei Habakuk Community and Its Veneration of Saints,” *Ethnology* 37, no. 4 (1998): 351-72; Yoram Bilu and Eyal Ben-Ari, “The Making of Modern Saints: Manufactured Charisma and the Abu-Hatseiras of Israel,” *American Ethnologist* 19, no. 4 (1992): 672-87; Eyal Ben-Ari and Yoram Bilu, “Saints’ Sanctuaries in Israeli Development Towns: On a Mechanism of Urban Transformation,” *Urban Anthropology* 16, no. 2 (1987): 243-72; Yoram Bilu, “Rabbi Yaacov Wazana: A Jewish Healer in the Atlas Mountains,” *Culture, Medicine, and Psychiatry* 12, no. 1 (1988): 113-35; Yoram Bilu, “Sigmund Freud and Rabbi Yehudah: On a Jewish Mystical Tradition of ‘Psychoanalytic’ Dream Interpretation,” *Journal of Psychohistory* 2, no. 4 (1979): 443-63; Yoram Bilu and Yehuda C. Goodman, “What Does the Soul Say? Metaphysical Uses of Facilitated Communication in the Jewish Ultraorthodox Community,” *Ethos* 25, no. 4 (1997): 375-407; Howard Schwartz, “Spirit Possession in Judaism,” *Parabola* 19, no. 4 (1994): 72-76; Yoram Bilu, “The Moroccan Demon in Israel: The Case of ‘Evil Spirit Disease,’” *Ethos* 8, no. 1 (1980): 24-39; Yoram Bilu, “Demonic Explanations of Disease among Moroccan Jews in Israel,” *Culture, Medicine, and Psychiatry* 3, no. 4 (1979): 363-80.

69 Michael Lerner, *Jewish Renewal: A Path to Healing and Transformation* (New York: HarperPerennial, 1995); Susan S. Sered, “Healing as Resistance: Reflections Upon New Forms of American Jewish Healing,” in *Religion and Healing in America*, eds. Linda L. Barnes and Susan S. Sered (New York: Oxford University Press, 2005), 231-52; Valerie Joseph and Alana Suskin, “Servants before the King: Raising up the Healer to Leadership,” in *New Jewish Feminism*, ed. Elyse Goldstein (Woodstock, VT: Jewish Lights Pub., 2009), 382-96, 424-25; Simcha H. Benyosef, *Empowered to Heal: Therapeutic Visualizations Drawn from the Lunar Months*, (New York: Devorah Publications, 2008); William Cutter, ed., *Healing and the Jewish Imagination: Spiritual and Practical Perspectives on Judaism and Health* (Woodstock, VT: Jewish Lights Pub., 2007); Danny Siegel, *Healing: Readings and Meditations* (Pittsboro, N.C.: The Town House Press, 1999); Steven M. Rosman, *Jewish Healing Wisdom* (Northvale, NJ: Jason Aronson, 1997); Avraham Greenbaum, *The Wings of the Sun: Traditional Jewish Healing in Theory and Practice* (New York: Breslov Research Institute, 1995); Estelle Frankel, *Sacred Therapy: Jewish Spiritual Teachings on Emotional Healing and Inner Wholeness* (Boston: Shambhala, 2003); Kerry M. Olitzky, *Jewish Paths toward Healing and Wholeness: A Personal Guide to Dealing With Suffering* (Woodstock, VT: Jewish Lights Pub., 2000).

that bridge the learned and the self-help, making for a cultural product in its own right.[70] On the other hand, issues related to individual trauma and suffering also found their way into the purview of healing concerns.[71]

Healing in Christianity

From the time of the early church, Christ was recognized as the Great Physician who healed the ills of the world. The miracle stories in the gospels, along with the Pentecost narrative, provide models for the presence of the divine. The aspiration to imitate Christ—*imitatio Christi*—inspired martyrdom, dedication to a holy life, and eventually the conviction that some individuals had so deeply achieved this identification that they could perform miraculous healing while alive and that their remains could also effect healing following their deaths. Different traditions of sainthood emerged, as did the association of specific saints with specific afflictions and related devotions. Hagiographies—writings, and often biographies, of the saints—can transmit details about the times during which the saint lived, conveying content related to illnesses of the day. Clare Pilsworth argues, for example, that two ninth-century episcopal hagiographies from Italy complement archeological, textual, and charter evidence from other sources, thereby contributing to the study of medicine and disease. But the process of recognizing and canonizing saints has not ended. The Catholic Church continues to gather evidence of miracles, subjecting it to scientific testing to rule out phenomena that can be explained by other means. A review of Vatican sources related to 1,400 episodes from six centuries (1588-1999) disclose the details of daily life among the poor and other groups who do not necessarily document their own histories. As Jacalyn Duffin notes, much of the evidence includes medical care and physician testimony.[72]

70 Lawrence Fine, *Physician of the Soul, Healer of the Cosmos: Isaac Luria and His Kabbalistic Fellowship* (Stanford: Stanford University Press, 2003); Jody E. Myers, *Kabbalah and the Spiritual Quest: the Kabbalah Centre in America* (Westport, CT: Praeger, 2007); Abner Weiss, *Connecting to God: Ancient Kabbalah and Modern Psychology* (New York: Bell Tower, 2005); Raphael Kellman, *Matrix Healing: Discover Your Greatest Health Potential Through the Power of Kabbalah* (New York: Harmony Books, 2004); Melinda Ribner, *Everyday Kabbalah: A Practical Guide to Jewish Meditation, Healing, and Personal Growth* (Secaucus, NJ: Carol Pub. Group, 1998); Joseph H. Gelberman with Lesley Sussman, *Physician of the Soul: A Modern Kabbalistic Approach to Health and Healing* (Freedom, CA: Crossing Press, 2000); Matityahu Glazerson, *Torah, Light, and Healing: Mystical insights into Healing Based on the Hebrew Language* (Jerusalem: Lev Eliahu, 5754, 1993); Yaella Wozner, *Everyday Miracles: The Healing Wisdom of Hasidic Stories* (Northvale, NJ: J. Aronson, 1989).

71 Rachel Lev, *Shine the Light: Sexual Abuse and Healing in the Jewish Community* (Boston: Northeastern University Press, 2003); Diane Gardsbane, ed., *Healing & Wholeness: A Resource Guide on Domestic Violence in the Jewish Community* (Washington, DC: Jewish Women International, 2002); Kerry M. Olitzky, *Recovery from Codependence: A Jewish Twelve Steps Guide to Healing Your Soul* (Woodstock, VT: Jewish Lights Pub., 1993); Marc Gellman, *And God Cried, Too: A Kid's Book of Healing and Hope* (New York: HarperTrophy, 2002).

72 R. Gerald Guest, *The Healing Saints of Medicine* (Stouffville, ON: Arma Dei Publishing, 2005); Clare Pilsworth, "Medicine and Hagiography in Italy C. 800—C. 1000," *Social History of Medicine* 13, no. 2 (2000): 253-64. A related topic involves the shrines that grew up at the tombs of saints as well as the related pilgrimages by those seeking healing.

As participants in larger cultures, Christians were enculturated into contemporary understandings of illness, disease, therapeutic interventions, medicine, practitioners, and possible outcomes. Early Christians, for example, combined the use of naturalistic illness models with Greek and Roman medical knowledge at the same time as they accepted the possibility of demonic possession and the need for exorcism and other forms of miraculous healing. On the other hand, they accepted that not all Christians would perform miracles but could nevertheless help the sick through medical care and charity. The medicine used would depend on when and where Christians found themselves. Likewise, Christian understandings of the self as including a soul informed early therapeutic models.[73]

The commitment to care for the sick was linked to the project of proselytization, resulting in medical and health care ministries both locally and abroad. Historically, these ministries functioned as medical missions, many of them operating alongside larger projects of colonization and intent on converting the colonized. Therapeutic efficacy was intended to convey not only the superiority of the invading culture but also the power of its religious traditions. Yet the outcome of the interchange varied, and it cannot be assumed that the colonized accepted the new medicine uncritically or that they ceased to use their own practices. For example, the Maryknoll Sisters in Guatemala introduced clinics, a nursing school, a midwifery program, and a program of health promoters. The Mayas, however, were selective in their acceptance, although what they did adopt they then helped to disseminate. Likewise, they worked out their own synthesis and transformation of Catholicism, biomedicine, and their own religious worldviews and therapies. Similarly, the indigenous peoples in the Ecuadorian Andean parish of Salasaca have sustained their own practices while adapting to Catholic traditions. These practices included shamans and mountain spirits, sometimes framed in terms of selected elements from Catholicism.[74]

Christian health ministries in a home setting have different agendas that may include introducing religious dimensions into the assessment of patients, elevating the "spiritual" dimensions of care, examining underlying religious dimensions of patients' explanatory models, and studying the potential impact of religiosity on biomedical outcomes. For some health care ministries, the latter, in particular, can function not only as a core conviction for the particular congregation but also as an important part of their message to others. This may be especially the case when faith healing stands at the heart of the group's theology, some of which may be culturally conservative, while others link their faith with engagement in social reform and service. Still others have provided a

73 Gary B. Ferngren, *Medicine and Health Care in Early Christianity* (Baltimore: Johns Hopkins University Press, 2009); Gerald J. Grudzen and Richard W. Bullet, *Medical Theory About the Body and the Soul in the Middle Ages: The First Western Medical Curriculum at Monte Cassino* (Lewiston, NY: Edwin Mellen Press, 2007). For more recent examples, see related chapters in Barnes and Sered, eds., *Religion and Healing in America.*

74 For interactions between Christian missionaries and the Chinese, see Linda L. Barnes, *Needles, Herbs, Gods, and Ghosts: China, Healing, and the West to 1848* (Cambridge, MA: Harvard University Press, 2005); Susan Fitzpatrick Behrens, "Maryknoll Sisters, Faith, Healing, and the Maya Construction of Catholic Communities in Guatemala," *Latin American Research Review* 44, no. 3 (2009): 27-49; Rachel Corr, *Ritual and Remembrance in the Ecuadorian Andes* (Tuscon: University of Arizona Press, 2010).

voice for women through the sanctioned profession of their testimonies. For some of these ministries, understanding the culture of the congregation, and constructing a ministry in relation not only to individual health but also that of a community, assumes a different primacy.[75]

Following evangelical faith healing, perhaps the religion most routinely identified with healing and faith and the rejection of biomedical care is the Church of Christ, Scientist or Christian Science. It was founded by Mary Baker Eddy (1821-1910) in 1879 to promote the "Science of Mind." Eddy claimed to have healed herself and discovered a healing power linked to human's being fashioned in the image of God. Popular during the last decades of the nineteenth century and into the twentieth, it then gradually lost ground. More recently, Christian Science, along with versions of Christian faith healing, has been legally targeted in pediatric cases for which biomedical care has been denied. However, the more complex history of tensions between allopathic medicine and Christian Science requires more in-depth discussion of the emergence of the former in the nineteenth century and how both utilized such constructs as "science."

What is usually less well known is the turning by some American Jews to Christian Science, to the alarm of Reform rabbis who countered with Jewish Science. It promoted a vision of health and happiness and of God as the source of healing, along with the power of visualization and affirming prayer. Thousands (and possibly hundreds of thousands) of Jews were influenced, although relatively few affiliated themselves formally.[76]

Islamic Starting Points

The roots of Muslim orientations to medicine and healing derive from the Prophet Muhammad, who provided therapeutic advice to his community as well as council related to health, knowledge, and inquiry into the natural world. As the living paradigm for what it meant to be Muslim, Muhammad's revelations, sayings, and actions have served as the model for what unfolded as Islamic medicine.[77] One approach, therefore, to the study of this tradition takes as its starting point those

75 Margaret A. Wills, ed., *Communicating Spirituality in Health Care* (Cresskill, NJ: Hampton Press, 2009); William F. Haynes and Geffrey B. Kelly, *Is There a God in Health Care? Toward a New Spirituality of Medicine* (New York: Haworth Pastoral Press, 2006); Heather D. Curtis, *Faith in the Great Physician: Suffering and Divine Healing in American Culture, 1860-1900* (Baltimore: Johns Hopkins University Press, 2007); James W. Opp, *The Lord for the Body: Religion, Medicine, and Protestant Faith Healing in Canada, 1880-1930* (Montreal: McGill-Queen's University Press, 2005); Mary Chase-Ziolek, *Health, Healing, and Wholeness: Engaging Congregations in Ministries of Health* (Cleveland: Pilgrim Press, 2005).

76 See Rolf Swensen, "Pilgrims at the Golden Gate: Christian Scientists on the Pacific Coast, 1880-1915," *Pacific Historical Review* 72, no. 2 (2003): 229-63; Deidre Michell, *Christian Science: Women, Healing, and the Church* (Lanham, MD: University Press of America, 2009); Shawn F. Peters, *When Prayer Fails: Faith Healing, Children, and the Law* (New York: Oxford University Press, 2008); Rennie B. Schoepflin, *Christian Science on Trial: Religious Healing in America* (Baltimore: Johns Hopkins University Press, 2003); Ellen M. Umansky, *From Christian Science to Jewish Science: Spiritual Healing and American Jews* (New York: Oxford University Press, 2005).

77 Ibn Qayyim al-Jawziyyah and Muhammad ibn Abī Bakr, *Medicine of the Prophet*, trans. Penelope Johnstone (Cambridge: Islamic Texts Society, 1998); Osman Bakar, *Tawhid and Science: The History and Philosophy of Islamic*

aspects that are more tightly connected with the textual tradition. One then includes the work of great physician-philosophers like Abū ʿAlī al-Ḥusayn ibn ʿAbd Allāh ibn Sīnā, or ibn Sīnā (c. 980-1037, Latinized as Avicenna), whose translations and interpretations of older Greek texts exercised an immeasurable influence on the medicine of Europe and North Africa. Popular versions—sometimes classified as "folk medicine"—tend to be treated more peripherally in such accounts, if at all.[78]

Yet, as with each of the other religious traditions, the broader topic lends itself to historical study and analysis not only in its more elite forms but also through variations thereof, popularized local versions, and the interchange between them. Islam, as a worldwide tradition, has acculturated into different national and regional environments while also exercising its own influence on these different settings. Equally varied local versions of Islamic approaches to medicine and healing have come about as a result. Each is important to consider insofar as it illuminates those aspects of the tradition that have been most compelling to particular individuals or groups in their own engagement in healing.[79]

A conceptual focus on gendered differences in practice has led to studies of women healers. Within this greater world of practice, we also find not only the more formally articulated branches of Islamic medicine but also spirits of different kinds. These can possess individuals, sometimes for their hosts' good and sometimes making them sick. These spirits, or *jinn/djinn*, are alluded to in the *Qu'ran* and can enter time and space through the possession and entrancement of individuals. In some instances, they expand the sense of self in the individual. The self can thereby come to encompass the spirit. If a white *djinn*, the possession will have relatively little impact; if a black *djinn*, the person may then fall seriously ill and require exorcism. Yet even if exorcised, the spirit may simply reside in the space above the person's head and may reenter at any time. In most cases, the person possessed is a woman.[80] These examples engage us in the broader issue of interactions

Science (Cambridge: Islamic Texts Society, 1999); Peter E. Portmann and Emilie Savage-Smith, *Medieval Islamic Medicine* (Baltimore: Georgetown University Press, 2007); Seema Alavi, *Islam and Healing: Loss and Recovery of an Indo-Muslim Medical Tradition, 1600-1900* (Basingstoke, NY: Palgrave Macmillan, 2008); Gerald J. Grudzen and Richard W. Bullet, *Medical Theory about the Body and the Soul in the Middle Ages: The First Western Medical Curriculum at Monte Cassino* (Lewiston, NY: Edwin Mellen Press, 2007).

78 Fazlur Rahman, *Health and Medicine in the Islamic Tradition: Change and Identity* (New York: Crossroad, 1987).

79 See, for example, C. B. M. Hoffer, "The Practice of Islamic Healing," in *Islam in Dutch Society: Current Developments and Future Prospects*, eds. W. A. R. Shadid and P. S. Koningsveld (Kampen, The Netherlands: Kok Pharos Publishing House, 1992), 40-53; Judy F. Pugh, "The Semantics of Pain in Indian Culture and Medicine," *Culture, Medicine, and Psychiatry* 15, no. 1 (1991): 19-43; Paula Schrode, "The Dynamics of Orthodoxy and Heterodoxy in Uyghur Religious Practice," *Die Welt des Islams* 48 (2008): 394-433.

80 Joyce Burkhalter Flueckiger, *In Amma's Healing Room: Gender and Vernacular Islam in South India* (Bloomington: Indiana University Press, 2006); Sylvia Wing Önder, *We Have No Microbes Here: Healing Practices in a Turkish Black Sea Village* (Durham: Carolina Academic Press, 2007); Amber Haque, "Spirits and Selves in Northern Sudan: The Cultural Therapeutics of Possession and Trance," *American Ethnologist* 15, no. 1 (1988): 4-27; Janice Boddy, "Spirit Possession Revisited: Beyond Instrumentality," *Annual Review of Anthropology* 23 (1994): 407-34; J. Nourse, "The Voice of the Winds Versus the Masters of Cure: Contested Notions of Spirit Possession among the Lauje of Sulawesi," *Journal of the Royal Anthropological Institute* 2, no. 3 (1996): 425-42; Barbara Drieskens, *Living with*

between humans and spirits, particularly because they add a dimension to the broader question of embodiment, on the one hand, and, on the other, to conceptions and experiences of other forces.

Immigrants from South Asia and the Ottoman Empire entered the United States beginning in the latter part of the nineteenth century. American Muslims are now, in descending order, primarily African American, Arab American, South Asian American, and of other origins, including European American converts. Although there are Muslim groups whose presence in the U.S. dates back to the nineteenth century, some two-thirds are immigrants and their descendants and are under forty years old. This cultural pluralism has led to equally varied histories with and perceptions of Islamic religious healing. Related practitioners range from immigrant Sufi sheikhs to home-based practices related to Fatima, daughter of Muhammad by his first wife, and conducted by women. Practices also include orientations favored by converts of various dispositions, some of them clearly influenced by the complementary and alternative medicines popular within the larger culture.[81]

Yet the tradition as a whole has also historically favored engagement with the sciences and dominant medicine systems of the day, making it important to examine intercultural processes involving Muslim groups, the larger cultures of biomedicine, and Muslim biomedical professionals. The more frequently recognized aspect of this interaction takes the form of bioethical discussions about whether certain biomedical procedures are acceptable under the purview of Islamic law (*Sharia*) as a lived practice.[82]

But a different tack takes us to ways in which biomedical literature represents Muslims, reflecting some of the influences that inform the opinions and perceptions of researchers, clinicians, and educators within the cultures of biomedicine. Yet that same literature also provides examples of perceptions by Muslim patients of non-Muslim doctors along with examples of health disparities facing these patients in the U.K. and the U.S. We also find that some Muslim physicians have founded clinics in different parts of the country, broadening the scope of discussion of faith-based organizations.[83]

Djinns: Understanding and Dealing with the Invisible in Cairo (San Francisco: Saqi, 2008).

81 Marcia Hermansen, "Dimensions of Islamic Religious Healing in America," in *Religion and Healing in America*, eds. Linda L. Barnes and Susan S. Sered (New York: Oxford University Press, 2005), 407-22; Noor Kassamali, "Healing Rituals and the Role of Fatima," in *Religious Healing in Boston: Body, Spirit, Community*, ed., Susan S. Sered (Cambridge, MA: Center for the Study of World Religions, Harvard University, 2005); G. M. Chishti, *The Traditional Healer's Handbook: A Classic Guide to the Medicine of Avicenna* (Rochester, VT: Healing Arts Press, 1991); Amira Avad and Jamila Hakam, *Healing Body & Soul: Your Guide to Holistic Wellbeing Following Islamic Teachings* (Riyadh: International Islamic Publishing House, 2008); and Robert Frager, *Heart, Self, & Soul: The Sufi Psychology of Growth, Balance, and Harmony* (Wheaton, IL: Quest Books, 1999).

82 See, for example, J. E. Brockop, "Islamic Ethics of Saving Life: A Comparative Perspective," *Medicine & Law* 21, no. 1 (2002): 225-41; Abdulaziz Sachedina, "End-of-Life: The Islamic View," *Lancet* 366, no. 9487 (2005): 774-79; Marcia C. Inhorn, "He Won't Be My Son," *Medical Anthropology Quarterly* 20, no. 1 (2006): 94-120; Dariusch Atighetchi, *Islamic Bioethics: Problems and Perspectives* (New York: Springer Verlag, 2007); Jonathan E. Brockopp and Thomas Eich, eds., *Muslim Medical Ethics: From Theory to Practice* (Columbia, SC: University of South Carolina Press, 2008); Abdulaziz Abdulhussein Sachedina, *Islamic Biomedical Ethics: Principles and Application* (New York: Oxford University Press, 2009).

83 Ghazala Mira and Aziz Sheikh, "'Fasting and Prayer Don't Concern the Doctors . . . They Don't Even Know What

By Regions and Transnationalities

Because traditions generally coexist within regions and, increasingly, as transnational phenomena, one can examine religion and healing through the phenomenon of indigenous traditions, local forms of pluralism, and the impacts of globalization, postcolonial history, and international economics and politics. The movement of traditions both within a region and across boundaries is prompted by as many factors as generate international migration, refuge-and-asylum seeking, spiritual seeking, and cultural tourism or appropriation. Those who relocate may hold documented or undocumented status or may travel on student or tourist visas. Their reception will vary, ranging from welcome, to indifference, to degrees of hostility. New technologies expedite communication across multiple boundaries, with audio and video recordings making it possible to become a virtual attendant at a ceremony or ritual. Possessing spirits may issue their messages into the recording as well. Nor is the process unidirectional. It involves the selective retention or adoption of particular facets of practice for strategic reasons and sometimes under the duress of being in a new location where one can no longer access necessary materials or paraphernalia.

To illustrate this process, in this section I will review two clusters: the Yorùbá religious tradition of West Africa and one of its descendants, the Cuban tradition of Regla de Ocha, or Santería, along with some illustrations of intersecting Chinese medicine and healing. Both clusters represent therapeutic systems still present in their countries of origin as well as flourishing internationally. Both bring different dimensions to the study of religion and healing.

Yorùbá Religious Tradition

The continent of Africa has a myriad of traditional religious traditions, which make it virtually impossible to make categorical statements about "African Religion." Nonetheless, scholars of African religions sometimes refer to the phenomenon in the singular, in which case they usually mean the indigenous religious traditions, in contrast with Christianity or Islam, and the discussion is often theological.[84] But to avoid generalizations, it is useful to speak of a particular tradition

It Is': Communication, Decision Making, and Perceived Social Relations of Pakistani Muslim Patients with Long-Term Illnesses," *Ethnicity & Health* 15, no. 4 (2010): 317-42. See also Lance D. Laird et al., "Muslim Patients and Health Disparities in the U.K. and the U.S.," *Archives for Diseases of the Child* 92 (2007): 922-26; Lance D. Laird and Wendy Cadge, *Caring for Our Neighbors: How Muslim Community-Based Health Organizations Are Bridging the Health Care Gap in America* (Clinton Township, MI: Institute for Social Policy and Understanding, 2008); Lance D. Laird and Wendy Cadge, "Constructing American Muslim Identity: Tales of Two Clinics in Southern California," *Muslim World* 99, no. 2 (2009): 270-93; Lance D. Laird and Wendy Cadge, "Negotiating Ambivalence: The Social Power of Muslim Community-Based Health Organizations in America," *Political and Legal Anthropology Review* 33, no. 2 (2010): 225-44; Lance D. Laird and Wendy Cadge, "Muslims, Medicines, and Mercy: Free Clinics in Southern California," in *Not by Faith Alone: Social Services, Social Justice, and Faith-Based Organizations in the U.S.*, eds. Julie Adkins, Laurie Occhipinti, and Tara Hefferan (Lanham, MD: Lexington Books, 2010). For resources pertinent for biomedical physicians, see http://www.bu.edu/bhlp/Resources/Islam/health/index.html.

