Guest Editor: Linda L. Barnes, Boston University

Linda L. Barnes is an Assistant Professor at Boston University School of Medicine. She directs urban fieldwork related to culturally and religiously grounded forms of complementary and alternative medicine used by local cultural communities, incorporating this work into teaching medical students, residents, fellows, and faculty. Barnes co-founded and chairs the Religions, Medicines, and Healing Consultation of the AAR.

Introduction

Healing is a process of restoring a person and/or group to wholeness and well-being, and relates to the experience and outcome of that effort and its effects. Healing permeates virtually every religious culture around the world, and can occur within and outside of conventional religious boundaries. In some cases, it means “curing,” the elimination of symptoms; it can also refer to other kinds of meaningful change. It is culturally and historically informed by the tradition(s) within which it is rooted.

In the study of anthropology, systems of healing have secured extensive scholarly attention, particularly in what has emerged as the field of medical anthropology. Many such systems are religious. Yet in the study of religion, issues of healing have often been conceptualized as limited to bioethics, or to the study of groups whose religious worldviews result in tensions with biomedical caregivers. The influence of New Age and self-help movements has generated widespread popular sources on healing that are sometimes incorporated uncritically when religion faculty address the topic of healing.

For a subdiscipline analogous to medical anthropology to develop, five steps are essential. First, religion scholars — as part of faculty development — must become familiar with the wealth of existing scholarship on religion and healing, both broadly and in relation to their own fields. Second, we must incorporate these materials into our teaching, using courses as

contexts for deepening our own knowledge, training students, and learning from their research. In this connection, we must also work towards doctoral concentrations in the study of religion and healing. Third, we must engage the issue in our own scholarship. Fourth, we must have forums where we can present such work — one of the rationales for the Religions, Medicines, and Healing Consultation. Finally, we must publish this work, with related attention to theory and analysis, and have our colleagues recognize it as a legitimate area within religious studies.

Types of Courses

One can start small. A unit in a course can introduce healing as a dimension of religious studies or, as Suzanne Crawford describes it, “healing as a religious activity.” One can also use healing to illustrate a different course theme. For example, I have taught a course on methods in religious studies, using scholarship on healing to demonstrate applications of methods. Interdisciplinary courses, such as the anthropology of religion, would also lend themselves well to this approach. Indeed, one might see whether a medical anthropologist is on the faculty of one’s school, and explore the possibility of developing a course together. For that matter, one could sit in on related courses to get up to speed on another discipline’s approach to the topic.

One can use healing as the organizing theme of a course in multiple ways. As the essays in this issue of *Spotlight* richly demonstrate, well-designed comparative courses prove highly effective. If focusing on a particular cultural group, as Lara Medina does, one can explore the history and variations of religious healing within that group. If concentrating on a particular tradition, one can look at the history of different understandings and practices of healing within that tradition or complex of traditions. As Amanda Porterfield shows, the history of healing in the trajectories of Christianity is a fertile field. I have taught a course on the history of Chinese healing traditions, which has entailed not only introducing Chinese religions but also Chinese healing, particularly as these have represented variations on religious worldviews and practices.

Scholarship in American medical history has included not only the emergence of biomedicine, but also concurrent vitalist practices that have regularly intersected with religious/spiritual traditions. There is a surfeit of resources for syllabus development representing both majority and minority groups in American culture and history, as some of Arvilla Payne-Jackson’s scholarship illustrates. Advanced courses could include textual translation and analysis, or more ambitious historical or fieldwork projects.

In settings where professional development is foremost, as in divinity schools and seminaries, one could teach how healing has figured in the history of a given denomination. One can also look at some of the cross-cultural resources developed in relation to chaplaincy training. Some

medical schools now offer courses on “medicine and spirituality” — many of them reflecting little scholarship on religion and healing, and few preparing medical students to engage in cultural and religious pluralism. As a member of a medical school faculty, where I teach medical students, residents, and faculty, it has been my experience that there is a generally untapped opportunity for religion scholars to engage in medical education.

To illustrate: I teach a semester-long elective for medical students on the cultural formation of the clinician and its implications for introducing unexamined biases into clinical practice — a course that includes a unit on religious formation. I also present lectures on an integrative approach to culture, complementary and alternative systems of healing, and religious worldviews, and give a fourth-year intensive elective (one month) that introduces students to cross-cultural understandings and practices of healing (including community site visits to traditional healers). I also engage residents and faculty in developing teaching cases that involve complex medical, cultural, and religious issues, drawing on their own clinical experience.

I find that developing an awareness of the local cultural groups present in a setting is a useful step toward exploring world traditions and related practices in ways that can make the course material more immediate for students. Whenever possible, I photograph such practices or purchase related paraphernalia, and use both in my teaching. Such examples range from the festival for Our Lady of Soccorso Boston’s North End and the festival for Saints Cosmas and Damian in my hometown of Cambridge, to photographing Chinese medicine practitioners. When I travel, I look for sites related to healing, such as the church of St. Roch in New Orleans, the Santuario de Chimayo in New Mexico, or pilgrimage sites that often include petitions for healing, such as the Hanuman Temple in Taos, New Mexico.

A Comparative Framework

In all of my teaching, I have found it essential to use a comparative framework that draws on the work of medical anthropologists like my own mentor, Arthur Kleinman, and Tom Csordas. Although each heading can be subdivided in various ways, I find the following seven categories analytically useful.