84 See, for example, Douglas E. Thomas, *African Traditional Religion in the Modern World* (Jefferson, NC: McFarland

from a particular place. A growing body of rich scholarship, particularly that of Jacob Olupona, has illuminated the complexities of the Yorùbá religious tradition from southwestern Nigeria and Benin. The tradition holds to a single creator, Olódùmarè, or Olòrún, on whose behalf a collective of intermediary guardian forces, or Òrìsà, act among humans. Through one of them, Ẹlégbara, or Eṣu, a person can convey prayers and queries to Orunmila, the second to Olódùmarè, by means of *àṣẹ* (ashay), an all-permeating life-giving force. Ẹlégbara opens the way (although he can also impose obstacles as well) through divination with the Odú Ifá.[85]

The tradition as a whole has involved healing, making it a critical illustration of how complicated it is to assume that religion and healing function as distinct categories in any number of traditions. For example, each of the Òrìsàs represents a particular aspect of Olódùmarè and of *àṣẹ*, and each oversees a domain of nature and of human life. Verses, stories, songs, and other narratives provide the gateways into which the petitioner can examine his or her experience to reflect on steps to take and not to take to heal a situation. All the Òrìsàs can assist a petitioner in cases of sickness, although one in particular—Shopona, or Babalú-Ayé—has historically been associated with both afflicting and healing with smallpox and, more recently, HIV/AIDS.[86]

The transatlantic slave trade resulted in the deaths of between one and almost two and one-half million Africans; those that survived were enslaved for generations. The Òrìsàs traveled with the enslaved Africans, putting down roots in what would become Cuba, Puerto Rico, Haiti, Brazil, Jamaica, Trinidad, and the United States and eventually into other countries; through processes of forced conversion to Christianity, they found ways to take on enough Catholic iconography to survive. In an unanticipated process, it became a world religion, even as many of its followers simultaneously identified as Catholic.[87]

& Company, 2005); E. Bọlaji Idowu, *African Traditional Religion: A Definition* (New York: Orbis Books, 1973).

85 See Peter Rutherford McKenzie, *Hail Orisha! A Phenomenology of a West African Religion in the Mid-Nineteenth Century*, (New York: Brill, 1997). Jacob K. Olupọna, "The Study of Yoruba Religious Tradition in Historical Perspective," *Numen* 40, no. 3 (1993): 240-73; Wande Abimbola, *Ifá Will Mend Our Broken World* (Roxbury, MA: AIM Books, 1997); Judith Gleason with Awotunde Aworinde and John Olaniyi Ogundipe, *A Recitation of Ifa, Oracle of the Yoruba* (New York: Grossman Publishers, 1973).

86 For more general information on the òrìsàs, see Toyin Falola and Ann Genova, eds., *Orisa: Yoruba Gods and Spiritual Identity in Africa and the Diaspora* (Trenton: Africa World Press, 2004); For sources directly focused on issues related to sickness and medicine, see "The God of Smallpox: Aspects of Yoruba Religious Knowledge," *Journal of Religion in Africa* 55, no. 2 (1985): 187-200. See also Norma H. Wolff, "The Use of Human Images in Yoruba Medicines," *Ethnology* 39, no. 3 (2000): 205-24. For a discussion of the role of ancestors, see Jacob Olupona, "To Praise and to Reprimand: Ancestors and Spirituality in African Society and Culture," in *Ancestors in Post-Contact Religion: Roots, Ruptures, and Modernity's Memory*, ed. Steven J. Friesen (Cambridge, MA: Center for the Study of World Religions, Harvard Divinity School, 2001), 49-63.

87 Theodore L. Trost, *The African Diaspora and the Study of Religion* (New York: Palgrave Macmillan, 2007); Jacob K. Olupona and Terry Rey, eds., *Òrìsà Devotion as World Religion: The Globalization of Yorùbá Religious Culture* (Madison, WI: University of Wisconsin Press, 2008); Olatunji Ojo, "'Heepa' (Hail) Orisa: The Orisa Factor in the Birth of Yoruba Identity," *Journal of Religion in Africa* 39, no. 2 (2009): 30-59; Jacob K. Olupona, ed., *African Traditional Religions in Contemporary Society* (New York: International Religious Foundation, 1991); Jacob K. Olupona and Regina Gemignani, eds., *African Immigrant Religions in America* (New York: New York University Press, 2007).

In Cuba its variations and branches became Regla de Ocha, Santería, Lukumi, and Palo Mayombe, among others, each representing the legacies of varied strains of combined traditions and reflecting the impact of colonial history. Each of the Orishas[88] took on new aspects while carrying over core elements of their original selves as processes of divination, ritual, and the veneration of Orishas and ancestors underwent corresponding adaptations.[89]

The living art that has given the religion embodied form has, likewise, acculturated. For example, in the experience of trance-possession, a given Orisha "mounts" the devotee and expresses him- or herself through a recognize dance. Each person who undergoes a full course of initiation is divined to be a "child" of a particular Orisha and, in gatherings to honor that Orisha, will dress in ceremonial garb that reflects the spirit's colors, iconography, and mannerisms. When petitioning for help with a problem or affliction, the gifts one makes are indicated through the divination process and reflect that spirit's preferences.[90]

One approaches the Orishas with the assistance of a *Babalawo* or *Santero/a* who has been initiated, trained, and authorized to carry out the necessary divinatory skills. This role has been compared with that of a local therapist, but the combination of spiritual and life advice may also intersect with recommendations of a variety of herbal remedies, making the practitioner a local herbalist and healer as well—a role embedded within and inseparable from its sacred frame.[91]

88 When referring to the spirits in Africa, I refer to them as *òrìsàs*; when referring to their presence abroad, I use the term *orishas.*

89 See, for example, Harry G. Lefever, "When the Saints Go Riding In: Santeria in Cuba and the United States," *Journal for the Scientific Study of Religion* 35, no. 3 (1996): 318-30; Elizabeth Perez, "The Virgin in the Mirror: Reading Images of a Black Madonna through the Lens of Afro-Cuban Women's Experiences," *Journal of African American History* 95, no. 2 (2010): 202-28; Joel E. Tishken, Toyin Falola, Akintunde Akinyemi, eds., *Sàngó in Africa and the African Diaspora* (Bloomington: Indiana University Press, 2009); Joseph M. Murphy and Mei-Mei Sanford, *Osun Across the Waters: A Yoruba Goddess in Africa and the Americas* (Bloomington: Indiana University, 2001). Murphy's work has been critical in tracing the variations in the religion in different New World settings. See, for example, Joseph M. Murphy, *Working the Spirit: Ceremonies of the African Diaspora* (Boston: Beacon Press, 1994); Joseph M. Murphy, *Santería: African Spirits in America* (Boston: Beacon Press, 1993). For an example of discussions of the divinatory system that emerged, see Ócha'ni Lele, *The Diloggun: The Orishas, Proverbs, Sacrifices, and Prohibitions of Cuban Santeria* (Rochester, VT: Destiny Books, 2003). The orishas have entered popular culture as well: comics artist Joe Quesada, editor-in-chief of Marvel Comics, has created the characters the "Santerians." Each one is dedicated to and possessed by a specific orisa—represented as a force of nature—who bestows powers on the individual. See http://www.santerians.com/index.html. The orisas have also found their way onto a myriad of websites. For an analysis, see Stefania Capone, "Les dieux sur le Net. L'essor des religions d'origine africaine aux États-Unis [Gods on the Net: The Rise of Religions of African Origin in the United States]," *L'Homme* 151 (1999): 47-74.

90 See, for example, Yvonne Daniel, *Dancing Wisdom: Embodied Knowledge in Haitian Vodou, Cuban Yoruba, and Bahian Candomblé* (Chicago: University of Illinois Press, 2005); David H. Brown, *Santería Enthroned: Art, Ritual, and Innovation in an Afro-Cuban Religion* (Chicago: University Of Chicago Press, 2003); Joseph M. Murphy. "Objects that Speak Creole: Juxtapositions of Shrine Devotions at Botanicas in Washington, DC," *Material Religion* 6, no. 1 (2010): 86-108.

91 For discussions of Santeria as a tradition of healing, see Roy Moodley and Patsy Sutherland, "Psychic Retreats in Other Places: Clients Who Seek Healing with Traditional Healers and Psychotherapists," *Counseling Psychology Quarterly* 23, no. 3 (2010): 267-82; Andrés Rodriguez Reyes, "Illness and the Rule of Ocha in Cuban Santeria,"

Race/Ethnicity/Tribe

By this point, it should be abundantly clear that the categories and sections I have used so far are inherently limited. Disciplines flow into one another. Religious/therapeutic traditions blur at the edges. Individuals may have multiple citizenships, while the borders of states and nations are imperfectly absolute. To render the situation even more complex (and interesting), one must account for the ways in which race and ethnicity transect each of these other categories, while also noting shifting definitions and cultural meanings assigned to each one. The alternative is to assume that majority-group experiences stand as the norm, thereby denying the vitality and influence of other cultural versions. Moreover, the part played by power disparities, overlaid on race and ethnicity—along with the historical variations of both—, is rendered invisible. So, here, I suggest some entry points to two groups drawn from the United States—African American and Native American, with the latter focusing on one tribe, the Navajo.

African American

African-descended Americans now represent multiple historical waves of entry into the country beginning with the Atlantic Slave Trade and continuing through to the present. One must now speak of Afro-Caribbeans, Afro-Latinos from other parts of Latin America, and African immigrants who include visiting students, professionals, and business people as well as refugees and asylees. At the same time, exchanges between the continents, with African-descended Americans returning to Africa for multiple reasons, had begun by the nineteenth century. One must therefore specify. Here, I limit my comments to African Americans descended from the enslaved Africans.[92]

The healing practices that circulated among this group and their descendants varied according to whether individuals were enslaved or freed; were a man or a woman; lived in an urban or rural setting; were literate or illiterate; were old enough to have learned practices in a country of origin or had access to others who were passing such practices along as an oral tradition; were able to

Transforming Anthropology 12, no. 1-2 (2004): 75-79; Johan Wedel, *Santeria Healing: A Journey into the Afro-Cuban World of Divinities, Spirits, and Sorcery* (Gainesville, FL: University of Florida Press, 2003). See also Margarite Fernández Olmos and Lizabeth Paravisini-Gebert, eds., *Healing Cultures: Art and Religion as Curative Practices in the Caribbean and Its Diaspora* (New York: Palgrave Macmillan, 2001). For sources on the religion's natural pharmacopeia as well as more widely publicized use of heavy metals (mercury in particular), see Erica Moret, "Afro-Cuban Religion, Ethnobotany, and Healthcare in the Context of Global Political and Economic Change," *Bulletin of Latin American Research* 27, no. 3 (2008): 333-50; James R. Gill, Christopher W. Rainwater, and Bradley J. Adams, "Santeria and Palo Mayombe: Skulls, Mercury, and Artifacts," *Journal of Forensic Sciences* 54, no. 6 (2009): 1458-62. It should be noted that although mercury use necessarily gains media and biomedical attention, it is only one substance within a much larger herbal repertoire.

92 The Schomberg Center for Research in Black Culture makes digitally available materials and resources from its exhibit "In Motion," which traces the different periods of migration from African countries into what would become the United States. See http://www.inmotionaame.org/migrations/resources.cfm;jsessionid=f83047212129880679093 6?type=text&bhcp=1.

participate in an African-rooted indigenous tradition, an Africanized form of Christianity and/or only a majority-culture church, or Islam; had access to mainstream medical education (regular or irregular—e.g., homeopathy, naturopathy, etc.). The region of the country as well as the histories and legacies of colonization—including their religious influences—also mattered. The nature of the labor to which individuals were assigned if enslaved, or the work available to them, if free, played a part as well. All such factors make it virtually impossible to generalize about African American approaches to religion and healing. One can, nonetheless, represent at least some of those approaches, suggesting some of the different outcomes to combinations of these factors.

Histories of medicine in the United States have tracked the blocking of African Americans not only from accessing regular medical care but also from entering medical schools. These sources trace, as well, the catastrophic health effects of such barriers.[93] More recent histories have examined specific periods, like the years of enslavement in relation to the forms of care provided among the slaves themselves. The practices sustained from Africa and given form in the conjuring traditions have also been traced, as have accounts of individual healers.[94] These practices transmuted over time into the different folk traditions, the responses to affliction both personal and social, and the adoption of complementary/alternative therapies practiced by the surrounding cultures.[95] Other recent work explores the roles played by the different Black churches, whether in the lives of Afri-

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93 See, for example, W. Michael Byrd and Linda A. Clayton, *An American Health Dilemma: Race, Medicine, and Health Care in the United States, 1900-2000* (New York: Routledge, 2001); Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, D.C.: National Academy of Sciences, 2003); Emilie M. Townes, *Breaking the Fine Rain of Death: African American Health Issues and a Womanist Ethic of Care*, (Eugene, OR: Wipf & Stock Publishers, 2006).

In 2008, the American Medical Association issued an apology for is countenancing of racial discrimination against Black physicians and patients and for maintaining medical professional segregation. See Robert B. Baker et al., "African American Physicians and Organized Medicine, 1846-1968: Origins of a Racial Divide," *JAMA* 300, no. 3 (2008): 306-14; Ronald M. Davis, "Commentary: Achieving Racial Harmony for the Benefit of Patients and Communities: Contrition, Reconciliation, and Collaboration," *JAMA* 300, no. 3 (2008): 323-25;

94 See Albert J. Raboteau, "The Afro-American Traditions," in *Caring and Curing: Health and Medicine in the Western Religious Traditions*, eds. Ronald L. Numbers and Darrel W. Amundson (New York: Macmillan, 1997), 539-62; Herbert C. Covey, *African American Slave Medicine: Herbal and Non-Herbal Treatments* (Lanham, MD: Lexington Books, 2007); Sharla M. Fett, *Working Cures: Healing, Health, and Power on Southern Slave Plantations* (Chapel Hill: University of North Carolina Press, 2002); Yvonne P. Chireau, *Black Magic: Religion and the African American Conjuring Tradition* (Berkeley: University of California Press, 2006); R. Marie Griffith. "Body Salvation: New Thought, Father Divine, and the Feast of Material Pleasures," *Religion and American Culture: A Journal of Interpretation* 11, no. 2 (2001): 119-53; Patricia Guthrie, "Mother Mary Ann Wright: African-American Women, Spirituality, and Social Activism," *Women & Therapy* 16, no. 2/3 (1995): 161-73.

95 See Loudell F. Snow, *Walkin' over Medicine* (Boulder: Westview Press, 1993); Stephanie A. Mitchem, *African American Folk Healing* (New York: NYU Press, 2007); Stephanie A. Mitchem and Emilie M. Townes, eds., *Faith, Health, and Healing in African American Life* (Westport: Praeger, 2008); Eric J. Bailey, *African American Alternative Medicine: Using Alternative Medicine to Prevent and Control Chronic Diseases* (Westport, CT: Bergin & Garvey, 2002).

can American women, people with HIV/AIDS, or the congregants of denominations more closely rooted in African heritage. On the other hand, some women's devotion to the Orisha Oshun is just as much a part of the larger story.[96]

Just as the impact of enslavement figures in the history of the earlier periods, so the impact of that trauma has migrated down over the generations, calling for new ways to conceptualize affliction and to address it. Some responses have encompassed the impact on whole families and formulated a response in terms of recovering roots; others put it as a matter of learning about love. Still others frame it as a matter of healing spoiled identities and of finding a place and way to belong or to address the effects of persisting anger.[97]

Native American—Navajo

From the first incursions by Europeans into the Americas and the first encounters with Native American peoples, a series of reports ensued, speculating about who and what they were. Perceptions ranged from idealized Rousseau-like renderings to efforts to position them in a series of inferior categories. The persisting, violent appropriation of land, internment of the tribes on reservations, and reduction of social and civil rights combined with initiatives designed to eliminate cultural traditions.[98]

The result was a broken foundation upon which eventual engagement by non-Native anthropologists in the study of tribal groups would build, although many were deeply committed to the people among whom they lived and worked. Over the years, a handful of Native Americans would also become anthropologists: Francis La Flesche (1857–1932, Omaha), William Jones

96 Examples include Stephanie A. Mitchem, "'Jesus Is My Doctor': Healing and Religion in African American Women's Lives," in *Religion and Healing in America*, eds. Linda L. Barnes and Susan S. Sered (New York: Oxford University Press, 2005), 281-90; Toinette M. Eugene, "There Is a Balm in Gilead: Black Women and the Black Church as Agents of a Therapeutic Community," *Women & Therapy* 16, no. 2-3 (1995): 55-71; Claude Jacobs, "Rituals of Healing in African American Spiritual Churches," in *Religion and Healing in America*, eds. Linda L. Barnes and Susan S. Sered (New York: Oxford University Press, 2005), 333-41; Rachel Elizabeth Harding, "'What Part of the River You're In': African American Women in Devotion to Òsun," in *Osun across the Waters: A Yoruba Goddess in Africa and the Americas*, eds. Joseph M. Murphy and Mei-Mei Sanford (Bloomington: Indiana University Press, 2001).

97 Roland C. Barksdale-Hall, *The African American Family's Guide to Tracing Our Roots: Healing, Understanding & Restoring Our Families* (Phoenix: Amber Books, 2005); Brenda Lane Richardson and Brenda Wade, *What Mama Couldn't Tell Us About Love: Healing the Emotional Legacy of Slavery: Celebrating Our Light* (New York: HarperCollins Publishers, 1999); Cynthia Burack, *Healing Identities: Black Feminist Thought and the Politics of Groups* (Ithica, NY: Cornell University Press, 2004); bell hooks, *Belonging: A Culture of Place* (New York: Routledge, 2008); Elaine McCollins Flake, *God in Her Midst: Preaching Healing to Wounded Women* (Valley Forge: Judson Press, 2007); Ernest H. Johnson, *Brothers on the Mend: Understanding and Healing Male Anger for African-American Men and Women* (New York: Pocket Books, 1998).

98 See http://www.aaanet.org/sections/aia/index.html; http://www.aarweb.org/meetings/annual_meeting/Current_Meeting/Call_for_Papers/list-call.asp?PUNum=AARPU029;http://www.aarweb.org/Meetings/Annual_Meeting/Program_Units/PUinformation.asp?PUNum=AARPU039

(1871–1909, Fox), Arthur Caswell Parker (1881-1955, Seneca, Scots, English), Louis Shotridge (c. 1882-1937, Tlingit), Gladys Tantaquidgeon (1899-2005, Mohegan), Edward Dozier (1916-1971, Pueblo), Emory Sekaquaptewa (1928-2007, Hopi), and George Horse-Capture (b. 1937, A'aninin [Gros Ventre]).

Two developments suggest, however, a shifting role within the fields of both anthropology and religious studies. The American Anthropological Association, for example, now includes a section called the Association of Indigenous Anthropologists. Its purposes are to foster the professional development of Indigenous anthropologists and support their place in the field as well as to "advocate and facilitate stronger ties between Indigenous communities and the field of anthropology" and "encourage professional work that will benefit both the discipline of anthropology and Indigenous communities." Similarly, the American Academy of Religion houses the Indigenous Religious Traditions Group and the Native Traditions in the Americas Group. Results of their work have been more likely to be situated within the field of Applied Anthropology, which combines scholarship with partnership, alliance, and advocacy work with the group being studied.

Several challenges beset the effort to comment on developments in the study of religion and healing in connection with Native American traditions. The first is the very diversity of these traditions, as well as the differences between their histories (alongside the commonalities). Each people has had its own formulations of what it means to be healthy and its own religiously grounded healthworlds. A second challenge involves the frequent inseparability of religion and healing, much as we saw in the concept of *bophelo.*[99]

Rather than try to review the topic in connection with the different tribes, here I shall again illustrate it with a specific example, the Navajo people of the American Southwest, for whom religion and healing figure in the term *hózhó*. It refers to everything considered to be good, in an environment of everything good, within which the Navajo are immersed. If that harmony is disturbed or broken they must put it right. Illness represents a disruption of *hózhó.* So, for example, when care for the tribe's sacred lands must work within land-management as defined by the federal government, the chances for disruption of core balances is increased. Likewise, when Navajo women experience domestic violence, it may be set within greater frames of reference involving both the Creation Story (in which First Man and First Woman argue, with grave consequences for the people) and the overarching need to sustain *hózhó.*[100]

99 For a collection that illustrates current examples of these meanings in relation to different tribes and contexts, see Suzanne J. Crawford O'Brien, *Religion and Healing in Native America: Pathways for Renewal* (Westport, CT: Praeger, 2008).

100 Csordas reminds us that even as healing is central to Navajo religious worlds, so the sacred is at the heart of all healing. See Thomas J. Csordas, "The Navajo Healing Project," *Medical Anthropology Quarterly* 14, no. 4 (2000): 463-75. For fuller treatments of *hózhó* in relation to the Navajo language and the religious healthworld, see Gary Witherspoon, *Language and Art in the Navajo Universe* (Ann Arbor: University of Michigan Press, 1977); Maureen Trudelle Schwarz, *Molded in the Image of Changing Woman: Navajo Views on the Human Body and Personhood* (Tuscon, AZ: University of Arizona Press, 1997); Paula Gunn Allen and Carolyn Anderson, eds., *Hozho: Walking in Beauty—Short Stories by American Indian Writers* (Los Angeles: Lowell House, 2001); Tom Jones, "Beauty Way—Harmony: Navajoland," *Legal Studies Forum* 32, no. 3 (2008): 532. For two illustrations of *hózhó* thrown out of

The process of doing so involves different diagnostic strategies, which—as is the case in other cultures of healing as well—can also function as cures in their own right. The authority of words is coupled with an expectancy of good intent, which combine to activate a process of healing. The related illness categories, explanatory models, sick roles, and health seeking strategies grow out of a different approach to classifying experience and to the very analysis of causality itself.[101]

The three traditions—Traditional Navajo Religion (TNR), the Native American Church, and Pentecostal Christianity—each organizes its approach in relation to *hózhó*. The complicated negotiation between self, tribe, land, surrounding culture, and identity gets worked and reworked through the different processes of healing. Different individuals engage in each of these traditions for reasons that combine family upbringing and expectations, experiences of calling, and particular experiences of affliction. For those engaged in TNR, ceremonials known as chantways must take place to expel the influence viewed as having caused the illness.[102]

Structural Violence

Structural violence refers to political and economic factors that generate and reinforce social inequities. It presumes the imposition of a constructed version of normalcy, to which all groups must adhere—even though only some groups, in reality, can do so. One of its effects is unequal access to social resources and assets. These examples of race, ethnicity, and tribe illustrate the impact of structural violence at the macro level as it plays out on the individual and group level. These effects occur in systemic ways through phenomena such as cycles of poverty, ill health, violence, social marginalization, and discrimination. The individuals or groups then tend to be blamed by

balance, see Sharon Milholland, "In the Eyes of the Beholder: Understanding and Resolving Incompatible Ideologies and Languages in US Environmental and Cultural Laws in Relationship to Navajo Sacred Lands," *American Indian Culture and Research Journal* 34, no. 2 (2010): 103-24; and Mary J. Rivers, "Navajo Women and Abuse: The Context for Their Troubled Relationships," *Journal of Family Violence* 20, no. 2 (2005): 83-89.

101 See, for example, Derek Milne and Wilson Howard, "Rethinking the Role of Diagnosis in Navajo Religious Healing," *Medical Anthropology Quarterly* 14, no. 4 (2000): 543-70; Raymond Neutra, Jerrold E. Levy, and Dennis Parker, "Cultural Expectations Versus Reality in Navajo Seizure Patterns and Sick Roles," *Culture, Medicine, and Psychiatry* 1, no. 3 (1977): 255-75; Michael Storck, Thomas J. Csordas, and Milton Strauss, "Depressive Illness and Navajo Healing," *Medical Anthropology Quarterly* 14, no. 4 (2000): 571-97; and Csordas, "The Sore That Does Not Heal."

102 Leland C. Wyman, "Navajo Ceremonial System," *Handbook of North American Indians*, ed., William C. Sturtevant, vol. 10, Southwest (Washington, D.C.: Smithsonian Institution, 1983); Elizabeth L. Lewton, "Identity and Healing in Three Navajo Religious Traditions: Są'ah Naagháí Bik'eh Hózhó," *Medical Anthropology Quarterly* 14, no. 4 (2000): 476-97; Thomas J. Csordas, "Gender and Healing in Navajo Society," in *Religion and Healing in America*, eds. Linda L. Barnes and Susan S. Sered (New York: Oxford University Press, 2005), 291-304; Thomas J. Csordas, "Healing and the Human Condition: Scenes from the Present Moment in Navajoland," *Culture, Medicine, and Psychiatry* 28, no. 1 (2004): 1-14; Karl W. Luckert, *Coyoteway: A Navajo Holyway Healing Ceremonial* (Tuscon: University of Arizona Press, 1989); Mary Wheelright, "The Myth of the Coyote Chant," in *The Myth and Prayers of the Great Star Chant and the Myth of the Coyote Chant*, ed. David McAllester (Tsaile, AZ: Navajo Community College Press, 1988), 97-107.

others who view them as somehow deserving of their fate.

Those who benefit generally have difficulty recognizing the multidirectional scope of structural violence or the full extent of its impact. Nor do they find it easy to own how it profits them, often choosing instead to ignore the related power dynamics. The embodiment of illness becomes the enactment of social suffering. Healing in such contexts requires more than addressing someone's individual illness experience; rather, it becomes a political undertaking, even when it appears to involve only an individual's circumstances.[103]

In Applied Domains

The questions that arise under the rubric of religion and healing are compelling not only for conceptual reasons but also because the topic itself resides at the core of human experience. For that reason, one branch of this sprawling domain concerns itself with matters of application. Within the study of religions we find this dimension most regularly within the fields of pastoral care and chaplaincy. Intersecting with medical anthropology is a sister sub-discipline, applied anthropology. Psychology and psychiatry, as clinical disciplines, are, in themselves, applied fields, as is biomedicine, which has, in recent years, developed new research interests in facets of religiosity.

103 For a chronological review of literature related to structural violence, see Johan Galtung, "Violence, Peace, and Peace Research," *Journal of Peace Research* 6, no. 3 (1969): 167-91; Raymond Massé, "Between Structural Violence and Idioms of Distress: The Case of Social Suffering in the French Caribbean," *Anthropology in Action* 14, no. 3 (2007): 6-17; Johan Galtung, "Cultural Violence," *Journal of Peace Research* 27, no. 3 (1990): 291-305; Paul Farmer, "On Suffering and Structural Violence: A View from Below," in *Social Suffering*, eds. Arthur Kleinman, Veena Das, and Margaret Lock (Berkeley: University of California Press, 1997), 261-83; Arthur Kleinman, Veena Das, and Margaret Lock, eds., *Social Suffering* (Berkeley: University of California Press, 1997); Linda Green, "Lived Lives and Social Suffering: Problems and Concerns in Medical Anthropology," *Medical Anthropology Quarterly* 12, no. 1 (1998): 3-7; J. Christopher Bernat, "Children and the Politics of Violence in Haitian Context," *Critique of Anthropology* 19, no. 2 (1999): 121-38; Jeffrey Andrew Weinstock and Rachel Riedner, "Introduction: Cultural Violences," *College Literature* 26, no. 1 (1999): 1-7; Elizabeth Grosz, "The Time of Violence: Deconstruction and Value," *College Literature* 26, no. 1 (1999): 8-18; David Hoegberg, "Principle and Practice: The Logic of Cultural Violence in Achebe's *Things Fall Apart*," *College Literature* 26, no. 1 (1999): 69-79; Daniel J. Christie, Richard V. Wagner, and Deborah DuNann Winter, eds., *Peace, Conflict, and Violence: Peace Psychology for the 21st Century* (Upper Saddle River, NJ: Prentice Hall, 2000 [Out of print]); Susan E. James et al., "The Violent Matrix: A Study of Structural, Interpersonal, and Intrapersonal Violence among a Sample of Poor Women," *American Journal of Community Psychology* 31, no. 1/2 (2003): 129-41; Jill E. Korbin, "Children, Childhoods, and Violence," *Annual Review of Anthropology* 32 (2003): 431-66; Polly Walker, "Colonising Research: Academia's Structural Violence Towards Indigenous Peoples," *Social Alternatives* 22, no. 3 (2003): 37-40; Paul Farmer, "An Anthropology of Structural Violence," *Current Anthropology* 45, no. 3 (2004): 305-25; Corina Salis Gross, "Struggling with Imaginaries of Trauma and Trust: The Refugee Experience in Switzerland," *Culture, Medicine, and Psychiatry* 28 (2004): 151-67; Paul E. Farmer et al., "Structural Violence and Clinical Medicine," *PLoS Medicine* 3, no. 10 (2006): e449; Maria Tapia, "Emotions and the Intergenerational Embodiment of Social Suffering in Rural Bolivia," *Medical Anthropology Quarterly* 20, no. 3 (2006): 399-415; and Linda L. Barnes, "Five Ways of Rethinking the Normal: Reflections on the Preceding Comments," *Religion & Theology* 14 (2007): 68-83.

Pastoral Care and Chaplaincy

Both pastoral care and chaplaincy provide theologically informed responses to suffering and illness. The literatures on both are vast, and here I will allude only to several developments. Perhaps the most striking is the reiterated admonition to adapt the practice of pastoral care to new social, medical, and theological realities. These include responses to the local effects of globalization and transnationalism on the one hand, and the indigenization of pastoral care on the other—that is, the adaptation of pastoral counseling practices to the cultural worlds of different groups within a larger tradition.[104]

A focus on multiculturalism has led to the development of pastoral care oriented to women from different racial/ethnic backgrounds, social classes, and sexual orientations, grounding them in feminist, womanist, and *mujerista* theologies, among others. It has resulted, too, in models designed to address the worldviews, healthworlds, and needs of particular cultural groups.[105] They include the critique of an individualistic paradigm, recognizing some of the suffering to which it contributes, as well as ills that have come to light within religious communities themselves.[106]

Chaplains continue to work within the military but face new wartime conditions with the effects of new technologies. Some now find themselves among service men and women who are part of longer-term peacekeeping missions, posing different meaning-centered challenges. Others serve in hospital settings where clinicians, patients, and families face the complex ethical and relational choices, some of which also grow out of new technologies and may involve highly charged, emotional choices.[107]

104 For a reference work that documents and explains topics in the field of pastoral care, see Rodney J. Hunter et al., eds., *Dictionary of Pastoral Care and Counseling*, expanded ed. with CD-ROM (Nashville: Abingdon Press, 2005); and Glenn H. Asquith Jr., ed., *The Concise Dictionary of Pastoral Care and Counseling* (Nashville: Abingdon Press, 2010). It should be noted, however, that the individuals representing the field still tend to be drawn from the Christian denominations and various streams of Judaism. Such sources often still do not recognize the growing role of Muslim chaplains but instead sometimes provide limited training related to bioethical issues from a generic Muslim perspective. For further discussion of this issue, see Wahiba Abu-Ras and Lance Laird, "How Muslim and Non-Muslim Chaplains Serve Muslim Patients? Does the Interfaith Chaplaincy Model Have Room for Muslims' Experiences?" *Journal of Religion and Health* 50 (2011): 46-61. For sources on the need to adapt pastoral care methods to changing realities, see Nancy J. Ramsey, *Pastoral Care and Counseling: Redefining the Paradigms* (Nashville: Abingdon Press, 200); and Carrie Doehring, *The Practice of Pastoral Care: A Postmodern Approach* (Louisville, KY: Westminster John Knox Press, 2006).

105 Jeanne Stevenson-Moessner and Teresa Snorton, eds., *Women out of Order: Risking Change and Creating Care in a Multicultural World* (Minneapolis: Fortress Press). Womanist theology generates theological models grounded in the experience of African American women; *mujerista* theology does the same for Latinas. See also Edward Wimberly, *African American Pastoral Care,* rev. ed. (Nashville: Abingdon Press, 2008); and R. Esteban Montilla, *Pastoral Care and Counseling with Latinos* (Minneapolis, MN: Fortress Press, 2006).

106 See, for example, Barbara J. McClure, *Moving Beyond Individualism in Pastoral Care and Counseling: Reflections on Theory, Theology, and Practice* (Eugene, OR: Cascade Books, 2010); Mikele Rauch, *Healing the Soul after Religious Abuse: The Dark Heaven of Recovery* (Westport, CT: Praeger, 2009); and Barbara M. Orlowski, *Spiritual Abuse Recovery: Dynamic Research on Finding a Place of Wholeness* (Eugene, OR: Wipf & Stock, 2010).

107 Two illustrative discussions are presented in Walter Moczynski, Hille Haker, and Katrin Bentele, eds., *Medical*

Moreover, related research has taken increasingly quantified turns, relying on large data sets and trying to operationalize religiosity and related effects. Operationalization occurs when one takes a concept, and converts it into one or more quantifiable characteristics that can be measured. Each characteristic must be exactly defined. For example, to say that children grow more quickly if they eat vegetables does not sufficiently specify how one is defining "children," "vegetables," "grow," or "quickly." Which children and vegetables, what kind of growth, and precisely at what rates? The point of operationalizing what might otherwise be a "fuzzy concept" is to ensure consistency in one's results. When applied to "religion," "religiosity," or "spirituality," however, operationalization can yield an unnuanced understanding that is disturbing to those trained in religious studies and, for that matter, to those in chaplaincy who view the field as incompatible with scientific research methods.[108]

Persisting Psychiatries

The second half of the nineteenth century saw early cross-fertilizations of psychiatry, psychology, and the study of religion (as distinct from theology). As we have seen, Sigmund Freud's writings about religion influenced not only the fields of psychiatry and psychology but also religious studies and anthropology. In representing religion as an illusion, he argued that one could neither prove nor refute its reality value, despite "[s]ome of them [being] so improbable, so incompatible with everything we have laboriously discovered about the reality of the world, that we may compare them—if we pay proper regard to the psychological differences—to delusions." And yet, he also made it clear that it lay beyond his inquiry to "assess the truth-value of religious doctrines." What was clear to him was that only scientific methods could lead to confirmable knowledge of things outside of ourselves. "It is," he added, "once again merely an illusion to expect anything from intuition and introspection; they can give us nothing but particulars about our own mental life, which are hard to interpret, never any information about the questions which religious doctrine finds it so easy to answer."[109]

The other influence that weighed heavily among some anthropologists and combined to cement a longstanding bias against religion was Karl Marx's characterization. For Marx, economic

Ethics in Health Care Chaplaincy (Berlin: Münster, Lit., 2009); Patricia Elyse Terrell, *Counseling Pregnancy, Politics, and Biomedicine: Empowering Discernment* (New York: Pastoral Press, 2007). For a discussion of service as a chaplain in a peacekeeping context, see Kenneth E. Lawson, *Faith and Hope in a War-Torn Land: The U.S. Army Chaplaincy in the Balkans, 1995-2005* (Fort Leavenworth, KS: Combat Studies Institute Press, 2006).

108 Martyn Shuttleworth, "Operationalization—Defining Variables into Measurable Factors," http://www.experiment-resources.com/operationalization.html; Larry Van De Creek, *Professional Chaplaincy and Clinical Pastoral Education Should Become More Scientific: Yes and No* (New York: Haworth Pastoral Press, 2003).

109 Sigmund Freud, *The Future of an Illusion*, trans. James Strachey, The Standard Edition of the Complete Psychological Works of Sigmund Freud, ed. James Strachey, Vol. XXI (1927-1931) *The Future of an Illusion, Civilization and its Discontents, and Other Works* (London: The Hogarth Press and the Institute of Psycho-Analysis, 1927),30-31.

inequities generated social ills, which those in power needed to persuade the disenfranchised to accept so that the latter would not act on their distress. Religions vary because the material foundations of the social order undergo change. Religion, like other governing ideologies, functions to mask an underlying injustice. The key factor is not, therefore, the actual teachings of a tradition. What mattered was its function—to convince people to ignore their current misery, trusting instead in a promised future happiness. This function Marx compared with opium.

One legacy of these arguments has been a significant cohort of anthropologists relatively hostile to religion, particularly as a contemporary phenomenon. Most have read Freud's injunction to apply scientific methods to realities outside of one's self to mean social-scientific methods. The related outcome usually involves reducing religion to a cover for sociological, economic, political, or psychological phenomena.

In Religious Studies, Jung's writings continue to have partisans in some quarters while remaining out of favor in others for many of the same reasons as before. In Analytical Psychology and Transcultural Psychiatry, his work is generally still out in the cold, but there is some thawing of the chill. For example, Henry Abramovitch and Laurence Kirmayer recommend that current thinking on Jung's work be applied to cultural psychiatry. They note especially his work with dreams, symbols, myths, and the related interpretation of religious experience, and point to the extent of his influence outside of the U.S.[110]

Quantified Psychologies

Generally speaking, psychological inquiry into religion-related topics concerns itself with whether religious worldviews and/or practices contribute to health or interfere with it. To arrive at such determinations, researchers have, in some instances, taken tools, scales, and instruments (e.g., surveys, questionnaires, and tests) developed and tested in relation to specified understandings of mental health, and applied them to religiosity. In others, they have constructed instruments designed to assess actual religiosity. In either case, the challenges involve the operationalization of what it is to be religious and the difficulty of explaining relationships between religiosity and health and the effects of the one upon the other.

Several models have proved particularly influential, especially in relation to constructions of religious types and religious orientations. William James developed one of the earliest efforts to bring together religion, science, and psychology, which he presented in *The Varieties of Religious*

110 Henry Abramovitch and Laurence J. Kirmayer, "The Relevance of Jungian Psychology for Cultural Psychiatry," *Transcultural Psychiatry* 40 (2003): 155-63. For examples of applications in transcultural psychiatry, see Shirley S. Y. Ma, "The I Ching and the Psyche-Body Connection," *Journal of Analytical Psychology* 50 (2005): 237-50; Craig Stephenson, "A Cree Woman Reads Jung," *Transcultural Psychiatry* 40, no. 2 (2003): 181-93; Joan D. Koss-Chioino, "Jung, Spirits, and Madness: Lessons for Cultural Psychiatry," *Transcultural Psychiatry* 40, no. 2 (2003): 164-80; John Ryan Haule, "Jung's Practice of Analysis: A Euro-American Parallel to Ch'an Buddhism," *Journal of Individual Psychology* 56, no. 3 (2000): 353-65; Mario Nuñez Molina, "Archetypes and Spirits: A Jungian Analysis of Puerto Rican Espiritismo," *Journal of Analytical Psychology* 41 (1996): 227-44.

Experience and which continues to play a part in the psychology of religion. A second influence grew from the contributions of psychologist Gordon Allport, whose book *The Individual and His Religion* (1950) posited a "mature" and "immature" religion.

Four years later, drawing on his work with refugees during World War II, Allport published *The Nature of Prejudice* (1954). He defined prejudice as "an attitude of favor or disfavor," which is "related to an overgeneralized (and therefore erroneous) belief" that is then used to target, scapegoat, and exploit others.[111] The book included a Scale of Prejudice and Discrimination, which typologized attitudes toward and expressions of prejudice. In 1966, he integrated sociology, theology, and psychology to argue that "immature" religion—which by then he was calling "communal and extrinsic religion"—grounded itself in doctrines of revelation and election, both of which, he contended, provided theological rationales for prejudice.

It was, however, in an article published during the last year of his life that Allport fully integrated his work on religious orientations with his analysis of prejudice. He put in place a Means/Ends formulation of religiosity through the concepts of "intrinsic religion"—the interior dimension of faith, which views religion as an end in itself—and "extrinsic religion." The latter represented a utilitarian, publicly oriented performance of religiosity in which one strives to influence public perceptions of oneself and gain some end. He then linked both with greater or lesser dispositions to prejudice, arguing that simply knowing that a person was "religious" did not indicate the part their religiosity played in the larger sphere of his or her life.[112]

To the effort of defining religious types and establishing measures with which to assess them, social psychologist C. Daniel Batson (b. 1943) added the concept of "Religion as Quest"—an orientation of seeking, especially in relation to existential questions, but without a definitive goal or end result. It made room for doubt as a constructive process. He characterized extrinsic, intrinsic, and quest religiosity as religion-as-means, religion-as-end, and religion-as-quest. To measure someone's motives for being religious, he developed a Religious Life Inventory, which combined questions related to external, internal, and interactional orientations (responding to questions generated by the experience of personal and/or social crises). He elaborated on religion-as-quest as the readiness to face existential questions without reducing their complexity, a perception of religious doubts as positive, and an openness to future change in one's religious views.[113]

111 Gordon W. Allport, *The Nature of Prejudice* (Cambridge: Addison-Wesley Publishing Co., 1954), 13

112 See William James, *The Varieties of Religious Experience: A Study in Human Nature, Being the Gifford Lectures on Natural Religion Delivered at Edinburgh 1901-02* (London: Longmans, Green & Co., 1902); Gordon W. Allport, *The Individual and His Religion: A Psychological Interpretation* (New York: Macmillan, 1950); Gordon W. Allport, "The Religious Context of Prejudice," *Pastoral Psychology* 18, no. 5 (1966): 20-30; Gordon W. Allport and J. Michael Ross, "Personal Religious Orientation and Prejudice," *Journal of Personality and Social Psychology* 5, no. 4 (1967): 432-43.

113 For Batson's discussions of "Religion as Quest" and the Religious Life Inventory, see C. Daniel Batson, "Religion as Prosocial: Agent or Double Agent?" *Journal for the Scientific Study of Religion* 15, no. 1 (1976): 29-45; C. Daniel Batson, Stephen J. Naifeh, and Suzanne Pate, "Social Desirability, Religious Orientation, and Racial Prejudice," *Journal for the Scientific Study of Religion* 17, no. 1 (1978): 31-41; C. Daniel Batson and W. Larry Ventis, *The Religious Experience: A Social-Psychological Perspective* (New York: Oxford University Press, 1983). For Batson's

Allport's "Religious Orientation Scale," used to assess the degrees of a person's interior or exterior orientation, continues to be revisited, although it is noteworthy that few who use it appear to have sustained Allport's emphasis on understanding the dynamics of prejudice. Likewise, Batson's work has been applied and, in some cases, amended.[114] These various scales illustrate the application of psychometrics, or psychological measurement tools. Such tools undergo a process of testing to ensure that with each use they secure the results that the researchers intended (a process known as *validation*, to produce a *valid* scale that will yield reliable results).

The applied psychology-of-religion literature has dedicated considerable attention to the issue of whether and how religiosity contributes to people's ability to cope with stress and trauma. Both, in and of themselves, constitute responses to suffering, including experiences of illness. The challenges here have involved selecting and refining measures related to "coping," operationalizing "religiosity" and its pertinent aspects, and then applying the one to the other.

The larger discussion of coping owes a great deal to the work of psychologist Richard S.

further elaborations on religion as quest, see C. Daniel Batson and Lynn Raynor-Prince, "Religious Orientation and Complexity of Thought About Existential Concerns," *Journal for the Scientific Study of Religion* 22, no. 1 (1983): 38-50. For Batson's discussion of issues related to the validity and reliability of his Religion as Quest instrument, see C. Daniel Batson and Patricia A. Schoenrade, "Measuring Religion as Quest: 1) Validity Concerns," *Journal for the Scientific Study of Religion* 30, no. 4 (1991): 416-29; and C. Daniel Batson, "Measuring Religion as Quest: 2) Reliability Concerns," *Journal for the Scientific Study of Religion* 30, no. 4 (1991): 430-47. Drawing on his earlier dissertation research on the disposition to help others, Batson examined connections between a Quest orientation on the one hand and, on the other, the extent to which one would be willing to show compassion to someone who disagreed with one's deepest values. See C. Daniel Batson, "'I'm Here to Help You': Variables Affecting the Implementation of Helping Behavior," (PhD diss. Princeton University, 1972); and C. Daniel Batson et al., "'And Who Is My Neighbor?' II: Quest Religion as a Source of Universal Compassion," *Journal for the Scientific Study of Religion* 40, no. 1 (2001): 39-50. It should be noted that Batson did examine issues related to religious orientation and prejudice. While not rejecting Allport's intrinsic/extrinsic categories, Batson argued that a Quest Orientation also might correlate negatively with religious prejudice, yet with even greater consistency.

114 For reassessments of Allport's work, see Richard A. Hunt and Morton King, "The Intrinsic-Extrinsic Concept: A Review and Evaluation," *Journal for the Scientific Study of Religion* 10, no. 4 (1971): 339-56; Lee A. Kirkpatrick and Jr. Ralph W. Hood, "Intrinsic-Extrinsic Religious Orientation: The Boon or Bane of Contemporary Psychology of Religion?*," *Journal for the Scientific Study of Religion* 29, no. 4 (1990): 442-62. For amendments to Batson's scales, see John Maltby and Liza Day, "Amending a Measure of the Quest Religious Orientation: Applicability of the Scale's Use among Religious and Non-Religious Persons," *Personality and Individual Differences* 25 (1998): 517-22; Richard Beck and Ryan K. Jessup, "The Multidimensional Nature of Quest Motivation," *Journal of Psychology & Theology* 32, no. 4 (2004): 283-94; Peter Hills, Leslie J. Francis, and Mandy Robbins, "The Development of the Revised Religious Life Inventory (R.L.I.-R) by Exploratory and Confirmatory Factor Analysis," *Personality and Individual Differences* 38, no. 6 (2005): 1389-99. In some cases, both Allport's and Batson's work have been discussed together, indicating the persistence of their influence. See, for example, Donald Capps and Ralph W. Hood, "Symposium on Religious Orientation Typologies," *Journal for the Scientific Study of Religion* 35, no. 4 (1985): 407-42; Michael J. Donahue, "Intrinsic and Extrinsic Religiousness: Review and Meta-Analysis," *Journal of Personality and Social Psychology* 48, no. 2 (1985): 400-19; Christopher T. Burris, "Curvilinearity and Religious Types: A Second Look at Intrinsic, Extrinsic, and Quest Relations," *International Journal for the Psychology of Religion* 4, no. 4 (1994): 245-60; Bart Neyrinck et al., "Updating Allport's and Batson's Framework of Religious Orientations: A Reevaluation from the Perspective of Self-Determination Theory and Wulff's Social Cognitive Model," *Journal for the Scientific Study of Religion* 49, no. 3 (2010): 425-38.

Lazarus (1922-2002), much of whose work focused on the emotions. These he defined in terms of "core relational themes," reflecting that persons exist in relation to others and to their environments. Lazarus argued that an individual appraises a situation in terms of how they feel it is likely to affect them or others, the demands they feel it may place on them. One part of this process is cognitive; another ties in with previous experiences a person may have that may color the expectations of what is likely to happen. A third aspect of appraisal entails the individual's perception of the resources they think they can bring to bear. Together, these strategies of response constitute the person's coping resources. The fewer resources a person believes they have, the greater the likelihood that they will experience stress and may have difficulty coping, which refers to "the cognitive and behavioral efforts made to master, tolerate, or reduce external and internal demands and conflicts among them."[115]

In some cases, a person may cope better by utilizing denial. They may also draw on religious resources—*not* the same thing as denial—which is where the work of Kenneth Pargament enters the picture. Beginning in the late 1980s, Pargament drew on attribution and problem-solving theories to inquire into how an individual facing a health situation attributes both its cause as well as their own ability to cope to God. He linked coping, too, with problem-solving as well as with the effects of community support experienced through congregations (his model for religiosity generally reflected Christian frames of reference as normative). He also addressed scenarios in which religious influences undercut people's ability to cope. He would go on not only to develop these themes further but also to integrate theories of intrinsic religiousness and apply these different approaches to a variety of specific health challenges. Gradually his work expanded to include the issue of forgiveness in connection with coping.[116]

115 Susan Folkman and Richard S. Lazarus, "An Analysis of Coping in a Middle-Aged Community Sample," *Journal of Health and Social Behavior* 21, no. 3 (1980): 223. See also Richard S. Lazarus. *Psychological Stress and the Coping Process* (New York: McGraw-Hill, 1966); and Richard S. Lazarus and Susan Folkman, *Stress, Appraisal, and Coping* (New York: Springer Publishing Company, 1984); Susan Folkman and Richard S. Lazarus, *Ways of Coping Questionnaire, Sampler Set, Manual, Test Booklet, Scoring Key* (Palo Alto, CA: Consulting Psychologists Press, 1988).

116 See Kenneth I. Pargament and J. Hahn, "God and the Just World: Causal and Coping Attributions to God in Health Situations," *Journal for the Scientific Study of Religion* 25 (1986): 193-207; Kenneth I. Pargament et al., "Religion and the Problem-Solving Process: Three Styles of Coping," *Journal for the Scientific Study of Religion* 27, no. 1 (1988): 90-104; William Hathaway and Kenneth I. Pargament, "Intrinsic Religiousness, Religious Coping, and Psychosocial Competence: A Covariance Structure Analysis," *Journal for the Scientific Study of Religion* 29 (1990): 423-41; and Kenneth I. Pargament et al., "God Help Me (I): Religious Coping Efforts as Predictors of the Outcomes of Significant Negative Life Events," *American Journal of Community Psychology* 18 (1990): 793-824. For illustrations of his work on negative versions of religious coping, see Kenneth I. Pargament et al., "Indiscriminate Proreligiousness: Conceptualization and Measurement," *Journal for the Scientific Study of Religion* 26, no. 2 (1987): 182-200; Kenneth I. Pargament et al., "Patterns of Positive and Negative Religious Coping with Major Life Stressors," *Journal for the Scientific Study of Religion* 37, no. 4 (1998): 710-24; Kenneth I. Pargament et al., "Red Flags and Religious Coping: Identifying Some Religious Warning Signs among People in Crisis," *Journal of Clinical Psychology* 54 (1998): 77-89. For examples of religious coping theories being applied to specific health conditions, see R. Jenkins and K. Pargament, "Religion and Spirituality as Resources for Coping with Cancer," *Journal of Psychosocial Oncology* 3, no. 1/2 (1995): 51-74; E. G. Bush and K. I. Pargament, "Family Coping with Chronic Pain," *Families, Systems &*

The discussion of *religious* coping adds a complex layer to the larger discussion of healing. For example, if we revisit the chart above, we could argue that it is the larger vision of healing that informs some individuals' and groups' understanding of the resources they bring to a situation. But one could also argue that, for some, a more existential take on why people suffer—and the idea that they may somehow deserve what is happening to them—may undermine their sense of having resources. Questions related to coping weave throughout an illness experience—indeed, contribute to that experience—just as they figure in the health-seeking process. If the toll taken by the process of coping is a heavy one, then a person's perception of the efficaciousness of an outcome may be compromised. Others, that is, may view the outcome as a success, which may not correspond to the inner state of the person involved. For this reason, coping, as Pargament formulates it, is at the core of conserving and transforming significance.[117]

Over the past decade, Pargament has turned his attention to rethinking the categories "religion" and "spirituality," moving from measures that reflect a more narrowly Christian orientation to conceptualizing commonalities that may underlie the different traditions. In particular, he theorizes about what he refers to as "the sacred" and a related process of sanctification. By the sacred, he means things set apart from the ordinary and experienced as deserving reverence. Positioning

Health: The Journal of Collaborative Family Health Care 15 (1997): 147-160; L. VandeCreek, K. I. Pargament, T. Belavich, B. Cowell, and L. Friedel, "The Unique Benefits of Religious Support During Cardiac Bypass Surgery," *Journal of Pastoral Care* 53 (1999): 19-29; E. G. Bush, M. S. Rye, C. R. Grant, E. Emery, K. I. Pargament, and C. A. Riessinger, "Religious Coping with Chronic Pain," *Applied Psychophysiology and Biofeedback* 24 (1999): 249- 260; F. J. Keefe, G. Affleck, J. Lefebvre, L. Underwood, D. S. Caldwell, J. Drew, J. Egert, J. Gibson, and K. Pargament, "Living with Rheumatoid Arthritis: The Role of Daily Spirituality and Daily Religious and Spiritual Coping," *The Journal of Pain* 2 (2000): 101-110; K. I. Pargament, B. Cole, L. Vandecreek, T. Belavich, C. Brant, and L. Perez, "The Vigil: Religion and the Search for Control in the Hospital Waiting Room," *Journal of Health Psychology* 4 (1999): 327-341; N. Tarakeshwar and K. I. Pargament, "Religious Coping in Families of Children with Autism," *Focus on Autism and Other Developmental Disabilities* 16 (2001): 247-260; J. Bowie, B. Curbow, T. LaVeist, S. Fitzgerald, and K. I. Pargament, "The Relationship between Religious Coping Style and Anxiety over Breast Cancer in African American Women," *Journal of Religion and Health* 40 (2001): 411-422; S. M. Pendleton, K. Cavalli, K. I. Pargament, and S. Z. Nasr, "Religious/Spiritual Coping in Childhood Cystic Fibrosis: A Qualitative Study," *Pediatrics* 109 (2002): 1-11; T. Belavich and K. I. Pargament, "The Role of Attachment in Predicting Spiritual Coping with a Loved One in Surgery," *Journal of Adult Development* 9 (2002): 13-29; J. M. Kinney, K. J. Ishler, K. I. Pargament, and J. C. Cavanaugh, "Coping with the Uncontrollable: The Use of General and Religious Coping by Caregivers to Spouses with Dementia," *Journal of Religious Gerontology* 14 (2003): 171-188. For Pargament's work on religion and forgiveness, see Kenneth I. Pargament and Mark S. Rye,

"Forgiveness as a Method of Religious Coping," in *Dimensions of Forgiveness: Psychological Research and Theological Perspectives*, eds. E. Worthington and M. McCullough (Philadelphia: Templeton Press, 1998), 57-76; Mark S. Rye et al., "Religious Perspectives on Forgiveness, in *Forgiveness: Theory, Research, and Practice*, eds. Michael E. McCullough and Kenneth I. Pargament (New York: Guilford Press, 2000), 299-320; Michael E. McCullough and Kenneth I. Pargament, eds., *Forgiveness: Theory, Research, and Practice* (New York: Guilford Press, 2000).

117 See, for example, Kenneth I. Pargament, "Religious Methods of Coping: Resources for the Conservation and Transformation of Significance," in *Religion and the Clinical Practice of Psychology*, ed. E. Shafranske (Washington, D.C.: A.P.A. Books, 1996), 215-39.

himself within the intellectual lineage of Durkheim, he points to the human capacity "to sanctify secular objects," actions, and activities.

One significant contribution of this formulation involves the reframing of a culturally widespread bifurcation between religion and spirituality that views the one as institutional and the other as individual. By focusing on the pursuit of the sacred, Pargament can argue that "spirituality (like religion) can be experienced and expressed individually and institutionally." In formulating the relationship between the two, he writes:

> Perhaps the hardest thing to accept in the approach I have presented here is the notion that religion is a broader construct than spirituality. Most people view it just the reverse (Zinnbauer et al., 1997), but I have harkened back to classic psychology of religion. Religion is a broadband construct. It encompasses the search for many objects of significance. Spirituality focuses on the search for one particular object of significance—the sacred.[118]

Initially, the category appears reminiscent of Rudolf Otto's (1869-1937) concept of the Holy, which he characterized as a mystery (Latin *mysterium*) that is simultaneously terrifying and fascinating—*mysterium tremendum et fascinans*. Both were properties of the *numinous*, Otto's term for both the presence of the sacred and its related power. Combined, they represented the human response of fear and trembling on the one hand and fascination and attraction on the other, drawing attention to the nature of religious experience as non-rational. *Heilige*, generally translated as "Holy," can also be translated as "sacred," in which case it would refer to the experience of the sacred.[119]

Here is where the term appears to intersect with Pargament's theory. The key distinction, however, lies in the source of sacrality. Otto makes the theological assumption that the Holy has an existential reality that manifests in a variety of ways to humans. In contrast, when defining the

118 Kenneth I. Pargament, "The Psychology of Religion and Spirituality? Yes and No," *International Journal for the Psychology of Religion* 9, no. 1 (1999): 3-16. See also Brian J. Zinnbauer et al., "Religion and Spirituality: Unfuzzying the Fuzzy," *Journal for the Scientific Study of Religion* 36, no. 4 (1997): 549-64. Emmons and Crumpler point to the number of meanings assigned to "sanctification" and suggest that it be used only in relation to inner transformative processes and that "sacrilization" refer to the sanctifying of external phenomena. See Robert A. Emmons and Cheryl A. Crumpler, "Religion and Spirituality? The Roles of Sanctification and the Concept of God," *International Journal for the Psychology of Religion* 9, no. 1 (1999): 17-24. For a discussion of the sanctification of a life experience, see Aaron Murray-Swank, Annette Mahoney, and Kenneth I. Pargament, "Sanctification of Parenting: Links to Corporal Punishment and Parental Warmth among Biblically Conservative and Liberal Mothers," *International Journal for the Psychology of Religion* 16, no. 4 (2006): 271-87. For other sources in which Pargament elaborates on the sacred, see Peter C. Hill et al., "Conceptualizing Religion and Spirituality: Points of Commonality, Points of Departure," *Journal for the Theory of Social Behaviour* 30, no. 1 (2000): 51-77; Kenneth I. Pargament, "Is Religion Nothing But . . . ? Explaining Religion Versus Explaining Religion Away," *Psychological Inquiry* 13, no. 3 (2002): 239-44; Kenneth I. Pargament and Annette Mahoney, "Sacred Matters: Sanctification as a Vital Topic for the Psychology of Religion," *International Journal for the Psychology of Religion* 15, no. 3 (2005): 179-98; and Kenneth I. Pargament and Annette Mahoney, "Spirituality: The Search for the Sacred," in *Oxford Handbook of Positive Psychology*, eds. Shane J. Lopez and C.R. Snyder (New York: Oxford University Press, 2009 [2002]), 611-20; and Kenneth I. Pargament, *Spiritually Integrated Psychotherapy: Understanding and Addressing the Sacred* (New York: The Guilford Press, 2007).

119 Rudolf Otto, *The Idea of the Holy: An Inquiry into the Non-Rational Factor in the Idea of the Divine and Its Relation to the Rational*, trans. John W. Harvey, (New York: Oxford University Press, 1923 [1917]).

sacred, Pargament makes no claims for inherent sacredness; rather, he focuses on the process by which sacrality is assigned to different phenomena. It is only indirectly, by classifying four *approaches* to the sacred—rejectionist, exclusivist, constructivist, and pluralist—that he includes this worldview. The constructivist "denies the existence of an absolute reality but recognizes the ability of individuals to construct their own personal meanings and reality," whereas the pluralist "recognizes the existence of a religious or spiritual absolute reality but allows for multiple interpretations and paths toward it."[120]

In Biomedicine

In a series of four articles, gerontologist Harold Koenig (b. 1951) argues that religion and medicine have, down through history, worked together. His historical review tracks a number of the threads that have converged into the roots of biomedicine. It culminates in the assertion that, with the Enlightenment, the two split and have since remained divided. In the larger scheme of things, he suggests, the separation is something of an historical aberration. Through a review of some hundred years of publications, he identifies research that has discussed religion in connection with "mental health, social support, substance abuse, well-being, hope and optimism, meaning and purpose, depression, suicide, anxiety, psychosis, social support and marital stability, alcohol and drug abuse, cigarette smoking, extra-marital sexual behaviors, and delinquency."[121]

120 Brian J. Zinnbauer and Kenneth I. Pargament, "Working with the Sacred: Four Approaches to Religious and Spiritual Issues in Counseling," *Journal of Counseling & Development* 78, no. 2 (2000): 162-71. This is in contrast with the exclusivist, who accepts the reality of an Absolute but sees only one pathway to it. Pargament also develops a theory of *sacrilege*, according to which experience of major loss may affect sanctified phenomena, leading to a depth of loss that exceeds other kinds. See, for example, Kenneth I. Pargament et al., "Sacrilege: A Study of Sacred Loss and Desecration and Their Implications for Health and Well-Being in a Community Sample," *Journal for the Scientific Study of Religion* 44, no. 1 (2005): 59-78. For a discussion of spiritual transformation in this context, see Kenneth I. Pargament, "On the Meaning of Spiritual Transformation," in *Spiritual Transformation and Healing: Anthropological, Theological, Neuroscientific, and Clinical Perspectives*, eds. Joan D. Koss-Chioino and Philip Hefner (Lanham, MD: AltaMira Press, 2006), 10-24. For an elaboration on what Pargament refers to as "spiritual struggle" see Kenneth I. Pargament et al., "Spiritual Struggle: A Phenomenon of Interest to Psychology and Religion," In *Judeo-Christian Perspectives on Psychology: Human Nature, Motivation, and Change*, eds. William R. Miller and Harold D. Delaney (Washington, D.C.: American Psychological Association Press, 2005), 245-68; Gina Magyar-Russell and Kenneth I. Pargament, "The Darker Side of Religion: Risk Factors for Poorer Health and Well-Being," in *The Psychology of Religious Experience,* ed. Patrick McNamara, vol. 3, Where God and Science Meet: How Brain and Evolutionary Studies Alter Our Understanding of Religion (New York: Oxford University Press, 2006), 91-118; Kelly M. McConnell et al., "Examining the Links between Spiritual Struggles and Symptoms of Psychopathology in a National Sample," *Journal of Clinical Psychology* 62, no. 12 (2006): 1469-84.

121 Harold G. Koenig, "Religion and Medicine I: Historical Background and Reasons for Separation," *International Journal of Psychiatry in Medicine* 30, no. 4 (2000): 385-98; Harold G. Koenig, "Religion and Medicine II: Religion, Mental Health, and Related Behaviors," *International Journal for Psychiatry in Medicine* 31, no. 1 (2001): 97-109.

Further History

Koenig's discussion focuses primarily on the history of the interaction between biomedicine and Christianity, long taken as the referents when one spoke of "medicine and religion." In addition, however, if we look at the larger therapeutic landscape of the United States, we also find varieties of Deism, Vitalism, and other alternate nature-based spiritualities present throughout the course of the country's history.[122] Likewise, these other religiosities were sometimes integral to parties within the ongoing turf wars that characterized each period. As historian Don Bates notes:

> Why not call modern medicine "alternative"? Because we can't. It has already become the name for the other side of the coin. Besides, in the institutional sense, homeopathy, naturopathy, acupuncture, and all the rest certainly are "alternatives" to the established version of medical care. But none of this should prevent us from noticing that in a broader historical and cultural context, using alternative to describe the 20th-century paradigm is warranted, at least in the deeper sense of its being so unlike all the other forms of medicine that have ever existed. In some sense, it is incommensurable, not just with the classical paradigm, but more fundamentally with our most basic intuitions about who we are, intuitions which are more clearly reflected in all those other healing traditions across many centuries and cultures.[123]

Koenig is, therefore, right—just more broadly than he may originally have been arguing.

The purported absolute split between medicine and religion has, in recent years, been linked with what is commonly referred to as "The Flexner Report." In the early years of the twentieth century, the Carnagie Foundation commissioned Abraham Flexner with the task of evaluating the state of medical education and recommending reforms. Published in 1910, the resulting report—*Medical Education in the United States and Canada*—took particular aim at the proliferation of for-profit medical schools—regardless of the type of medicine they taught—viewing them as responsible for "the wave of commercial exploitation which swept the entire profession so far as medical education is concerned."[124] As a remedy, Flexner advocated for the adoption of a structure that focused on two years of didactic content grounded in the sciences, followed by two years of supervised clinical training. These recommendations inspired the current four-year medical school curriculum.

It has become something of a commonplace to lay at Flexner's door the demise of all medical programs that did not adopt the anatomically-based approach to physiology and science, making

122 See in particular the work of Catherine Albanese: *Nature Religion in America: From the Algonkian Indians to the New Age* (Chicago: University of Chicago Press, 1991); *American Spiritualities: A Reader* (Bloomington: Indiana University Press, 2001); *America: Religions and Religion* (Florence, KY: Wadsworth Publishing, 2006 [1981]); *A Republic of Mind and Spirit: A Cultural History of American Metaphysical Religion* (New Haven: Yale University Press, 2008).

123 Don G. Bates, "Why Not Call Modern Medicine 'Alternative'?" *American Academy of Political and Social Science* 583 (2002): 12-28.

124 Abraham Flexner, *Medical Education in the United States and Canada: A Report to the Carnagie Foundation for the Advancement of Teaching*, (New York City: The Carnagie Foundation, 1910), 8.

him something of a villain among practitioners of non-biomedical modalities. To some degree, these critics are right, although the actual data is less conclusive.[125] However, some advocates of the inclusion of religion and spirituality in medical training and practice now also subscribe to the notion that Flexner can be blamed for the exclusion of attention to religiosity and spirituality from clinical training in particular. Christina Puchalski, for example, represents Flexner's *Report* as a call for American medical schools "to adhere strictly to the protocols of mainstream science in their teaching and research," in the process reinforcing "the separation of body and spirit, focusing on scientific evidence of physical health, disease, and treatment. Suffering was largely looked upon as physical pain."[126] A closer reading of Flexner, however, yields a far more complex picture.

Flexner had two key commitments: first, delineating the relationship between professional education in medicine and the broader educational system; second, establishing the "fundamental sciences"— chemistry, physics, and biology—as the essential basis of medical training. These, however, he was quick to add, provided *only* the professional minimum and were even "instrumentally inadequate." They did not, that is, address the other domain essential to one's preparation as a doctor, "a different apperceptive and appreciative apparatus to deal with other more subtle elements," requiring the cultivation of "insight and sympathy on a varied and enlarging cultural experience." He went on to add, "It goes without saying that this type of doctor is first of all an educated man."[127] The *Report* took for granted that a student would enter medical school already having laid a foundation in the humanities and classics. Flexner's ideal doctor was only in part a scientist.

Equally important in relation to a discussion of religion and healing is Flexner's attitude toward what he called "religious education." He had, it appears, little use for induction into a "particular form of religious belief or worship," professing allegiance to no tradition in particular. He wrote, "We no longer believe in a monopoly of truth. We recognize in every religious organization, as in every philosophical scheme, some glimpse of a reality that all are inadequate to express." This worldview led him to oppose any religious education that worked "to fix prejudice and to barricade the mind against alien influences by a powerful rampart of fears, phrases, and ill-digested theological ideas," which he viewed as a "fatal and unjustifiable invasion of [a child's] individuality."[128]

What did concern him, though, was "the wakening and cultivation of the religious spirit as the important task, the critical task, and, alas, the neglected task." What he was after was "religious feeling," the cultivation of a "religious instinct," or what he called "the religious sense":

> The religious sense is, then, essentially the principle of unity, if we may speak so precisely, without which we are lost in this world of time and matter; and it is towards the awakening

125 Mark D. Hiatt and Christopher G. Stockton, "The Impact of the Flexner Report on the Fate of Medical Schools in North America after 1909," *Journal of American Physicians and Surgeons* 8, no. 2 (2003): 37-40.

126 Christina Maria Puchalski. "Religion, Medicine and Spirituality: What We Know, What We Don't Know and What We Do." *Asian Pacific Journal of Cancer Prevention* 11.MECC Supplement (2010): 46.

127 Flexner, *Medical Education*, 26

128. Abraham Flexner, "The Religious Training of Children," *International Journal of Ethics* 7, no. 3 (1897): 314-28.

> of this sense of spiritual unity, beneath the changing aspects of phenomenal life, that religious education must first of all strive. Certainly such religious education cannot be deemed antagonistic to any religious organization or profession; it would be a curious implication of weakness, should any denomination fear religiosity as such.[129]

Without this support, he wrote, the soul was lost. To be cultivated, instead, were one's natural curiosity and wonder, which would naturally lead to religious feeling independent of the content of any given tradition. "Doubt," he insisted, "must become a means of advancing spirituality," through a process that must be "organic" (Flexner's own word).[130] Although he did not articulate such ideas in direct connection with medicine or medical education, he lamented the suppression of this curiosity, wonder, and related form of spirituality, leading me to suppose that all of them would, ideally, have informed the worldview of the "educated man" he envisioned becoming the ideal physician.

Although writing about the religious education of children, I suspect, too, that Flexner would not have excluded older learners from the following position: "I regard it, indeed, as a most positive misfortune that existing conditions make it impossible to unite religious with secular training, for its scope, practical and theoretical, is wide and essential." That he did not view science and religion as incompatible is clear. "Surely," he wrote:

> . . . the highest powers of the human soul meet in that transcendent mood where science and ethics and philosophy, music, art, and poetry fuse to form the developed religious consciousness. And this developed religious consciousness, as I have tried to show, must be the main bulwark of humanity against the forces that threaten the disruption of society, for the supreme fact of the religious sense is spiritual unity."[131]

As Flexner biographer Thomas Bonner observes, since the 1960s and '70s, the "'Flexnerian model' of medical learning" has been increasingly charged by some medical historians with undermining "the holistic sympathies of the clinically trained physician for patients," prioritizing scientific training over all other facets of practice. Moreover, Bonner adds, "Though never demonstrated, Flexner's prescriptions of a half-century earlier for the training of physicians are assumed to be identical with the practices now under attack by modern critics."[132] I suggest that Puchalski's critique and others like it in relation to Flexner's attitudes toward medicine and religion might be said to fall into this category.[133]

129 Ibid., 321

130 Ibid., 327

131 Ibid., 328

132 Thomas Neville Bonner, "Abraham Flexner and the Historians," *Journal of the History of Medicine and Allied Sciences* 45 (1990): 5.

133 For other related discussions of Flexner's ideas and influence, see Henry C. Johnson, Jr., "'Down from the Mountain': Secularization and the Higher Learning in America," *Review of Politics* 54, no. 4 (1992): 551-88; K. Patrick Ober, "The Pre-Flexnerian Reports: Mark Twain's Criticism of Medicine in the United States," *Annals of Internal Medicine* 126 (1997): 157-63; Thomas Neville Bonner, "Searching for Abraham Flexner," *Academic Medicine* 73, no. 2 (1998): 160-66; Carol Carraccio et al., "Shifting Paradigms: From Flexner to Competencies," *Academic Medicine* 77 (2002): 361-67; Andrew H. Beck, "Medical Education: The Flexner Report and the Standardization of American,"

It is worth noting that in the same year that Flexner's *Report* came out, the *British Medical Journal*—widely circulated in the United States—published an issue devoted to matters of faith, suggestion, spiritual and faith healing, the occult, mental healing, and "psychopneumatology; or, the Interactions of Mind, Body, and Soul."[134] Among these articles was one by William Osler on faith, which Osler characterized as tri-partite: faith in the unseen, in one's relationships with others, and in oneself. He pointed, as well, to the many illustrations of "remarkable cures through the influence of the imagination, which is only an active phase of faith," and recommended "the late Daniel Hack Tuke's book, *The Influence of the Mind on the Body.*"[135]

Why do such things matter? I point to these earlier influences to say that the history of religion and healing in a country like the United States is far more woven throughout them than the more official narratives would indicate. Moreover, none of these influences died away. They may not have remained identified with these individuals, but the concerns they represented persisted, resurfacing in different ways throughout the twentieth century and up to the present.

JAMA 291, no. 17 (2004): 2139-40; John H.V. Gilbert, "Abraham Flexner and the Roots of Interprofessional Education," *Journal of Continuing Education in the Health Professions* 28, no. S1 (2008): S11-S14; David J. Doukas, Laurence B. McCullough, and Stephen Wear, "Reforming Medical Education in Ethics and Humanities by Finding Common Ground with Abraham Flexner," *Academic Medicine* 85, no. 2 (2010): 318-23; Richard B. Gunderman et al., "A 'Paradise for Scholars': Flexner and the Institute for Advanced Study," *Academic Medicine* 85, no. 11 (2010): 1784-89; Garrett Riggs, "Are We Ready to Embrace the Rest of the Flexner Report?" *Academic Medicine* 85, no. 11 (2010): 1669-71. In 2010, with the centenary of the Flexner Report, *Academic Medicine* produced an issue revisiting Flexner's legacy in medical education, and thinking toward the future. For examples of the issues raised, see Darrell G. Kirch, "The Flexnerian Legacy in the 21st Century," *Academic Medicine* 85, no. 2 (2010): 190-92; Kenneth M. Ludmerer, "Understanding the Flexner Report," *Academic Medicine* 85, no. 2 (2010): 193-96; William M. Sullivan, "Expanding Flexner's Legacy through New Understandin," *Academic Medicine* 85, no. 2 (2010): 201-02; Michael D. Prislin, John W. Saultz, and John P. Geyman, "The Generalist Disciplines in American Medicine One Hundred Years Following the Flexner Report: A Case Study of Unintended Consequences and Some Proposals for Post-Flexnerian Reform," *Academic Medicine* 85, no. 2 (2010): 228–35; Ann Steinecke and Charles Terrell, "Progress for Whose Future? The Impact of the Flexner Report on Medical Education for Racial and Ethnic Minority Physicians in the United States," *Academic Medicine* 85, no. 2 (2010): 236–45; Louis W. Sullivan and Ilana Suez Mittman, "The State of Diversity in the Health Professions a Century after Flexner," *Academic Medicine* 85, no. 2 (2010): 246–53; and J. Donald Boudreau and Eric J. Cassell, "Abraham Flexner's 'Mooted Question' and the Story of Integration," *Academic Medicine* 85, no. 2 (2010): 378-83.

134 Clifford Allbutt, "Reflections on Faith Healing," *BMJ* 1 (1910): 1453-57; Henry Morris, "'Suggestion' in the Treatment of Disease," *BMJ* 1 (1910): 1457-66; H. T. Butlin, "Remarks on Spiritual Healing," *BMJ* 1 (1910): 1466-70; T. Claye Shaw, "Considerations on the Occult," *BMJ* 1 (1910): 1472-77; James Rorie, "Abstract of a Lecture on Psychopneumatology; or, the Interactions of Mind, Body, and Soul," *BMJ* 1 (1910): 1477-78; Anon., "Mental Healing," *BMJ* 1 (1910): 1483-97; Geoffrey Rhodes, "Health Values," *BMJ* 1 (1919): 1497-98; Anon., "Review: Mind and Body," *BMJ* 1910 (1910): 1498-99.

135 William Osler, "The Faith That Heals," *BMJ* 1 (1910): 1470-72. The full citation is Daniel Hack Tuke, *Illustrations of the Influence of the Mind Upon the Body in Health and Disease, Designed to Elucidate the Action of the Imagination*, 2nd ed. 2 vols. (London: J. & A. Churchill, 1884 [1872]).

Medicalizing the Religious

What has changed, to some extent, are the methods now employed within biomedical research, with the evolving expectation that practice be based on specific forms of evidence, the most reliable of which is considered to be generated by the randomized, double- (and sometimes triple-)blind, placebo-controlled clinical trials, or RCT. This approach draws on an epidemiological method—that is, one that examines phenomena at the level of larger groups or populations. It entails, among other things, testing for the effectiveness of a particular intervention either against a placebo or an existing therapy. Study participants are randomly assigned to the group receiving the intervention being tested and to a control group either not getting the treatment or getting a placebo. The objective is to eliminate the effects of chance and of bias.[136] Even as the discussion of religion and healing unfolded in other disciplinary areas, some physicians were drawn to examine its potential ramifications—and beneficial effects—for biomedicine. However, to have any chance of persuading others in the biomedical community required the application of the RCT.

Four biomedical physicians in particular focused a significant part of their research, writing, and teaching on identifying and studying intersections between biomedicine and religion: cardiologist Herbert Benson (b. 1935), internist Larry Dossey (b. 1940), psychiatrist David Larson (1947-2002), and Harold Koenig. At the time they began to do so, there was little overlap between

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136 For histories and explanations of the randomized controlled trial, see Marcia L. Meldrum, "A Brief History of the Randomized Controlled Trial from Oranges and Lemons to the Gold Standard," *Hematology/Oncology Clinics of North America* 14, no. 4 (2000): 745-60**;** Sylvan B. Green, "Hypothesis Testing in Clinical Trials," *Hematology/Oncology Clinics of North America* 14, no. 4 (2000): 785-95, vii-viii; Harald O. Stolberg, Geoffrey Norman, and Isabelle Trop, "The Practice of Radiology: Randomized Controlled Trials," *American Journal of Roentgenology* 183 (2004): 1539-44; Stefan Timmermans and Marc Berg, *The Gold Standard: The Challenge of Evidence-Based Medicine* (Philadelphia: Temple University Press, 2005). For reviews of the history of the concept and application of placebo, along with critical discussions, see Ted J. Kaptchuk, "Intentional Ignorance: A History of Blind Assessment and Placebo Controls in Medicine," *Bulletin of the History of Medicine* 72, no. 3 (1998): 389-433; Ted J. Kaptchuk, "Powerful Placebo: The Dark Side of the Randomised Controlled Trial," *Lancet* 351, no. 9117 (1998): 1722-25; Ted J. Kaptchuk et al., "Do Medical Devices Have Enhanced Placebo Effects?" *Journal of Clinical Epidemiology* 53 (2000): 786–92; Ted J. Kaptchuk, "The Double-Blind, Randomized, Placebo-Controlled Trial: Gold Standard or Golden Calf?" *Journal of Clinical Epidemiology* 54 (2001): 541-49; Ted J. Kaptchuk, David Eisenberg, and Anthony Komaroff, "Special Report: Pondering the Placebo Effect," *Newsweek*, December 2, 2002, 71; Ted J. Kaptchuk, "The Placebo Effect in Alternative Medicine: Can the Performance of a Healing Ritual Have Clinical Significance?" *Annals of Internal Medicine* 136, no. 817-82 (2002): 817-25; Ted J. Kaptchuk, "Effect of Interpretive Bias on Research Evidence," *BMJ* 326 (2003): 1453-55; Ted J. Kaptchuk et al., "Sham Device V Inert Pill: Randomised Controlled Trial of Two Placebo Treatments," *BMJ* 332 (2006): 391-97; Ted J. Kaptchuk, Catherine E. Kerr, and Abby Zanger, "Placebo Controls, Exorcisms, and the Devil," *Lancet* 374 (2009): 1234-35; Ted J. Kaptchuk et al., "'Maybe I Made up the Whole Thing': Placebos and Patients' Experiences in a Randomized Controlled Trial," *Culture, Medicine, and Psychiatry* 33 (2009): 382-411; Anne Harrington, *The Placebo Effect: An Interdisciplinary Exploration* (Cambridge: Harvard University Press, 1999); Daniel E. Moerman, *Meaning, Medicine, and the 'Placebo Effect'* (New York: Cambridge University Press, 2002). Fabrizio Benedetti, *Placebo Effects: Understanding the Mechanisms in Health and Disease* (New York: Oxford University Press, 2008); Richard Kradin, *The Placebo Response and the Power of Unconscious Healing* (New York: Routledge, 2008).

the domains of the physician and the clergyman. Indeed, through the 1960s and into the 1970s, media attention to the issue of religion and healing focused largely on reporting about faith healers. Opinions were divided, with both warnings and support issuing from some of the mainline Christian denominations. Tragic stories of child deaths—due to parents' refusal of biomedical care on religious grounds and their reliance on a faith healer instead—contributed to a pervasive sense that faith, when mixed with illness, could harm the innocent.[137]

By the 1970s and into the '80s, however, other kinds of healers had come to the public's attention, ranging from Native American medicine men to practitioners of Tibetan medicine. Discussions of the mind's influence over the body gained ground as well, with the word "biofeedback" being coined in 1969. Probably the single best-known figure was the Maharishi Mahesh Yogi (1914-2008), who made his first global tour in 1958. During the late 1960s he came to the attention of the Beatles, whose involvement brought him international publicity. Hundreds of thousands took up the practice of Transcendental Meditation, or TM[138]

One factor contributing to its popularity was the Maharishi's insistence that his style of meditation could be uncoupled from a Hindu worldview. He referred to it as a "science of being" that supported "the art of living." For Americans leery of Eastern traditions, this fairly innocuous presentation—reinforced by a self-characterization as scientific—removed potential barriers. After all, during a 1975 tour through the United States, he appeared on the Merv Griffith Show. When informed that Fundamentalist Christians were protesting outside the studio, he responded that TM was not a religion. A *Time Magazine* article reported:

> All it demands of its practitioners is that they sit still for 20 minutes each morning and evening and silently repeat, over and over again, their specially assigned Sanskrit word, or mantra.
>
> This simple exercise is the cureall, its adherents claim, for almost everything from high blood pressure and lack of energy to alcoholism and poor sexual performance. "I use it the way I'd use a product of our technology to overcome nervous tension," says Stanford Law Professor John Kaplan. "It's a nonchemical tranquilizer with no unpleasant side effects."[139]

137 See, for example, John Wicklein, "Church Cautions on Faith Healing," *New York Times*, February 3, 1962; George Dugan, "Lutherans Back Healing by Faith," *New York Times*, October 23, 1966; George Dugan, "Bonnell Appeals for Faith Healing: Urging Responsible Use, He Cites Jesus' Commands," *New York Times*, November 21, 1966; George Vecsey, "'Mainline' Churches Rediscover Healing," *New York Times*, March 21, 1979; George Vecsey, "Spiritual Healing Gaining Ground with Catholics and Episcopalians," *New York Times*, June 18, 1978.

138 For reportage on other kinds of medicine, see Anon., "A Medicine Man Heard at Parley: Apache Gives Demonstration to Health Professionals," *New York Times*, May 21, 1972; Edward B. Fiske, "Indians Reviving Religious Heritage," *New York Times*, August 23, 1972; John F. Avedon, "Exploring the Mysteries of Tibetan Medicine," *New York Times*, January 11, 1981.

139 For coverage of biofeedback and Transcendental Meditation, see Gay Luce, Erik Peper, and Lew Merrim, "Mind over Body, Mind over Mind," *New York Times*, September 12, 1971; Robert Reinhold, "A School for Meditation Teachers," *New York Times*, June 22, 1971; Edward B. Fiske, "Thousands Finding Meditation Eases Stress of Living," *New York Times*, December 11, 1972; and Anon., "Behavior: The TM Craze: 40 Minutes to Bliss," *Time*, October 13 1975, http://www.time.com/time/printout/0,8816,947229,00.html. Detractors—especially more conservative

The practice had also come to the attention of Herbert Benson because its self-assigned secularity presented a lower threshold to cross than, say, the Hare Krishna movement might have.[140] By 1974, Benson was offering meditation seminars and conducting research. By 1975, studies conducted through Harvard, UCLA, and the Maharishi International University in Iowa were demonstrating that the practice led to reductions in blood pressure, reduced oxygen consumption and metabolism, and denser alpha waves. The Federal Government had funded some of the projects. Still, Benson—who had been involved in the Harvard studies—remained unconvinced that TM afforded the only gateway to such results. Instead, he proposed that there were different ways to learn deep relaxation, which is what he took TM to be. This, he said, one could learn in a minute for free.[141]

Although it had become something of a commonplace to refer to "mind-body medicine," when Benson published *The Relaxation Response* in 1975, arguing that meditative techniques had certain features in common, the book marked a major milestone in the emerging field of alternative medicine. Moreover, although Benson described his observations of Tibetan monks, as a Harvard cardiologist he was already going out on a limb by exploring meditation. Like the Maharishi, he insisted that the Relaxation Response did not involve religious practice. He argued that one could divorce the process from religiosity or a particular tradition altogether—a position he maintained while, at the same time, gradually making more room for religious dimensions in subsequent books written over the next several decades.[142]

In 1975 he also published an article advocating for greater medical attention to placebo, pointing in particular to the related impact of the doctor-patient relationship and contrasting this with the negative effects of using "computer facilities to obtain histories." Twenty years later he would continue to make the case on behalf of nonspecific factors that evoked the placebo effect—"that aspect of treatment not attributable to specific pharmacologic or physiologic properties" (as op-

Christians—were quick to single out all of the Hindu roots that were not necessarily evident to the uninformed but that, in their judgment, rendered TM unsuitable for Christians.

140 Founded in New York City in 1966 by A. C. Bhaktivedanta Swami Prabhupada (1896-1977), the International Society for Krishna Consciousness (ISKON), otherwise know as the Hare Krishna movement, recruited converts around the world and promoted the sacred text the *Bhagavad Gita* in particular. The more involved devotees were readily identifiable, shaving their heads and donning saffron robes. They emulated the *gopi* (cowherd girl) devotees of God Vishnu in his incarnation as Krishna, by dancing and chanting "Hare Krishna" in public places, the most routinely satirized being airports. By adopting overtly Hindu devotional practices and setting up related temples, ISKON represented a transplanted version of Hinduism.

141 See Jane E. Brody, "Cardiologist Offers Meditation Exercise," *New York Times*, November 8, 1974.

142 See Herbert Benson, *The Relaxation Response* (New York: Morrow, 1975); Herbert Benson, *Beyond the Relaxation Response: How to Harness the Healing Power of Your Personal Beliefs* (New York: Times Books, 1984); Herbert Benson with William Proctor, *Your Maximum Mind* (New York: Times Books, 1987); Herbert Benson with Marg Stark, *Timeless Healing: The Power and Biology of Belief* (New York: Scribner, 1996). At the same time, he continued to hold that the specific religious meditative practices themselves were variations on the Relaxation Response. This position has been critiqued from within Religious Studies for commodifying meditation and ignoring the value of formation within a religious community. See, for example, Wakoh Shannon Hickey, "Meditation as Medicine: A Critique," *Crosscurrents* 60, no. 2 (2010): 168-84.

posed to a placebo). At the same time, he recognized that the very notion of placebo did not elicit uniformly favorable impressions, and he began to speak, instead, of "remembered wellness." It was at this point that Benson's work took a significant turn in connection with the discussion of religion and healing. In *Timeless Healing: The Power and Biology of Belief* (1996), he laid out the case that humans are "wired for God" and that the affirmation of beliefs—especially in a "higher power"—can change the state of one's health.[143]

In contrast, Larry Dossey has advocated openly for the inclusion of prayer and other religious devotional practices in relation to medical care, arguing that both are associated with positive health outcomes. The consistent thread running through all of Dossey's work has been that prayer, which he defines as an attitude of the heart, can heal, effecting change from the cellular level to the level of disease. He therefore refers to it as a medicine that can be used in tandem with biomedical and other interventions. The premise upon which he bases this assertion is that the mind is not limited by time or by space. Nor is it confined to one's body. Instead, he argues, something in each person is infinite, eternal, and omnipresent. It is related both to ideas of the soul and to a Universal Mind.

Dossey characterizes the latter as an Absolute that is indefinable. All individual minds and Mind are connected. Dossey traces the lineage of this idea to R.M. Bucke, Ralph Waldo Emerson, Arthur Lovejoy, and Carl Jung, among others, suggesting that they share the conviction that consciousness is larger than the individual mind. With this argument, he positions himself within a particular stream in the history of the psychology of religion.

He asserts that prayer, which is not exclusive to any particular tradition, can take an infinite number of forms. Because the Absolute is in everything, prayer can resonate with, and therefore influence, the state of everything else, although it may not always be answered. Thus, Dossey can also posit the notion of "time-displaced prayer"—prayers answered before they are ever actually made. He argues, too, that its effects can be assessed through laboratory experiments and scientific studies. For that matter, he views both scientific biomedicine and prayer as synergistic.[144]

143 Herbert Benson and Mark D. Epstein, "The Placebo Effect: A Neglected Asset in the Care of Patients," *JAMA* 232, no. 12 (1975): 1225-26, commented on in Lawrence K. Altman, "Physicians Urged to Widen Understanding of Placebos," *New York Times*, July 2, 1975. For other contemporary discussions of placebo, see Anon., "The Therapeutic Value of Placebos," *New York Times*, July 13, 1975; Laurence Cherry, "How the Mind Affects Our Health," *New York Times*, November 23, 1980; Dava Sobel, "Placebo Studies Are Not Just 'All in Your Mind.'" *New York Times*, January 6, 1980. For discussions of "remembered wellness," see Herbert Benson and Richard Friedman, "Harnessing the Power of the Placebo Effect and Renaming It 'Remembered Wellness.'" *Annual Review of Medicine* 47 (1996): 193-99; and Herbert Benson and Marg Stark, *Timeless Healing: The Power and Biology of Belief* (New York: Scribner, 1996).

144 Larry Dossey, *Healing Words: The Power of Prayer and the Practice of Medicine* (San Francisco: HarperSanFrancisco, 1993); Larry Dossey, *Prayer is Good Medicine: How to Reap the Healing Benefits of Prayer* (San Francisco: HarperSanFrancisco, 1996); Larry Dossey, "The Return of Prayer," *Alternative Therapies in Health & Medicine* 3, no. 6 (1997): 10-17, 113-20; Larry Dossey, *Be Careful What You Pray For: You Just Might Get It* (San Francisco: HarperSanFrancisco, 1997); Larry Dossey, *Reinventing Medicine: Beyond Mind-Body to a New Era of Healing* (San Francisco: HarperSanFrancisco, 1999); Larry Dossey, *Healing Beyond the Body: Medicine and the Infinite Reach of the Mind* (Boston: Shambhala, 2001); Larry Dossey, "The Power of Premonition," *Noetic Sciences*

David Larson took a different approach. Having served with the U.S. Public Health Service Commissioned Corps, the NIH, the Department of Health and Human Services, and the National Institute of Mental Health, Larson regularly had to evaluate research findings for possible selection bias. He developed a quantitative research method, "systematic review," that facilitated comprehensive literature reviews. He applied this method to analyze the extent and ways in which religiosity was addressed in different branches of the psychiatric and biomedical literatures. These searches addressed, as well, the extent to which the literature appeared to suggest that religiosity contributed to both mental and physical health outcomes. As a psychiatrist, he was particularly interested in the topics of coping and mental illness. Identifying also as a Christian psychiatrist, he brought an added dedication to exploring integrations of faith with clinical work.[145]

There are no absolute lines dividing the more psychologically oriented research from work that explores "physical" outcomes. Both take an interest in matters of coping and social support—the former more oriented toward depression and stress, the latter more toward specific disease states. Some look at prayer and its health effects. To include the ways an illness has affected a person's life, others focus on whether or not some dimension of religiosity helps to offset these, using measures developed to assess "Quality of Life." Some of these measures have been modified to include

Review 23, no. 12 (2009): 12-17. See also Trina Hart, "An Interview with Larry Dossey MD, Author of *the Science of Premonitions*," *Quantum Health* 6 (2010): 6-9. For a brief review of Dossey's concepts of the mind, prayer, and the Absolute, see "Interview with Dr. Larry Dossey," *Tricycle* 9, no. 3 (2000), http://www.tricycle.com/special-section/interview-with-dr-larry-dossey; Larry Dossey, "Larry Dossey Official Website: Lectures and Presentations, http://www.dosseydossey.com/larry/lecture.html; and Larry Dossey, "Does Technology Reveal a Hidden Imperative toward Empathy?" *The Huffington Post*, May 1, 2010, Accessed March 8, 2011 http://www.huffingtonpost.com/dr-larry-dossey/does-technology-reveal-a_b_557818.html. Most recently, Dossey has turned his attention to the phenomenon of premonitions as another way of discussing the mind's ability to go beyond limits related to time and space. See *The Power of Premonitions: How Knowing the Future Can Shape Our Lives* (New York: Dutton, 2009).

145 See David B. Larson et al., "Systematic Analysis of Research on Religious Variables in Four Major Psychiatric Journals, 1978-1982," *American Journal of Psychiatry* 143, no. 3 (1986): 329-34; David B. Larson et al., "Religious Affiliations in Mental Health Research Samples as Compared with National Samples," *Journal of Nervous and Mental Disease* 177 (1989): 109-11; David B. Larson et al., "The Impact of Religion on Men's Blood Pressure," *Journal of Religion and Health* 28 (1989): 265-78; David B. Larson et al., "Dimensions and Valences of Measures of Religious Commitment Found in the American Journal of Psychiatry and the Archives of General Psychiatry, 1978-1989," *American Journal of Psychiatry* 149 (1992): 557-59; David B. Larson et al., "Religious Content in the DSM-III-R Glossary of Technical Terms," *American Journal of Psychiatry* 150 (1993): 1884-85; Shelley Dean Kilpatrick et al., "A Review of Spiritual and Religious Measures in Nursing Research Journals: 1995-1999," *Journal of Religion and Health* 44, no. 1 (2005): 55-66; Marilyn Baetz et al., "Canadian Psychiatric Inpatient Religious Commitment: An Association with Mental Health," *Canadian Journal of Psychiatry* 47, no. 2 (2002): 159-66; Marilyn Baetz et al., "Religious Psychiatry: The Canadian Experience," *The Journal of Nervous and Mental Disease* 190, no. 8 (2002): 557-59; Linda K. George, Christopher G. Ellison, and David B. Larson, "Explaining the Relationships between Religious Involvement and Health," *Psychological Inquiry* 13, no. 3 (2002): 190-200; Peter H. Van Ness and David B. Larson, "Religion, Senescence, and Mental Health: The End of Life Is Not the End of Hope," *American Journal of Geriatric Psychiatry* 10, no. 4 (2002): 386-97. For examples of Larson's work advocating the incorporation of religious and spiritual issues into clinical practice, see David B. Larson et al., "The Couch and the Cloth: The Need for Linkage," *Hospital and Community Psychiatry* 39 (1988): 1064-69; David B. Larson and M.A. Greenwold, "Are Religion and Spirituality Clinically Relevant in Health Care?" *Mind/Body Medicine* 1, no. 3 (1995): 147-57.

variables related to constructions of religion and/or spirituality. It is well beyond the scope of this article to review the extent of this literature, but a significant portion of it reviews research about outcomes related to specific diseases, chronic conditions, and surgical procedures. It also includes RCTs.[146]

Koenig draws on the research he cites to argue that there must be some mechanism through which religiosity can affect one's physical health. In response, he presents a theoretical model for such "pathways." He summarizes a review of connections between religion, physical health, and mortality, with a focus on pain and disability, cardiovascular disease, immune and neuroendocrine function, susceptibility to infection, cancer, and overall mortality.[147]

He traces his interest in these questions to clinical experience as a psychiatrist, when patients talked with him about the importance of their religious lives in the face of their health challenges. Much of his work combines to build a case for the intentional inclusion of such discussions in clinical care. He does so by developing measures, gathering data related to the importance to patients of integrating religion and medicine, related health outcomes, and tools for actual practice, which he also tests.

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146 For examples of sources related to coping, see Camelia Rohani et al., "Health Index, Sense of Coherence Scale, Brief Religious Coping Scale, and Spiritual Perspective Scale: Psychometric Properties," *Journal of Advanced Nursing: Research Methodology* 66, no. 12 (2010): 2796-806; Kenneth F. Ferraro and Jerome R. Koch, "Religion and Health among Black and White Adults: Examining Social Support and Consolation," *Journal for the Scientific Study of Religion* 33, no. 4: 362-75. For a sample of sources related to stress, see Jennifer N. Belding et al., "Social Buffering by God: Prayer and Measures of Stress," *Journal of Religion and Health* 49 (2010): 179-87; Gracie H. Boswell, Eva Kahana, and Peggye Dilworth-Anderson, "Spirituality and Healthy Lifestyle Behaviors: Stress Counter-Balancing Effects on the Well-Being of Older Adults," *Journal of Religion and Health* 45, no. 4 (2006): 587-602; Jane K. Ferguson, Eleanor W. Willemsen, and MayLynn V. Castañeto, "Centering Prayer as a Healing Response to Everyday Stress: A Psychological and Spiritual Process," *Pastoral Psychology* 59 (2010): 305-29. For illustrations of literature focused on specific disease states, see A. L. Ai et al., "Long-Term Adjustment after Surviving Open Heart Surgery: The Effect of Using Prayer for Coping Replicated in a Prospective Design," *Gerontologist* 50, no. 6 (2010): 798-809; Anna Vespa et al., "Evaluation of Intrapsychic Factors, Coping Styles, and Spirituality of Patients Affected by Tumors," *Psycho-Oncology* 20 (2011): 5-11; Sian Cotton, Daniel Grossoehme, and Meghan E. McGrady, "Religious Coping and the Use of Prayer in Children with Sickle Cell Disease," *Pediatric Blood & Cancer* (2011): doi:10.1002/pbc. For the original formulation of a Quality of Life scale, see John C. Flanagan, "A Research Approach to Improving Our Quality of Life," *American Psychologist* 33, no. 2 (1978): 138-47. Flanagan argued that one area key to people's feeling that their life quality was good involved "personal understanding and planning," which included "developing and gaining orientation, purpose, and guiding principles' for one's life" which, for some people "arises from religious or spiritual experiences or activities. This scale has since undergone multiple modifications and revisions; other scales have been developed as well with a more direct focus on different understandings of spirituality. For an example, see S. N. Davison and G. S. Jhangri, "Existential and Religious Dimensions of Spirituality and Their Relationship with Health-Related Quality of Life in Chronic Kidney Disease," *Clinical Journal of the American Society of Nephrology* 5, no. 11 (2010): 1969-76. The various QOL measures have not persuaded everyone. For an illustration of critiques, see Alain Leplège and Sonia Hunt, "The Problem of Quality of Life in Medicine," *JAMA* 278 (1997): 47-50.

147 Harold G. Koenig, "Religion and Medicine III: Developing a Theoretical Model," *International Journal for Psychiatry in Medicine* 31, no. 2 (2001): 199-216; Harold G. Koenig, "Religion and Medicine IV: Religion, Physical Health, and Clinical Implications," *International Journal for Psychiatry in Medicine* 31, no. 3 (2001): 321-36.

Intercessory Prayer and Distant Healing

It has been the randomized controlled trials undertaken by these physician researchers that have drawn the greatest amount of media attention, particularly when they made it to the cover of *Time*.[148] A good deal of this attention goes to the set of studies claiming to have shown the efficacy of prayer—particularly intercessory prayer on behalf of the sufferer but offered by others. Prayer, in its own right, generally presupposes the presence of a deity or other being to whom one petitions or with whom one communicates. It can also be an expression of praise.

Studies of intercessory prayer generally refer to God, who is characterized as the "Judeo-Christian" deity.[149] These studies have, almost without exception, focused on measuring outcomes of related "effects." In part, this focus has included efforts to develop guidelines for conducting research into a topic that is often viewed as outside of a research domain. A second focus has involved appraising the quality of the related evidence and evaluating the different studies. Regular attention has also gone into testing study designs, reflecting the frequent argument that one simply cannot quantify or operationalize the nature, quality, or impact of prayer.[150]

148 For examples of mainstream media representations of these developments, see Peter Steinfels, "A Doctor Looks to Science for Proof of a Spiritual Realm," *New York Times*, December 19, 1993; Claudia Wallis et al., "Faith & Healing," *Time*, June 24, 1996, http://www.time.com/time/printout/0,8816,984737,00.html; David Van Biema et al., "Deepak Chopra: Emperor of the Soul," *Time*, June 24, 1996, http://www.time.com/time/printout/0,8816,984738,00.html; Cornelia Dean, "Churchgoing May Aid Health," *New York Times*, November 4, 1997; Hampton Sides, "The Calibration of Belief," *New York Times*, December 7, 1997; Nadine Brozan, "Breaking Down the Barriers between Religion and Medicine," *New York Times*, July 18, 1998; Nancy Beth Jackson, "Paths to a Higher Plane and Longer Life," *New York Times*, August 17, 1999; Stephen S. Hall, "Is Buddhism Good for Your Health?" *New York Times*, September 14, 2003; Claudia Kalb, "Faith & Healing: Can Religion Improve Health? While the Debate Rages in Journals and Med Schools, More Americans Ask for Doctors' Prayers," *Newsweek*, November 10, 2003 http://www.newsweek.com/2003/11/09/faith-healing.print.html; Raymond Lawrence, "Faith-Based Medicine," *New York Times*, April 11, 2006; Nicholas Bakalar, "Most Doctors See Religion as Beneficial, Study Says," *New York Times*, April 17, 2007; Alice Park, "Faith and Healing: A Forum," *Time*, February 12, 2009 http://www.time.com/time/printout/0,8816,1879202,00.html.

149 The term "Judeo-Christian" appeared in the 1950s, melding two traditions that shared historical roots but that have sharply divergent theologies in relation to their understanding of the role of Jesus. The term has undertones of supersessionism, a Christian view that God's revelation through the birth, death, and resurrection of Jesus superseded the covenants of Judaism. The term is therefore problematic although widely used.

150 See Jeffrey S. Levin, "How Prayer Heals: A Theoretical Model," *Alternative Therapies in Health & Medicine* 2, no. 1 (1996): 66-73; Elisabeth Targ and Keith Stewart Thomson, "Can Prayer and Intentionality Be Researched? Should They Be?: Point and Counterpoint," *Alternative Therapies in Health & Medicine* 3, no. 6 (1997): 92-96; Randolph C. Byrd, "Positive Therapeutic Effects of Intercessory Prayer in a Coronary Care Unit Population," *Alternative Therapies in Health & Medicine* 3, no. 6 (1997): 87-90; Russell Targ and Jane Katra, *Miracles of Mind: Exploring Non-Local Consciousness and Spiritual Healing* (Novato, CA: New World Library, 1997); Seán O'Laoire, "An Experimental Study of the Effects of Distant, Intercessory Prayer on Self-Esteem, Anxiety, and Depression," *Alternative Therapies in Health & Medicine* 3, no. 6 (1997): 38-53; Scott R. Walker et al., "Intercessory Prayer in the Treatment of Alcohol Abuse and Dependence: A Pilot Investigation," *Alternative Therapies in Health & Medicine* 3, no. 6 (1997): 79-86; Dorothea J. Eicher and Shelley Cypher Springer, "Effects of a Prayer Circle on a Moribund Premature Infant," *Alternative Therapies in Health & Medicine* 5, no. 3 (1999): 114-18; Janice Bell Meisenhelder and

A second term sometimes used in the intercessory-prayer studies, but also used independently, is "distant healing." Whereas "prayer" implies a divine recipient of the petition, "distant healing" merely specifies the location of the petitioner. In such discussions, prayer is sometimes characterized as one form of distant healing because it can be conducted both in the presence of and at a distance from the person on whose behalf one is praying. Likewise, various forms of energy healing can be performed both in someone's company and remotely. An even more encompassing category is "mind-body medicine."[151]

Related studies—much like the research into prayer—have examined research guidelines for studying the effects of distant healing, evaluating the evidence and the outcomes as well as the actual quality of the research.[152] At the same time, studies of both prayer and distant healing have their detractors who generally focus on challenging the studies' research methods. Such challenges then naturally extend to the outcomes. In general, critics have argued that there are no conclusive findings substantiating claims for the efficacy of either intervention.[153]

Emily N. Chandler, "Prayer and Health Outcomes in Church Members," *Alternative Therapies in Health & Medicine* 6, no. 4 (2000): 56-60; William J. Matthews, James M. Conti, and Stephen G. Sireci, "The Effects of Intercessory Prayer, Positive Visualization, and Expectancy on the Well-Being of Kidney Dialysis Patients," *Alternative Therapies in Health & Medicine* 7, no. 5 (2001): 42-52; Karen T. Lesniak, "The Effect of Intercessory Prayer on Wound Healing in Nonhuman Primate," *Alternative Therapies in Health & Medicine* 12, no. 6 (2006): 42-48.

151 The National Center for Complementary and Alternative Medicine positions spirituality under the rubric of the mind-body connection and includes prayer in that category (along with meditation, mindfulness, and yoga). See, for example, National Advisory Council for Complementary and Alternative Medicine, "Minutes of the Seventeenth Meeting," Bethesda, MD, 2004.www.ccam.nih.gov/about/naccam/minutes/2005june.pdf. NCCAM has also sponsored in-house talks in the subject.

152 Marilyn Schlitz, "Intentional in Healing: Mapping the Integration of Body, Mind, and Spirit," *Alternative Therapies in Health & Medicine* 1, no. 5 (1995): 118-19; Marilyn Schlitz and William Braud, "Distant Intentionality and Healing: Assessing the Evidence," *Alternative Therapies in Health & Medicine* 3, no. 6 (1997): 62-73; Elisabeth Targ, "Evaluating Distant Healing: A Research Review," *Alternative Therapies in Health & Medicine* 3, no. 6 (1997): 74-78; Barbara G. Koopman and Richard A. Blasband, "Distant Healing Revisited: Time for a New Epistemology," *Alternative Therapies in Health & Medicine* 8, no. 1 (2002): 100-01; Barbara G. Koopman and Richard A. Blasband, "Two Case Reports of Distant Healing: New Paradigms at Work?" *Alternative Therapies in Health & Medicine* 8, no. 1 (2002): 115-19; Edzard Ernst, "Distant Healing—an 'Update' of a Systematic Review," *Wiener Klinische Wochenschrift/The Middle European Journal of Medicine* 115, no. 7-8 (2003): 241-45; Roeland Van Wijk and Eduard P.A. Van Wijk, "The Search for a Biosensor as a Witness of a Human Laying on of Hands Ritual," *Alternative Therapies in Health & Medicine* 9, no. 2 (2003): 48-54; Wayne B. Jonas and Cindy C. Crawford, "A Systematic Review of the Quality of Research on Hands-on and Distance Healing," *Alternative Therapies in Health & Medicine* 9, no. 2 (2003): 56-61; Kenjiro Tsubono, Paul Thomlinson, and C. Norman Shealy, "The Effects of Distant Healing Performed by a Spiritual Healer on Chronic Pain: A Randomized Controlled Trial," *Alternative Therapies in Health & Medicine* 15, no. 3 (2009): 30-34; and Barbara Findlay et al., "Methodological Complexities Associated with Systematic Review of Healing Relationships," *Alternative Therapies in Health & Medicine* 16, no. 5 (2010): 46-57.

153 Richard P. Sloan and Emilia Bagiella, "Claims About Religious Involvement and Health Outcomes," *Annals of Behavioral Medicine* 25, no. 1 (2002): 14-21; John A. Astin et al., "The Efficacy of Distant Healing for Human Immunodeficiency Virus Results of a Randomized Trial," *Alternative Therapies in Health & Medicine* 12, no. 6 (2006): 36-41; Edzard Ernst, "Spiritual Healing: More Than Meets the Eye," *Journal of Pain and Symptom Management* 32, no. 5 (2006): 393-95; Richard P. Sloan and Rahasekhar Ramakrishnan, "Science, Medicine, and Intercessory Prayer," *Perspectives in Biology and Medicine* 49, no. 4 (2006): 504-14; and Richard P. Sloan, *Blind Faith: The*

Physician Engagement

Proponents draw not only on their outcome studies but also on research they have conducted related to patient preferences. On this basis, they argue that a patient's own degree of religiosity is likely to inform how much they want (or don't care) to know about their physician's religious worldview and to discuss their own. However, what patients and doctors do seem to have in common is the view that, if a patient becomes seriously ill, it is more appropriate for their doctor to ask about their religious beliefs. Even patients who don't expect their doctors to discuss religiosity do hope they will ask about the patient's coping and support mechanisms. They also want physicians to respect whatever religious convictions they do raise. Roughly a fifth think that their doctors should pray with them.[154]

The other part of the equation has been, of course, the provider, leading to a number of related questions: first, how clinicians themselves view engaging in such discussions; second, factors tending to influence some of these positions; third, how one might train clinicians to feel equipped for such conversations; and fourth, the related ethics issues. As might be expected, there is no uniform consensus about whether or not it is part of the clinician's role to address a patient's religiosity or spirituality in a clinical setting. Those who advocate for inclusion point to studies that link positive spiritual states with mental and physical health (it is not clear whether "positive" in this case resembles what William James would have called the healthy-minded soul). Critical or palliative care settings, in which patients' mortality stands in the foreground, seem to elicit more consistent support and a greater readiness to provide a spiritual care that integrates doctors, nurses, social workers, chaplains, psychologists, and others.[155]

Unholy Alliance of Religion and Medicine (New York: St. Martin's Griffin, 2008). Such critiques have also made their way into the mainstream media. See, for example, Benedict Carey, "Can Prayers Heal? Critics Say Studies Go Past Science's Reach," *New York Times*, October 10, 2004; Benedict Carey, "Long-Awaited Medical Study Questions the Power of Prayer," *New York Times*, March 31, 2006.

154 For resources related to patient attitudes, see D. E. King and B. Bushwick, "Beliefs and Attitudes of Hospital Inpatients About Faith Healing and Prayer," *Journal of Family Practice* 39, no. 4 (1994): 349-52; Oliver Oyama and Harold G. Koenig, "Religious Beliefs and Practices in Family Medicine," *Archives of Family Medicine* 7 (1998): 431-35; John W. Ehman et al., "Do Patients Want Physicians to Inquire About Their Spiritual or Religious Beliefs If They Become Gravely Ill?" *Archives of Internal Medicine* 159 (1999): 1803-06; Randy S. Hebert et al., "Patient Perspectives on Spirituality and the Patient-Physician Relationship," *Journal of General Internal Medicine* 1, no. 16 (2001): 685-92; Charles D. MacLean et al., "Patient Preference for Physician Discussion and Practice of Spirituality: Results from a Multicenter Patient Survey," *Journal of General Internal Medicine* 18, no. 1 (2003): 38-43; and Seth M. Holmes and Michael W. Rabow, "Screening the Soul: Communication Regarding Spiritual Concerns among Primary Care Physicians and Seriously Ill Patients Approaching the End of Life," *Journal of Pain and Symptom Management* 37, no. 3 (2009): 461. It should be noted that Regional differences affect the outcomes of such studies. Many of the earlier ones were conducted in the Southeastern U.S., thereby reflecting a somewhat more conservative Protestant religiosity that was then sometimes presented as though it represented the broader population.

155 See, for example, Walter L. Larimore, Michael Parker, and Martha Crowther, "Should Clinicians Incorporate Positive Spirituality into Their Practices? What Does the Evidence Say?" *Annals of Behavioral Medicine* 24, no. 1 (2002): 69-73; Russell D'Souza, "The Importance of Spirituality in Medicine and Its Application to Clinical Practice," *Medical Journal of Australia*, supplement, 186, no. 10, (2007): S57-S59; Pat Fosarelli, "Medicine, Spirituality, and

Those opposed to having physicians direct attention to patients' spiritual and religious concerns frame their reluctance in relation to a lack of preparation in the face of patients' religious diversity. They point to the potential reductionism of prayer or the inappropriateness of having doctors recommend religious or spiritual involvement on the basis of potential health benefits. They question, as well, the evidence upon which proponents base their position. Others point to the range of meaning-related issues that arise in medical settings, requiring careful attention to those that fall within the purview of medicine and those that do not. The greatest concern tends to arise in relation to an unintended abuse of physician power. These same physicians, in general, support a collaborative relationship with chaplains instead.[156] I would add that this reluctance in some cases traces to the field's underlying Protestant Christian roots and related overtones, which are more evident than advocates are often aware.

The more common perspective tends to reflect contingencies. Variables such as the degree of religiously-oriented behavior or discussion (e.g., taking a spiritual history), the nature of the patient's health condition and its relative severity, the provider's own religious or spiritual orientation, and indications from the patient that he or she wishes the provider to address such topics or to pray with the patient all inform where a given physician may stand in a given case. Again, the doctor's personal orientation plays a part, with those who view themselves as more religious also reporting a higher occurrence of patients raising the subject. In one survey of 2,000 U.S. physicians from all specialties (with a 63% response rate), 56% believed that religion and spirituality influenced health, but only 6% subscribed to the idea that either could affect "hard" medical outcomes. Most of them, however, accepted the ideas that religiosity helped patients cope with their own illness or that of others, achieve a more positive frame of mind, and find emotional and practical support though their faith community.[157]

Patient Care," *JAMA* 300, no. 7 (2008): 836-38; and Christina M. Puchalski and Betty Ferrell, *Making Health Care Whole: Integrating Spirituality into Patient Care* (West Conshohocken, PA: Templeton Press, 2010).

156 For illustrative discussions, see Hector Avalos, "Can Science Prove That Prayer Works?" *Free Inquiry* 17, no. 3 (1997): 27-31; Larry VandeCreek, "Should Physicians Discuss Spiritual Concerns with Patients?" *Journal of Religion and Health* 38, no. 3 (1999): 193-201; Richard P. Sloan et al., "Should Physicians Prescribe Religious Activities?" *New England Journal of Medicine* 342, no. 25 (2000): 1913-16; Richard P. Sloan and Emilia Bagiella, "Claims About Religious Involvement and Health Outcomes," *Annals of Behavioral Medicine* 25, no. 1 (2002): 14-21; Neil Scheurich, "Reconsidering Spirituality and Medicine," *Academic Medicine* 78 (2003): 356-60; Raymond J. Lawrence, "Faith-Based Medicine: Why Doctors Shouldn't Prescribe Prayer," *New York Times*, April 11, 2006; and Richard P. Sloan, *Blind Faith*.

157 For examples of the kind of contingencies and variables reviewed above, see Benjamin Siegel et al., "Faculty and Resident Attitudes About Spirituality and Religion in the Provision of Pediatric Health Care," *Journal of Ambulatory Care* 2, no. 1 (2002): 5-10; Carla M. Messikomer and Willy De Craemer, "The Spirituality of Academic Physicians: An Ethnography of a Scripture-Based Group in an Academic Medical Center," *Academic Medicine* 77, no. 6 (2002): 562-73; Michael H. Monroe et al., "Primary Care Physician Preferences Regarding Spiritual Behavior in Medical Practice," *Archives of Internal Medicine* 163 (2003): 2751-56; Mark R. Ellis and James D. Campbell, "Concordant Spiritual Orientations as a Factor in Physician–Patient Spiritual Discussions: A Qualitative Study," *Journal of Religion and Health* 44, no. 1 (2005): 39-53; Roger D. Smalligan, "Physician's Perspective: Combining Spirituality and Medicine: One Physician's Approach," *Southern Medical Journal* 99, no. 12 (2005): 1240-41; Sara E. Luckhaupt

To the extent that clinicians express reluctance to engage in discussions of spirituality and/or religion due to a lack of training or preparation, advocates have worked to introduce related curricula into the education of both medical students and residents. Beginning in the mid-1990s, the John Templeton Foundation developed a program to fund new courses in medical and osteopathic schools that would address spirituality, cultural awareness, and end of life issues in medical care. Awards for curriculum development for Primary Care and Psychiatry residency programs were also given out. The program ran from 1995 to 2006 as the Spirituality in Medicine Curricular Awards, under the direction of Dr. Christina Puchalski at the George Washington Institute for Spirituality & Health (GWish) at George Washington University.

By 2006, Puchalski reported that some seventy-five percent of U.S. medical schools said that they directed some curricular attention to the issue of spirituality in medical care.[158] In addition to more general recommendations for the inclusion of curricula in spirituality in medical curricula, the literature also includes descriptions of particular courses.[159] Another set of programs introduces

et al., "Beliefs of Primary Care Residents Regarding Spirituality and Religion in Clinical Encounters with Patients: A Study at a Midwestern U.S. Teaching Institution," *Academic Medicine* 80 (2005): 560–70; Michael M. Olson et al., "Mind, Body, and Spirit: Family Physicians' Beliefs, Attitudes, and Practices Regarding the Integration of Patient Spirituality into Medical Care," *Journal of Religion and Health* 45, no. 2 (2006): 234-47; Farr A. Curlin et al., "The Association of Physicians' Religious Characteristics with Their Attitudes and Self-Reported Behaviors Regarding Religion and Spirituality in the Clinical Encounter," *Medical Care* 44, no. 5 (2006): 446-53; Farr A. Curlin et al., "Physicians' Observations and Interpretations of the Influence of Religion and Spirituality on Health," *Archives of Internal Medicine* 167 (2007): 649-54; Farr A. Curlin et al., "Religion, Spirituality, and Medicine: Psychiatrists' and Other Physicians' Differing Observations, Interpretations, and Clinical Approaches," *American Journal of Psychiatry* 164 (2007): 1825–31; Elizabeth Ann Catlin et al., "The Spiritual and Religious Identities, Beliefs, and Practices of Academic Pediatricians in the United States," *Academic Medicine* 83 (2008): 1146-52; Aaron Saguil, Annette L. Fitzpatrick, and Gary Clark, "Are Residents Willing to Discuss Spirituality with Patients?" *Journal of Religion and Health* (2011), doi: 10.1007/s10943-011-9467-7; Aaron Saguil, Annette L. Fitzpatrick, and Gary Clark, "Is Evidence Able to Persuade Physicians to Discuss Spirituality with Patients?" *Journal of Religion and Health* (2011), doi: 10.1007/s10943-010-9452-6.

158 See http://www.gwish.org/. The Templeton Foundation funded a parallel initiative in religion departments to fund courses in religion and science. In both cases, the Foundation's influence generated the impression that a spontaneous interest had led to these curricular developments in the two domains. If, for example, one reviews the published literature on courses in medicine and spirituality, many if not most of them received Templeton funding.

159 Christina M. Puchalski and David B. Larson, "Developing Curricula in Spirituality and Medicine," *Academic Medicine* 73 (1998): 970-74; J. T. Chibnall et al., "Medical School Exposure to Spirituality and Response to a Hypothetical Cancer Patient," *Journal of Cancer Education* 17, no. 4 (2002): 188-90; Auguste H. Fortin VI and Katherine Gergen Barnett, "Medical School Curricula in Spirituality and Medicine," *JAMA* 291, no. 23 (2004): 2882-83; Christina M. Puchalski, "Spirituality and Medicine: Curricula in Medical Education," *Journal of Cancer Education* 21, no. 1 (2006): 14-18; Gowri Anandarajah and Sister Maureen Mitchell, "A Spirituality and Medicine Elective for Senior Medical Students: 4 Years' Experience, Evaluation, and Expansion to the Family Medicine Residency," *Family Medicine* 39, no. 5 (2007): 313-15; Katherine Gergen Barnett and Auguste H. Fortin VI, "Spirituality and Medicine: A Workshop for Medical Students and Residents," *Journal of General Internal Medicine* 21 (2006): 481-85; and John T. Chibnall and Paul N. Duckro, "Does Exposure to Issues of Spirituality Predict Medical Students' Attitudes toward Spirituality in Medicine?" *Academic Medicine* 75 (2000): 661.

the topic into residency education.[160] A small number of programs are designed for health care professionals and for nurses.[161] In part, these curricula introduce definitions of spirituality, illustrations of how it surfaces in the lives of clinicians and in clinical scenarios, varieties of expression and experience, and ways to respond. They also provide learners with tools used to gather a "spiritual history" from their patients or to perform a "spiritual assessment."[162]

160 Elisabeth Targ, "A Curriculum on Spirituality, Faith, and Religion for Psychiatry Residents," *Psychiatric Annals* 29, no. 8 (1999): 485-88; Gowri Anandarajah, Richard Long, and Marcia Smith, "Integrating Spirituality into the Family Medicine Residency Curriculum," *Academic Medicine* 76, no. 5 (2001): 519-20; Mark C. Pettus, "Implementing a Medicine–Spirituality Curriculum in a Community-Based Internal Medicine Residency Program," *Academic Medicine* 77, no. 7 (2002): 745; Gowri Anandarajah et al., "Toward Competency-Based Curricula in Patient-Centered Spiritual Care: Recommended Competencies for Family Medicine Resident Education," *Academic Medicine* 85, no. 12 (2010): 1897-904; Sheila Loboprabhu and James Lomax, "The Role of Spirituality in Medical School and Psychiatry Residency Education," *International Journal of Applied Psychoanalytic Studies* 7, no. 2 (2010): 180-92; Christina Puchalski, David B. Larson, and Francis G. Lu, "Spirituality in Psychiatry Residency Training Programs," *International Review of Psychiatry* 13 (2001): 131-38; and Larry VandeCreek et al., "Attention to Spiritual/Religious Concerns in Pediatric Practice: What Clinical Situations? What Educational Preparation?" *Chaplaincy Today* 23, no. 2 (2007): 3-9.

161 For examples, see I. David Todres, Elizabeth A. Catlin, and Mary Martha Thiel, "The Intensivist in a Spiritual Care Training Program Adapted for Clinicians," *Critical Care Medicine* 33, no. 12 (2005): 2733-36; Pamela Meredith et al., "Can Spirituality Be Taught to Health Care Professionals?" *Journal of Religion and Health* (2010), doi: 10.1007/s10943-010-9399-7. For forty years, the Benson-Henry Institute for Mind Body Medicine at Massachusetts General Hospital, founded by Herbert Benson, offered continuing medical education courses in Spirituality and Healing in Medicine. The courses ran through at least 2008, at which point the Institute returned to offering courses more broadly under the heading of mind-body medicine. For training direct to nurses, see Jan P. Vlasblom et al., "Effects of a Spiritual Care Training for Nurses," *Nurse Education Today* (2010), doi:10.1016/j.nedt.2010.11.010.

162 For examples and discussions of these tools, see Gowri Anandarajah and Ellen Hight, "Spirituality and Medical Practice: Using the Hope Questions as a Practical Tool for Spiritual Assessment," *American Family Physician* 63 (2001): 81-89; Harold G. Koenig, "Taking a Spiritual History," *JAMA* 291, no. 23 (2004): 2881; T. Ford, "None of Your 'Darn' Business! Taking a Spiritual History While Preserving Your Professional Boundaries, Your Rapport, and Your Pride," *Journal of Pain and Symptom Management* 39, no. 2 (2010): 364; T. A. Maugins, "The SPIRITual History," *Archives of Family Medicine* 5 (1997): 11-16; Christina Maria Puchalski, "Formal and Informal Spiritual Assessment," *Asian Pacific Journal of Cancer Prevention* 11, MECC supplement (2010): 51-57; Tami Borneman, Betty Ferrell, and Christina M. Puchalski, "Evaluation of the FICA Tool for Spiritual Assessment," *Journal of Pain and Symptom Management* 40, no. 2 (2010): 163-73; Stefanie M. Monod et al., "The Spiritual Distress Assessment Tool: An Instrument to Assess Spiritual Distress in Hospitalised Elderly Persons," *BMC Geriatrics* 10 (2010), http://www.biomedcentral.com/1471-2318/10/88; Mark A. Larocca-Pitts, "FACT: Taking a Spiritual History in a Clinical Setting," *Journal of Health Care Chaplaincy* 15, no. 1 (2008): 1-12; Mark LaRocca-Pitts, "In FACT, Chaplains Have a Spiritual Assessment Tool," *Australian Journal of Pastoral Care and Health* 3, no. 2 (2009): 8-15; Amy H. Peterman et al., "Measuring Spiritual Well-Being in People with Cancer: The Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being Scale (FACIT-Sp)," *Annals of Behavioral Medicine* 24 (2002): 49-58; Alan J. Gow et al., "A Stairway to Heaven? Structure of the Religious Involvement Inventory and Spiritual Well-Being Scale," *Journal of Religion and Health* 50 (2011): 50-19; and Larry VandeCreek, "Spiritual Assessment: Six Questions and an Annotated Bibliography of Published Interview and Questionnaire Formats," *Chaplaincy Today* 21, no. 1 (2005): 11-22. For a discussion of the RCOPE instrument, see Jeffrey P. Bishop, "Biopsychosociospiritual Medicine and Other Political Schemes," *Christian Bioethics* 15, no. 3 (2009): 254-76. Another physician who has dedicated a significant part of his research career to the study of religion and biomedicine is Timothy P. Daaleman, an Associate Professor of Family Medicine and a Research Fellow with the Program on Aging, Disability, & Long-Term Care at the University of North

Building from a Biopsychosocial Model

In addition to making the case that faith and religious practice have the potential to improve physical and emotional health as well as to help people cope with illness and suffering, advocates have turned to a model developed in the late 1970s by psychiatrist George Engel, who viewed with alarm the impact of a disease model that omitted the social, psychological, and behavioral dimensions of illness. Engel proposed, instead, that clinicians employ what he termed a "biopsychosocial model" in their practice, research, and teaching. This systemic approach gained considerable currency in fields ranging from biomedicine to clinical social work and psychology, due particularly to its emphasis on the connection between clinician and patient.[163]

Advocates of attending to the spiritual and religious in medicine have borrowed and modified Engel's model in two ways. The first proposes a "biopsychosociospiritual" approach.[164] The

Carolina at Chapel Hill. For a general argument in favor of incorporating religion and spirituality into the practice of medicine, see: Timothy P. Daaleman. "Religion, Spirituality, and the Practice of Medicine." *Journal of the American Board of Family Practice* 17 (2004): 370-76. For Daaleman's Spirituality Index, see: Timothy P. Daaleman et al., "Spirituality Index of Well-Being Scale: Development and Testing of a New Measure," *Journal of Family Practice* 51, no. 11 (2002): 952; Timothy P. Daaleman and Bruce B. Frey, "The Spirituality Index of Well-Being: A New Instrument for Health-Related Quality-of-Life Research," *Annals of Family Medicine* 2 (2004): 499-503; Bruce B. Frey, Timothy P. Daaleman, and Vicki Peyton, "Measuring a Dimension of Spirituality for Health Research: Validity of the Spirituality Index of Well-Being," *Research on Again* 27, no. 5 (2005): 556-77. Daaleman has also addressed issues of life stages, geriatric patients, and end of life care in connection with religion and spirituality. See Timothy P. Daaleman, Subashan Perera, and Stephanie A. Studenski, "Religion, Spirituality, and Health Status in Geriatric Outpatients," *Annals of Family Medicine* 2 (2004): 49-53; Timothy P. Daaleman and Jr. Glen H. Elder, "Family Medicine and the Life Course Paradigm," *Journal of the American Board of Family Medicine* 20 (2007): 85-92; Timothy P. Daaleman et al., "An Exploratory Study of Spiritual Care at the End of Life," *Annals of Family Medicine* 6 (2008): 406-11.

163 George L. Engel, "The Need for a New Medical Model: A Challenge for Biomedicine," *Science* 196, no. 4299 (1977): 129-36. See also Rolf H. Adler, "Engel's Biopsychosocial Model Is Still Relevant Today," *Journal of Psychosomatic Research* 67 (2009): 607-11. For recent rethinking of the applicability of the model in psychiatry, see S. Nassir Ghaemi, *The Concepts of Psychiatry: A Pluralistic Approach to the Mind and Mental Illness* (Baltimore: Johns Hopkins University Press, 2003); "Paradigms of Psychiatry: Eclecticism and Its Discontents," *Current Opinion in Psychiatry* 19, no. 6 (2006): 619-24; "The Rise and Fall of the Biopsychosocial Model," *British Journal of Psychiatry* 195 (2009): 3-4; and *The Rise and Fall of the Biopsychosocial Model: Reconciling Art and Science in Psychiatry* (Baltimore: Johns Hopkins University Press, 2010).

164 Ann Kane, "The Biopsychosociospiritual Approach to Birth Care," *International Journal of Childbirth Education* 14, no. 1 (1999): 34; Kathryn A. O'Connell and Suzanne M. Skevington, "The Relevance of Spirituality, Religion, and Personal Beliefs to Health-Related Quality of Life: Themes from Focus Groups in Britain," *British Journal of Health Psychology* 10 (2005): 379-98; David Katerndahl and Daniel Oyiriaru, "Assessing the Biopsychosociospiritual Model in Primary Care: Development of the Biopsychosociospiritual Inventory," *International Journal of Psychiatry in Medicine* 37, no. 4 (2007): 393-414; Christina M. Puchalski, "Spirituality and the Care of Patients at the End-of-Life: An Essential Component of Care," *Omega* 56, no. 1 (2007-2008): 33-46; David A. Katerndahl, "Impact of Spiritual Symptoms and Their Interactions on Health Services and Life Satisfaction," *Annals of Family Medicine* 6, no. 5 (2008): 412-20; Jeffrey P. Bishop, "Biopsychosociospiritual Medicine and Other Political Schemes," *Christian Bioethics* 15, no. 3 (2009): 254-76; Maxine Adegbola, "Biopsychosociospiritual Integrative Approach for Adults with Sickle Cell Disease: Relationships among Spirituality, Self-Efficacy, and Quality of Life," *Nursing and Health*

second bridges Engel and developments in psychoneuroimmunology (PNI). The latter explores relationships between different stressors—which can include psychosocial factors—and the nervous, endocrine, and immune systems. Stress, it is argued, has an impact on a person's mental and emotional health and can generate effects in their physical health. By enabling a person to cope more effectively, experience a faith community and its social support, and to build a sense of hope, religiosity may exercise a constructive impact on a person's neuroendocrine and immune mechanisms and, thereby, on his or her physical health. PNI thus provides a biological foundation for the argument that the mind plays a key role in both disease and health while, at the same time, factoring in biological, psychological, social, and spiritual variables.[165] One sees this progression, for example, in Harold Koenig's writing.[166]

Earlier in the process of operationalizing spirituality, the measures tended to reflect rather uncritically the practices of Protestant Christianity in the Southeastern United States (church attendance, Bible reading, personal prayer, listening to religious radio programming, etc.). Critiques prompted some reformulation: attendance at religious services, reading religious texts, prayer, and listening to or watching religious programs. The underlying paradigms in other cases also derived primarily from an individually oriented version of religiosity.[167] More recently, however, arguments have emerged that recognize the ways in which this approach has treated "religion" as a generic category rather than a complex of often extremely divergent lifeworlds. As a result, some of the prior criteria, such as attendance at religious services, have been looked at more critically.[168] And, in a move oddly reminiscent of earlier critiques directed from within Religious Stud-

Sciences 12 (2010): 276; Marc Galanter, "Spirituality in Psychiatry: A Biopsychosocial Perspective," *Psychiatry* 73, no. 2 (2010): 145-57; Christina Maria Puchalski, "Religion, Medicine, and Spirituality: What We Know, What We Don't Know, and What We Do," *Asian Pacific Journal of Cancer Prevention* 11, MECC supplement (2010): 45-49.

165 Janice K. Kiecolt-Glaser et al., "Emotions, Morbidity, and Mortality: New Perspectives from Psychoneuroimmunology," *Annual Review of Psychology* 42 (2002): 83–107; Robert Zachariae, "Psychoneuroimmunology: A Bio-Psycho-Social Approach to Health and Disease," *Scandinavian Journal of Psychology* 50, no. 6 (2009): 645-51; Janice K. Kiecolt-Glasera, Jean-Philippe Gouin, and Liisa Hantsoo, "Close Relationships, Inflammation, and Health," *Neuroscience and Biobehavioral Reviews* 35 (2010): 33-38.

166 Harold G. Koenig, *Faith and Mental Health: Religious Resources for Healing* (Philadelphia: Templeton Foundation Press, 2005); Harold G. Koenig, *Medicine, Religion, and Health: Where Science and Spirituality Meet* (West Conshocken, PA: Templeton Foundation Press, 2008); and Harold G. Koenig and Harvey J. Cohen, *The Link between Religion and Health: Psychoneuroimmunology and the Faith Factor* (Oxford: Oxford University Press, 2002). Other researchers have also looked for biological pathways. See, for example, Teresa E. Seeman, Linda Fagan Dubin, and Melvin Seeman, "Religiosity/Spirituality and Health: A Critical Review of the Evidence for Biological Pathways," *American Psychologist* 58, no. 1 (2003): 53-63. See also Andrew Newberg and Mark Robert Waldman, *How God Changes Your Brain: Breakthrough Findings from a Leading Neuroscientist* (New York: Ballantine Books, 2009).

167 See, for example, Adam B. Cohen et al., "Social Versus Individual Motivation: Implications for Normative Definitions of Religious Orientation," *Personality and Social Psychology Review* 9, no. 1 (2005): 48-61.

168 See, for example, Richard P. Sloan, "Attendance at Religious Services, Health, and the Lessons of Trinity," *Psychosomatic Medicine* 69 (2007): 493-94; and Ellen L. Idler et al., "Looking inside the Black Box of 'Attendance at Services': New Measures for Exploring an Old Dimension in Religion and Health Research," *International Journal for the Psychology of Religion* 19 (2009): 1-20.

ies toward the treatment of "mysticism" as an undifferentiated category, researchers interested in measuring religiousness have begun to call for tools that reflect the differences between traditions. This represents a significant development.[169] Indeed, a small number of such studies have recently been published.[170]

Culturally Competent Care

Finally, there is quite a different way of conceptualizing religion and healing in relation to biomedical clinical practice. It represents a response to the increasingly complex and pluralistic nature of the American religious landscape. As I noted at the beginning of this essay, that landscape intersects on many levels with an equally complex cultural and therapeutic pluralism and has made its way into the many clinical settings of the United States. Practitioners find themselves ill equipped in some cases to understand (or even recognize) the presence and influence of religious lifeworlds different from their own.

169 Researchers like Pargament and Koenig have played a part in these developments, but new contributors like Peter Hill, Daniel Hall, Ellen L. Idler, and Keith Meador have moved the discussion in this direction as well. See, for example, Peter C. Hill and Kenneth I. Pargament, "Advances in the Conceptualization and Measurement of Religion and Spirituality: Implications for Physical and Mental Health Research," *American Psychologist* 58, no. 1 (2003): 64-54; Ellen L. Idler et al., "Measuring Multiple Dimensions of Religion and Spirituality for Health Research: Conceptual Background and Findings from the 1998 General Social Survey," *Research on Aging* 25, no. 4 (2003): 327-65; Daniel E. Hall, Harold G. Koenig, and Keith G. Meador, "Hitting the Target: Why Existing Measures of 'Religiousness' Are Really Reverse-Scored Measures of 'Secularism,'" *Explore: The Journal of Science and Healing* 4 (2008): 368-73; Daniel E. Hall, Keith G. Meador, and Harold G. Koenig, "Measuring Religiousness in Health Research: Review and Critique," *Journal of Religion and Health* 47 (2008): 134-63.

170 Pargament in particular has reviewed more tradition-specific studies and has collaborated with other researchers to conduct exploratory research into the process of coping among American Buddhists, Jews, and Muslims. See Russell E. Phillips et al., "Spiritual Coping in American Buddhists: An Exploratory Study," *International Journal for the Psychology of Religion* 19 (2009): 231-43; David H. Rosmarin et al., "Religious Coping among Jews: Development and Initial Validation of the JCOPE," *Journal of Clinical Psychology* 65, no. 7 (2009): 670-83. Of particular note have been efforts to work from *within* these traditions to formulate models grounded in frameworks of the traditions themselves. See, for example, Hisham Abu Raiya et al., "A Psychological Measure of Islamic Religiousness: Development and Evidence for Reliability and Validity," *International Journal for the Psychology of Religion* 18, no. 4 (2008): 291-315; Hisham Abu Raiya and Kenneth I. Pargament, "Religiously Integrated Psychotherapy with Muslim Clients: From Research to Practice," *Professional Psychology: Research & Practice* 41, no. 2 (2010): 181-88; and Hisham Abu Raiya and Kenneth I. Pargament, "Empirically Based Psychology of Islam: Summary and Critique of the Literature," *Mental Health, Religion & Culture* 14, no. 2 (2011): 93-115. Some of these researchers have also examined perceptions of Muslims as threats: Hisham Abu Raiya et al., "When Muslims Are Perceived as a Religious Threat: Examining the Connection between Desecration, Religious Coping, and Anti-Muslim Attitudes," *Basic & Applied Social Psychology* 30, no. 4 (2008): 311-25. Hall, Koenig, and Meador have conducted a study of religiosity among Episcopalian Christians: Daniel E. Hall, Harold G. Koenig, and Keith G. Meador, "Episcopal Measure of Faith Tradition: A Context-Specific Approach to Measuring Religiousness," *Journal of Religion and Health* 49 (2010): 164-78. See also David R. Hodge and Cordon E. Limb, "A Native American Perspective on Spiritual Assessment: The Strengths and Limitations of a Complementary Set of Assessment Tools," *Health & Social Work* 35, no. 2 (2010): 121-31.

Since the 1990s, medical educators have worked to define, standardize, and operationalize the functions necessary to the practice of biomedicine. They examined the different roles and functions exercised by the clinician and translated these into eight areas in which he or she had to be able to demonstrate a testable level of competence. Each area, in turn, covered a body of knowledge, a set of skills, and related understanding and attitudes. Hypothetically, one first masters specific knowledge about an aspect of practice, then learns in principle how to implement it, begins to acquire practice, and ends up being able to perform it.[171] These competency areas include patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning, and systems-based practice.

The Civil Rights movement that began in the 1960s and '70s drew attention to economic, political, and social disparities related to racial and ethnic differences. Efforts to reform and rectify these inequities in education and other social practices can be traced to these decades. However, in 2003, the Institute of Medicine published *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* on the impact of discrimination in the treatment provided to minority patients. The report flagged the imperative to address the effects of bias and racism in the context of clinical practice and clinical working and training environments.[172] One outcome was the formalizing of "cultural competence" as a domain in medicine that required training and assessment within the medical curriculum and residency training. Generally, this body of knowledge, skills, and related attitudes is situated under the competence related to interpersonal and communication skills, which is defined as learning to "communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds."[173]

If one reviews the website of the Accreditation Council for Graduate Medical Education (ACGME), the body responsible for accrediting post-MD medical training programs within the United

171 For a brief history of the development of competency-based medical training, see WaiChing Leung, "Competency Based Medical Training: Review," *British Medical Journal* 325 (2002): 693-96.

172 See Brian D. Smedley et al., eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, D.C.: National Academies Press, 2003), http://www.nap.edu/catalog.php?record_id=10260.

173 For recent discussions of issues in the field of cultural competence, see Sonia J. Crandall et al., "Applying Theory to the Design of Cultural Competency Training for Medical Students: A Case Study," *Academic Medicine* 78, no. 6 (2003): 588-94; Peter H. Koehn and Herbert M. Swick, "Medical Education for a Changing World: Moving Beyond Cultural Competence into Transnational Competence," *Academic Medicine* 81, no. 6 (2006): 548-56; David R. Hodge, "Developing Spiritual Competence in Practice," *Journal of Ethnic & Cultural Diversity in Social Work* 15, no. 3-4 (2007): 101-27; Zofia Kumaş-Tan et al., "Measures of Cultural Competence: Examining Hidden Assumptions," *Academic Medicine* 82 (2007): 548–57; Carla Boutin-Foster, Jordan C. Foster, and Lyuba Konopasek, "Physician, Know Thyself: The Professional Culture of Medicine as a Framework for Teaching Cultural Competence," *Academic Medicine* 83, no. 1 (2008): 106-11; Arno K. Kumagai and Monica L. Lypson, "Beyond Cultural Competence: Critical Consciousness, Social Justice, and Multicultural Education," *Academic Medicine* 84, no. 6 (2009): 782-87; Conny Seeleman, Jeanine Suurmond, and Karien Stronks, "Cultural Competence: A Conceptual Framework for Teaching and Learning," *Medical Education* 43 (2009): 229-37; Joseph R. Betancourt and Alexander R. Green, "Linking Cultural Competence Training to Improved Health Outcomes: Perspectives from the Field," *Academic Medicine* 85, no. 4 (2010): 583-85; Katie Crenshaw et al., "What Should We Include in a Cultural Competence Curriculum? An Emerging Formative Evaluation Process to Foster Curriculum Development," *Academic Medicine* 86, no. 3 (2011): 333-41.

States, the term “spiritual” currently appears only in relation to training in hospice and palliative medicine core competencies.[174] Although the application of the RCT model to connections between religiosity and health outcomes might potentially position this field under the heading of medical knowledge, with implications for patient care, discussions of religious or spiritual content are usually construed as falling under the rubric of this competence. This happens in two ways. For advocates of introducing religion and spirituality in their own right into patient care, the cultural dimension generally remains marginal. A different approach to the topic frames it as a dimension of a patient’s cultural lifeworld, often a foundational one.

This distinction proves to be extremely important in the world of clinicians where, as I noted earlier, many resist the idea of introducing discussions of religion or spirituality into their relationship with a patient. However, when addressed within the larger issue of cultural worlds, with no question of physicians themselves participating or necessarily recommending religious activity, there tends to be a far greater openness. When linked to the contributions of medical anthropology—that branch of anthropology whose basics are known to most physicians (usually in the form of “the Kleinman questions”[175])—and to working across cultural differences, barriers generally go down.[176] To the extent that they assume that the discussion of religiosity pertains to cultural groups

174 It is worth noting that the National Cancer Institute now provides related guidelines for addressing spirituality in oncological contexts. See http://www.cancer.gov/cancertopics/pdq/supportivecare/spirituality/Patient/AllPages.

175 These questions appeared in two key sources—Kleinman’s *Patients and Healers in the Context of Culture* and in Arthur Kleinman, Leon Eisenberg, and Byron Good, “Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research,” *Focus* 4, no. 1 (2006 [1978]): 140-49. They have become a routine part of medical school education:

1) What do you call your problem? What name does it have?

2) What do you think caused your problem?

3) Why do you think it started when it did?

4) What does your sickness do to you? How does it work?

5) How severe is your sickness? How long do you expect it to last?

6) What do you fear most about your illness?

7) What are the biggest problems your illness has caused for you?

8) What kind of treatment do you think you should receive? What are the most important results you hope to receive from treatment?

176 For discussions of the application of methods from medical anthropology to clinical practice, see the following articles. They do not overtly address issues related to religion and healing, but embedded within the meaning-centered inquiry fostered by medical anthropology, they make a different kind of room for this discussion: Arthur Kleinman, “Lessons from a Clinical Approach to Medical Anthropological Research,” *MAN* 8, no. 4 (1977): 11-15; Arthur E. Hippler, “On Stein and Kleinman, and the Crucial Issues in Medical Anthropology,” *MAN* 9, no. 1 (1977): 18-19; Arthur Kleinman, “The Need for Ethnomedical Understanding of Clinical Categories and Praxis: On Stein and Hippler,” *MAN* 9, no. 2 (1978): 29-30; Peggy Golde and Demitri B. Shimkin, “Clinical Anthropology—an Emerging Health Profession?” *MAN* 12, no. 1 (1980): 15-16; Lorraine Kaufman, “Thoughts on Clinical Anthropology,” *MAN* 12, no. 1 (1980): 17-18; Thomas W. Maretzki, “Reflections on Clinical Anthropology,” *MAN* 12, no. 1 (1980): 19-21; Joan Ablon, “Thoughts on a ‘Clinical Anthropology.’” *MAN* 12, no. 1 (1980): 22-23; Ailon Shiloh, “Therapeutic

like their own and the discussion of culture pertains to "others," it can be a helpful reminder that "every clinical encounter is a cross-cultural experience."[177]

In Public Health

As a field, public health addresses health-related issues at the level of populations, not individuals, and involves the design and implementation of public policy to foster health and prevent disease. To the extent that the topic of religion or religiosity enters the public health discussion, it does so in connection with its impact on collective health or related policy implications. Do religious worldviews and practices contribute to or detract from that health? Do religious communities impede the implementation of health policies, or can they be engaged to help promote it? It is beyond the scope of this article to review the full range of public health treatments of religion.[178]

Anthropology," *MAN* 12, no. 1 (1980): 14-15; Howard F. Stein, "Clinical Anthropology and Medical Anthropology," *MAN* 12, no. 1 (1980): 18-19; John C. Russell, "The Couch in the Field: Comments on Clinical Anthropology," *MAN* 12, no. 1 (1980): 22; Clifford R. Barnett, "Commentary," *MAN* 12, no. 1 (1980): 23-25; Peggy Golde, "The Practice of Clinical Anthropology: An Illustration of Cultural Consultation," *Practicing Anthropology* 4, no. 1 (1981-82): 12-13; Howard F. Stein, "The Culture of the Patient as a Red Herring in Clinical Decision Making: A Case Study," *Medical Anthropology Quarterly* 17, no. 1 (1985): 2-5; Cecil Helman, "Anthropology and Clinical Practice," *Anthropology Today* 1, no. 4 (1985): 7-10; Howard F. Stein, "Principles of Style: A Medical Anthropologist as Clinical Teacher," *Medical Anthropology Quarterly* 16, no. 3 (1985): 64-67; Irwin Press, "Speaking Hospital Administration's Language: Strategies for Anthropological Entrée in the Clinical Setting," *Medical Anthropology Quarterly* 16, no. 3 (1985): 67-69; Hans Baer, "How Critical Can Clinical Anthropology Be?" *Medical Anthropology* 15, no. 3 (1993): 299-317; Jacqueline Rabaim-Jamin, "Anthropology and Clinical Studies. Using Cultural Ideas and Beliefs in Clinical Practice," *L'Autre: cliniques, cultures et sociétés* 1, no. 1 (2000): 127-43; and R. Bennegadi, "Cultural Representations of Illness. Contributions to Clinical Medical Anthropology," *Psycho-Oncologie* 2, no. 4 (2008): 266-70.

177 Joseph R. Betancourt and R.C. Like, "Invited Editorial. A New Framework of Care," in "Caring for Diverse Population: Breaking Down Barriers," *Patient Care* 34, no. 9 (2000): 10-12. The literature conceptualizing cultural competence and designing strategies for addressing its demands is vast and far exceeds the scope of this essay. Here, I point to some prior reflections on ways in which we might consider religiosity in relation to cultural and therapeutic pluralism in clinical contexts: Linda L. Barnes and Grove Harris, "Religious Pluralism and Culturally Competent Care," *Park Ridge Center Bulletin*, (November/December 2001): 7-8; Linda L. Barnes and Gregory A. Plotnikoff, "Fadiman and Beyond: The Dangers of Extrapolation," *Bioethics Forum* 17, no. 1 (2001): 32-40; Linda L. Barnes, "Spirituality and Religion in Health Care," in *Cross-Cultural Medicine*, ed. JudyAnn Bigby (Philadelphia: American College of Physicians-American Society of Internal Medicine, 2003), 237-67; Linda L. Barnes, *Concept Paper: Culturally Competent Care. Commissioned for the May 2004 Consensus Building Meeting for the Culturally Competent Nursing Modules (CCNM) Project*: Office of Minority Health, Office of Public Health and Sciences, U.S. Department of Health and Human Services, 2004; Linda L. Barnes and David Coulter, "Concepts of Holistic Care," in *Developmental Disabilities: Delivery of Medical Care for Children and Adults*, eds. I. Leslie Rubin and Allen C. Crocker, 2nd ed. (Baltimore: Paul H. Brookes Publishing Co., Inc., 2006), 645-55; Linda L. Barnes, "Religion and Spirituality in the Lives of Immigrants in the United States," in *Immigrant Medicine*, eds. Elizabeth Barnett and Patricia Walker (Santa Barbara: ABC-CLIO, 2007), 681-92; and Veronica Meneses et al., "'Footprints in the Bathroom': The Role of Spirituality in Patient Diagnosis," *Journal of Developmental and Behavioral Pediatrics* 32 (2011): 169-71.

178 See Lance D. Laird and Linda L. Barnes, "Religion and Healing," in *International Encyclopedia of Public Health*, eds. Stella Quah and Kristian Heggenhougen (Amsterdam: Elsevier, 2008), 514-19. See also Paul D. Simmons, *Faith*

Instead, here I will sketch some of the types of treatments the topic receives, and then review a number of public health discussions of religion in relation to a specific disease, HIV/AIDS.

Three broad trends tend to surface in relation to public health and religion. The first provides cases suggesting that being religiously observant may pose specific health risks (e.g., the impact of fasting during Ramadan for observant Muslims with diabetes). The second looks at populations for whom, it argues, religiously-based traditions may impede the growth of modernity. The third targets religious convictions that may obstruct the implementation of biomedical healthcare delivery. In each of these, a common feature is the tendency to view religion as a problem. Occasionally, two countervailing themes may arise, suggesting that some religious practices benefit the health of a population and that religious communities may be recruited to help implement a particular health policy.[179] In general, scholars trained not in religious studies but in public health have generated the related literature. Many, therefore, turn primarily to medical literature, where they find operationalized constructions of religiosity.[180]

However, more recent collaborations between public health researchers, religion scholars, and theologians have countered with methods that include far more complex analyses of the varied roles played by religious communities. One group in particular has built an intentionally interdisciplinary model that joins religious health leaders, public policy decision-makers, and other health workers to explore the multiple ways in which people understand and respond to HIV/AIDS both with and through their forms of religiosity.

The African Religious Health Assets Programme (ARHAP), an international research group, has taken as their departure point the concept of "health assets"—the analysis of the capacities present within a given population, which serve as resources in the support and promotion of health.[181] ARHAP has found, however, that related discussions routinely overlook the spectrum of roles played by faith communities. In response, it has identified four domains of research activity requiring systematic analysis in order to understand what it terms "religious health assets" in faith-based organizations and initiatives:

> The four domains (agency, capability, material assets, policy) identify particular fields of

and Health: Religion, Science, and Public Policy (Macon, GA: Mercer University Press, 2008).

179 For an illustration of these trends, see Lance D. Laird, Justine de Marrais, and Linda L. Barnes, "Portraying Islam and Muslims in MEDLINE: A Content Analysis," *Social Science & Medicine* 65 (2007): 2425–39.

180 For compelling examples in terms of both content and methods, see in particular Felicitas Becker and P. Wenzel Geissler, eds., *AIDS and Religious Practice in Africa* (Boston: Brill, 2009); Jude Aguwa, "Religion and HIV/AIDS Prevention in Nigeria," *Crosscurrents* 60, no. 2 (2010): 208-23; and Jill Olivier, "In Search of Common Ground for Interdisciplinary Collaboration and Communication: Mapping the Cultural Politics of Religion and HIV/AIDS in Sub-Saharan Africa" (PhD diss. University of Cape Town, 2010).

181 For discussions and analyses of the concept "health assets," see Antony Morgan and Erio Ziglio, "Revitalising the Evidence Base for Public Health: An Assets Model," in "Promotion and Education," supplement, *Global Health Promotion* 14, no. 2 (2007): 17-22; Antony Morgan, Erio Ziglio, and Maggie Davies, eds., *Health Assets in a Global Context: Theory, Methods, Action* (New York: Springer, 2010); Ann Kristin Rotegård et al., "Health Assets: A Concept Analysis," *Nursing Studies* 47, no. 4 (2010): 513-25. For the resources produced by ARHAP, see http://www.arhap.uct.ac.za/.

> research activity, each of which requires specific tools. These tools differ according to the particular conceptual field they are designed to investigate (e.g. resilience, livelihood strategies, GIS mapping, performance and outcomes, policy processes).[182]

The purpose underlying these domains is to identify the "value added" by faith-based groups to public health initiatives. In this connection, the group has adopted the Sesotho term *bophelo*, which spans meanings associated with "religion" and "health," tying them together through a notion of holistic relational well-being. To express *bophelo*, they have drawn on the concept of "lifeworld" (*Lebenswelt*), originally introduced by Husserl in 1936. Schutz adopted the term as part of his theorizing about the sociology of knowledge, and it was then picked up by Jürgen Habermas to characterize the directly and subjectively experienced daily life.[183] From there, ARHAP researchers Paul Germond and James Cochrane coined the term "healthworld," which they characterize as "a distinctive 'region' of the lifeworld defined by a particular *telos*—that of comprehensive well-being, a lifeworld without dysfunction."[184]

The theoretical premise is that resource-deprived groups face not only risk factors and deficits; they also have agency, which they exercise in the struggle to maintain or gain health. ARHAP makes the case that the field of public health must, in its research and planning, take this agency into account, especially insofar as it can leverage religious health assets to confront and change the circumstances contributing to ill health.[185]

Closing Thoughts

I close with three recommendations to the field, going forward. First, it may seem self-evident that each of the traditions, practices, approaches, and orientations discussed above does not occur in a vacuum. As we have seen, each tradition has multiple branches with related variations. There

182 James R. Cochrane, ed., "A.R.H.A.P. Tool Set," University of Captetown, 2008, <http://www.arhap.uct.ac.za/tools.php>.

183 See Edmund Husserl, *The Crisis of European Sciences and Transcendental Phenomenology: An Introduction to Phenomenological Philosophy*, trans. David Carr (Evanston, IL: Northwestern University Press, 1970 [1936]); Alfred Schütz and Thomas Luckmann, *The Structures of the Life World*, trans. Richard M. Zaner and H. Tristram Engelhardt (Evanston, IL: Northwestern University Press, 1973); and Jürgen Habermas, *The Theory of Communicative Action*, trans. Thomas McCarthy, 2 vols. (Boston: Beacon Press, 1984).

184 Paul Germond and James R. Cochrane, "Healthworlds: Conceptualizing Landscapes of Health and Healing," *Sociology* 44, no. 2 (2010): 307-24.

185 James R. Cochrane, "Of Bodies, Barriers, Boundaries and Bridges: Ecclesial Practice in the Face of HIV and AIDS," *Journal of Theology for Southern Africa* 126 (2006): 7-26; James R. Cochrane, "Religion, Public Health, and a Church for the 21st Century," *International Review of Mission* 95, no. 376/377 (2006): 59-72; James R. Cochrane, "Seeing Healthworlds Differently," *Religion & Theology* 14 (2007): 6-27; James R. Cochrane, "'Fire from Above, Fire from Below': Health, Justice, and the Persistence of the Sacred," *Theoria: A Journal of Social & Political Theory* 55, no. 116 (2008): 67-96. See also Jill Olivier, James Cochrane, and B. Schmid, *ARHAP Bibliography: Working in a Bounded Field of Unknowing* (Cape Town: African Religious Health Assets Programme, 2006); Gary Gunderson and Larry Pray, *Leading Causes of Life*, (Memphis, TN: The Center of Excellence in Faith and Health, Methodist LeBonheur Healthcare, 2007).

is, therefore, the pluralism internal to traditions themselves. Likewise, there are regional and historical versions that introduce another plural dimension. Yet other dimensions of pluralism require attention as well.

An early fallacy in the field of anthropology involved the notion that there existed such a thing as "primitive" peoples who lived in isolation, representing traditions in some pure, pristine form. Given the influence of Darwinian theory, it was thought that, the more remote the group, the likelier their practices came to the first evolutionary forms of culture and religion (with European-descended forms being the most advanced). It took time for the field to begin to examine the ways in which groups interacted, borrowing, sharing, and/or imposing their ways on others. Boundaries did and did not exist, then or now, and had degrees of permeability—some deliberate, some unrecognized. With globalization manifesting in growing numbers of way, I would argue that these instances of exchange and cross-fertilization are the norm rather than the exception and must be considered on multiple levels, beginning with a systemic approach. Systems themselves involve definition, classification, comparison, and analysis. The discussion of systems gives us models for moving beyond conceptualizing traditions in isolation.[186]

One factor influencing these dynamics involves power differences and disparities—a factor that characterized interactions between colonizing and colonized peoples. Operating on political and economic levels, these imbalances functioned as well in religious and therapeutic realms. Not only was the religion of the colonizers part of what was imposed, but so were therapeutic systems, with medical missions sometimes used as a conversion strategy. Insofar as local traditions did not conceptualize the religious and therapeutic as separate phenomena, the imposition intruded on many planes.[187] If we loop back around to some of the examples discussed above, we find impor-

186 Michael S. Goldstein, "The Persistence and Resurgence of Medical Pluralism," *Journal of Health Politics* 29, no. 4-5 (2004): 925-45; Arthur Kleinman, "Toward a Comparative Study of Medical Systems," *Science, Medicine, and Man* 1 (1973): 55-65; Arthur Kleinman, "Concepts and a Model for the Comparison of Medical Systems as Cultural Systems." *Social Science & Medicine* 12: (1978): 85-93; Murray Last. "The Importance of Knowing About Not Knowing." *Social Science & Medicine* 15B (1981): 387-92; Irwin Press, "Problems in the Definition and Classification of Medical Systems," *Social Science & Medicine* 14B (1980): 45-7; Ursula Sharma, "Contextualizing Alternative Medicine: The Exotic, the Marginal, and the Perfectly Mundane," *Anthropology Today* 9, no. 4 (1993): 15-8; Elizabeth D. Whitaker, "The Idea of Health: History, Medical Pluralism, and the Management of the Body in Emilia-Romagna, Italy," *Medical Anthropology Quarterly* 17, no. 3 (2003): 348-75; Bradley P. Stoner, "Understanding Medical Systems: Traditional, Modern, and Syncretic Health Care Alternatives in Medically Pluralistic Societies," *Medical Anthropology Quarterly* 17, no. 2 (1985): 44-8; Marwan Kraidy, "Hybridity in Cultural Globalization," *Communication Theory* 12, no. 3 (2002): 316-39; K. A. Hirschkorn and I. L. Bourgeault, "Conceptualizing Mainstream Health Care Providers' Behaviours in Relation to Complementary and Alternative Medicine," *Social Science & Medicine* 61 (2005): 157–70. In connection with questioning categories that may seem like givens, see Margaret Lock, "The Tempering of Medical Anthropology: Troubling Natural Categories," *Medical Anthropology Quarterly* 15, no. 4 (2001): 478-492.

187 For examples, see H. K. Heggenhougen, "Bomohs, Doctors, and Sinsehs—Medical Pluralism in Malaysia," *Social Science & Medicine* 14B (1980): 235-44; Christian Hochmuthd, "Patterns of Medical Culture in Colonial Bengal, 1835-1880," *Bulletin for the History of Medicine* 80 (2006): 39-72; David Sowell, "Contending Medical Ideologies and State Formation: The Nineteenth Century Origins of Medical Pluralism in Contemporary Columbia," *Bulletin for the History of Medicine* 77 (2003): 900-26; Ronald Niezen. "Healing and Conversion: Medical Evangelism in James Bay Cree Society," *Ethnohistory* 44, no. 3 (1997): 463-91; Johannes Triebel, "Living Together with the Ancestors:

tant examples there as well.[188]

Ancestor Veneration in Africa as a Challenge for Missiology," *Missiology: An International Review* 30, no. 2 (2002): 187-97; Markku Hokkanen, "Quests for Health and Contests for Meaning: African Church Leaders and Scottish Missionaries in the Early Twentieth Century Presbyterian Church in Northern Malawi," *Journal of Southern African Studies* 33, no. 4 (2007): 733-50; and Aneeta A. Minocha, "Medical Pluralism and Health Services in India," *Social Science & Medicine* 14B (1980): 217-23. These discussions provide not only illustrations but also methodological considerations.

188 For illustrations related to the Yoruba religion and its globalized forms, see James L. Cox, "Missionaries, the Phenomenology of Religion, and 'Re-Presenting' Nineteenth-Century African Religion: A Case Study of Peter McKenzie's 'Hail Orisha!'" *Journal of Religion in Africa* 31, no. 3 (2001): 336-53; M. A. Clark, "Orisha Worship Communities: A Reconsideration of Organizational Structure (Innovations in the Colonial Practice of the Yoruba Religion in the New-World)," *Religion* 30, no. 4 (2000): 379-89; Adekunle Oyinloye Dada, "The Interaction of Prophecy and Yoruba Culture in Selected African Indigenous Churches," *Black Theology: An International Journal* 7, no. 2 (2009): 167-81; Amidu Olalekan Sanni, "Between Orthodox and Popular Islam: The Medico-Religious Realm in Yorubaland (Nigeria)," *Hamdard Islamicus* 31, no. 4 (2008): 67-74. Other examples include Karen Flint, "Indian-African Encounters: Polyculturalism and African Therapeutics in Natal, South Africa, 1886-1950s," *Journal of South African Studies* 32, no. 2 (2006): 367-85; Leah Gilbert, "Medical Pluralism in Action? A Case Study of Community Pharmacies in Johannesburg, South Africa," *Journal of Alternative and Complementary Medicine* 10, no. 3 (2004): 547-55. Brazil, as one of the settings for the African Diaspora, provides further illustrations: André Mary, "From One Syncretism to Another: Culture of Trance and Charisma of Deliverance," *Social Compass* 48, no. 3 (2001): 315-31; Sidney M. Greenfield, *Spirits with Scalpels: The Cultural Biology of Religious Healing in Brazil* (Walnut Creek, CA: Left Coast Press, 2008); Beatriz Caiuby Labate and Edward MacRae, eds., *Ayahuasca, Ritual, and Religion in Brazil* (Oakville, CT: Equinox, 2010); Cristina Rocha, "Seeking Healing Transnationally: Australians, John of God, and Brazilian Spiritism," *Australian Journal of Anthropology* 20 (2009): 229-46. For discussions of pluralism in connection with the Navajo, see Thomas J. Csordas, "Ritual Healing and the Politics of Identity in Contemporary Navajo Society," *American Ethnologist* 26, no. 1 (1999): 3-23; Elizabeth L. Lewton, "Identity and Healing in Three Navajo Religious Traditions: Są'ah Naagháí Bik'eh Hózhó," *Medical Anthropology Quarterly* 14, no. 4 (2000): 476-97; David H. Begay and Nancy C. Maryboy, "The Whole Universe Is My Cathedral: A Contemporary Navajo Spiritual Synthesis," *Medical Anthropology Quarterly* 14, no. 4 (2000): 498-520; and Wade Davies, *Healing Ways: Navajo Health Care in the Twentieth Century* (Albuquerque: University of New Mexico Press, 2001). For other examples of pluralism and interchange in different Native American tribes, see Douglas K. Novins et al., "Use of Biomedical Services and Traditional Healing Options among American Indians: Sociodemographic Correlates, Spirituality, and Ethnic Identity," *Medical Care* 42, no. 7 (2004): 670-79; Julianne Cordero, "The Gathering of Traditions: The Reciprocal Alliance of History, Ecology, Health, and Community among the Contemporary Chumash," in *Religion, Healing, and America*, eds. Linda L. Barnes and Susan S. Sered (New York: Oxford University Press, 2005), 139-57; and Suzanne J. Crawford O'Brien, *Religion and Healing in Native America: Pathways for Renewal* (Westport, CT: Praeger, 2008). For an example of the appropriation of Native traditions, see Lisa Aldred, "Plastic Shamans and Astroturf Sun Dances," *American Indian Quarterly* 24, no. 3 (2000): 329-52*;* Line Laplante, "Spirituality: Spirit Piracy and Native Sweat Lodges," *Journal of Northwest Anthropology* 42, no. 2 (2008): 143-55. Because biomedicine is a cultural system with many variations in its own right, it is important to examine its interplay with other systems. For several examples, see Norman Gevitz, ed., *Other Healers: Unorthodox Medicine in America* (Baltimore: Johns Hopkins Press, 1988); Linda M. Hunt, "The Metastasis of Witchcraft: The Interrelationship between Traditional and Biomedical Concepts of Cancer in Southern Mexico," *Collegium Antropologicum* 17 (1993): 249-55; Matthew Ramsey, "Alternative Medicine in Modern France," *Medical History* 43 (1999): 286-322; Ole Bjørn Rekdal, "Cross-Cultural Healing in East African Ethnography," *Medical Anthropology Quarterly* 13, no. 4 (1999): 458-82; Lori Arviso Alvord and Elizabeth Cohen van Pelt, *The Scalpel and the Silver Bear: The First Navajo Woman Surgeon Combines Western Medicine and Traditional Healing* (New York: Bantam Books, 1999), esp. 1-4, 90-115, 137-49; Robert Frank and Gunnar Stollberg, "Medical Acupuncture in Germany: Patterns of Consumerism Among Physicians and Patients,"

The second is a brief reminder to attend to the structural factors surrounding and informing the aspects of religion and healing that we choose to study. I point, in particular, to those dimensions of structural violence that introduce dimensions of inequity and require rectification. The dynamics of many systemic interactions, as well as their outcomes, remain opaque without consideration of such factors.

Finally, as I hope I have demonstrated over the course of this essay, there are many vantage points from which to examine the expansive field of religion and healing. Each state within that larger field has its own questions, conventions, disciplinary lenses, and stakes in the matter. We find, in some instances, active traffic across state lines, as well as unexplored possibilities awaiting attention. As we know, to do serious and genuine interdisciplinary work is to engage in commonalities as well as interdisciplinary differences, particularly in relation to methods and underlying paradigms. I present these resources in the hope that they will encourage us all to engage in these possible broader conversations.

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Sociology of Health & Illness 26, no. 3 (2004): 351-72; Chih-Yin Lew-Ting, “Antibiomedicine Belief and Integrative Health Seeking in Taiwan,” *Social Science & Medicine* 60 (2005): 2111-16; Jo Thobeka Wreford, *Working with Spirit: Experiencing Izangoma Healing in Contemporary South Africa* (New York: Berghahn Books, 2008); Seth Meehan, “From Patriotism to Pluralism: How Catholics Initiated the Repeal of Birth Control Restrictions in Massachusetts,” *Catholic Historical Review* 96, no. 3 (2010): 470-97; Mike Poltorak, “‘Traditional’ Healers, Speaking and Motivation in Vava’u, Tonga: Explaining Syncretism and Addressing Health Policy,” *Oceania* 80, no. 1 (2010): 1-23.

Appendix: Further Resources

Academic Programs

A number of universities offer degree programs and other educational opportunities related to different dimensions of the study of religion and healing. Examples include:

Religious Studies & Medical Anthropology Focus

The Masters Program in Medical Anthropology & Cross-Cultural Practice at Boston University School of Medicine (http://www.bu.edu/bhlp/Education/index.html)

This graduate program, founded and directed by Linda Barnes and Lance Laird, is based in the Division of Graduate Medical Sciences at Boston University School of Medicine. The program trains interdisciplinary scholars and clinicians to study and engage with the growing cultural, religious, and therapeutic pluralism that characterizes the United States, as well as other countries around the world. Coursework goes into depth in both the theories and methods of medical anthropology and cross-cultural practice while supporting students' own research interests and career goals. The program includes the option to focus on the interdisciplinary study of religion and healing.

Biomedical Research Focus

The Duke Center for Spirituality, Theology, and Health (http://www.spiritualityandhealth.duke.edu/)

Harold Koenig and others founded the Center in 1998. It focuses on conducting research, training others to conduct research, and field-building activities related to religion, spirituality, and health. Koenig writes on their website, "We are particularly interested in the biological mechanisms by which spirituality may affect health and medical outcomes, acting through psychological, social, and behavioral pathways. In addition, we serve as a clearinghouse for information on religion, spirituality, and health and seek to support and encourage dialogue between researchers, clinicians, clergy, and others interested in the intersection."

The George Washington Institute for Spirituality and Health (GWish) (http://www.gwish.org/)

GWish was established in May 2001 as a leading organization on education and clinical issues related to spirituality and health. Under the direction of Founder and Director Christina M. Puchalski, MD, associate professor of Medicine and

Health Care Sciences, GWish is changing the face of healthcare through innovative programs for physicians and other members of the multidisciplinary healthcare team, including clergy and chaplains. Dr. Puchalski's pioneering work has had a major impact on medical education, professional education, and clinical programs locally, nationally, and internationally.

The Center for Spirituality & Healing at the University of Minnesota (http://www.csh.umn.edu)

A resource and leader in integrated health, the Center for Spirituality & Healing provides interdisciplinary education, conducts research, and delivers programs that advance integrative health and healing. Students in medicine, nursing, pharmacy, dentistry, veterinary medicine, and public health study integrative medicine as part of their curricula and can design programs focusing on topics including mind/body healing, spirituality, culturally-based healing traditions, and energy medicine. There is an online module on Spirituality in Healthcare: (http://www.csh.umn.edu/modules/spirituality/index.html)

Public Health Focus

The Kalsman Institute on Judaism & Health (http://huc.edu/kalsman/)

A department at Hebrew Union College—Jewish Institution of Religion in Los Angeles, California, the Kalsman Institute is a center for training, collaboration, and dialogue about Judaism and Health, bringing together spiritual leaders, healthcare providers, and Jewish community members. Kalsman provides pastoral education to Reform leaders, as well as convening and co-sponsoring conferences and workshops to generate ideas and projects on Jewish spirituality and healing, bioethics, illness and wellness, and the health of the healthcare system. One of Kalsman's significant features is its development of models growing out of Jewish paradigms. Dr. Jeff Levin is the Scientific Chair of the Kalsman Roundtable on Judaism and Health Research as well as director of the PRPH at Baylor University (below).

The Program on Religion and Population Health (PRPH) (http://www.isreligion.org/programs-research/program-on-religion-and-population-health-prph/)

The PRPH is based in the Institute for Studies of Religion at Baylor University and directed by Dr. Jeff Levin. Its mission is to conduct and promote social, behavioral, and epidemiologic research on the impact of religious involvement on indicators of population health. Investigations are grounded in theory and methods drawn from the fields of sociology, psychology, epidemiology, and social demography. Special emphasis is given to longitudinal, gerontological, and life-course research; to age,

gender, social class, and racial and ethnic variation; and to under-investigated religious populations.

The Religion and Health Collaborative at Emory University (http://www.rhcemory.org/)

The Religion and Public Health Collaborative of Emory University is committed to an interdisciplinary and interfaith approach to exploring the intersection of religion and public health, both in partnership and in tension. The RPHC explores these relationships by engaging the community to help develop models for wellness that can be replicated worldwide, developing academic programs that will promote understanding of the impact of world religions on community health, and generating opportunities for applied research that will help shape a more holistic view of religion and health.

Teaching Resources

For those interested in teaching courses on religion and healing from a Humanities perspective, see:

Linda L. Barnes and Inés Talamantez, eds., *Teaching Religion and Healing* (New York: Oxford University Press, 2006).

Journals

In addition to the many journals that have published content related to religion and healing, a number of publications concentrate on the topic. For examples, see:

Religion and Health (1952-)

Journal of Religion and Health (1961-)

Second Opinion (Park Ridge Center, IL, 1986-1995)

Journal of Religion, Disability, & Health (1994-)

Making the Rounds in Health, Faith, & Ethics (1995-1996)

Journal of Religion in Disability & Rehabilitation (1996)

Journal of Spirituality in Mental Health (In 2007, incorporated *American Journal of Pastoral Counseling*, [1997-2007], relaunching as *JSMH*)

Mental Health, Religion, & Culture (1998-)

Sacred Space: The International Journal of Spirituality and Health (Originally published by Sacred Space Publications; in 2000 taken over by Wiley and in 2002 retitled *Spirituality and Health International*)

Spirituality and Health International (2002-2008)[189]

Further Bibliographic Resources

Wesley J. Wildman, Connor Wood, Eric Dorman, and Joel Daniels. "Bibliography of Literature on Spirituality, Medicine & Health," Boston University website, October 31, 2009, http://people.bu.edu/wwildman/smhbib/.

189 For a discussion of the end of this journal, see Harald Walach, "Editorial: New Horizons Ahead," *Spirituality and Health International* 9 (2008): 183-84.