Paradigms of Healing: Ultimate Human Possibility

Paradigms of Healing — with a capital “H” — refer to an understanding of ultimate human possibility. Healing, here, represents a tradition’s deepest hope and promise. It may be a way of talking about a person’s relation to a highest reality, whether that be known as God, Yahweh, Allah, Atman, Nirvana, Obatala, kamis, Tian, or other names. It may take the form of salvation, a place in Heaven, life in a World to Come, Paradise, Nirvana, freedom from cycles of rebirth, immortality, sagehood, revered ancestral status, remaining alive in human memory, or something else not related to any particular tradition.

Healing, understood in this way, relativizes everything else about human life. It functions as the frame of reference within which someone may interpret the rest of his or her experience, including the meaning of health in this lifetime. The influence of such visions of ultimate possibility is often read back into how people conduct their lives, leading them to try to live in ways that will bring about this healing.

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. In contrast, biomedicine is a tradition with no way of talking about what follows death, since the demise of the body represents the end of biomedicine intervention. As a result, death can only represent failure, and is often experienced as such by biomedical clinicians.

Paradigms of Suffering and Affliction

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 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 onto 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?” 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 adequate 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 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 and loving, and as a force of judgment that is sometimes terrifying. The challenge may involve navigation through such paradoxes.

The Parts of Personhood

Virtually no tradition defines a person only in relation to bodily dimensions. Even biomedicine includes “mind,” although often in relation to neurological structures. American popular culture, through the influence of New Age thought, has oriented many people to conceptualize “the whole person” as a combination of “body, mind, and spirit.” Because these categories have taken such deep root in the culture, they can seem self-evident. But not every culture or tradition understands “body, mind, and spirit” to be the only parts or aspects constituting a person.

In some traditions, the key element may be a vital force. In Chinese systems, for example, *qi* (pronounced “ch’ee”) is a subtle force that has both energetic and material dimensions, and of which all reality consists. Rocks are
qi
, winds and clouds are
qi
, blood is
qi
, and so is everything else about the body and all its subtle aspects. Chinese systems often emphasize patterns of process, change, and transformation. A clear division between “body” and “mind,” therefore, does not pertain. Even though there are words for both things, their meanings are not the same.

For that matter, some traditions include one or more souls (which may be differentiated from the spirit). Here, the religious tradition involved makes a difference. “Soul” in the Christian tradition is not the same thing as “soul” in the Confucian tradition. If the culture or tradition views reincarnation as a process intrinsic to human life, then a person is conceptualized not only in terms of this life, but also of previous lives that may underlie who he or she is. In some West African traditions, when elders die, they reincarnate back into the family line. Grandchildren may then be recognized not only as themselves, but also as a returned grandparent.

One particularly powerful and normative model of personhood in many Western cultures privileges the stand-alone individual. Yet this is *not* an ideal in all cultures, some of which value the capacity to sustain interconnectedness. For systems that view family, clan, tribe, or analogous networks as the ground from which a person emerges and finds meaning, the relational and communal is yet another intrinsic part of the person. Gender provides another key variable in thinking about understandings of personhood.

Illness and Disease

Why does it matter to know how the parts of personhood are conceptualized? Because if we do not know the parts of a person, we do not know all the ways a person can get sick or be afflicted. Generally, each aspect of a person is conceptualized as susceptible to particular kinds of illness or affliction. Etiologies and causal factors point, on the one hand, to broader paradigms of suffering. As has been elaborated on by medical anthropologists like Kleinman and others, there are also key differences between illness — the term used to refer to the lived experience — and disease, the classification of that experience according to a medical system. Each reflects different illness models, related to different forms of narrative about the etiology — the cause or causes understood to have generated the problem.

Things get complicated when the parties involved conceive of the person in different and even conflicting terms. A now-classic example is Ann Fadiman’s narrative about the Hmong child, Lia Lee, in *The Spirit Catches You and You Fall Down*. From infancy, Lia suffered from epilepsy. According to her pediatricians, for whom her physiology and neurology were the key aspects involved, the initial problem arose in these domains, and needed to be addressed in these domains. For Lia’s parents, however, a radically different key aspect involved Lia’s souls, which could be stolen or lost. Similarly, in traditional Chinese thought, each person had multiple souls, all of them various forms of *qi*. After death, certain souls entered the ground with the corpse. If not properly tended, they could become hungry ghosts and afflict the neglectful descendant.

Healers

People identify different kinds of healers as best qualified to address different kinds of problems. Frequently, they will resort to more than one — sometimes sequentially, sometimes concurrently. The very term “complementary and alternative medicine” reflects this reality in the United States. Healers arrive at this identity sometimes through culturally and religiously recognized forms of calling or by taking steps recognized as conferring a professional identity often modeled after the process of becoming a physician. Healers may not only be individuals, but also communities and groups.

Related Interventions

Just as people classify health conditions in different ways, so do they identify specific interventions as appropriate and/or necessary for each one. The identification of necessary or desirable interventions is culturally shaped. As Martin Rein and Donald Schön have suggested, how a problem is framed is also directly related to what people think can and should be done for it. What should be done for it is, in turn, related to each of the aspects discussed so far. Each therapy touches on these multiple levels, with different layers of hope, expectation, and things at stake. The hopes and expectations are tied in both with normative ideas of personhood and, in the case of persons with disabilities, with how the disability is construed.

Meanings of Efficacy

It is a common question to ask whether a therapeutic intervention has “worked.” However, this apparently simple question can hold many meanings. For example, which aspect of personhood was suffering, and to what was the suffering attributed? What intervention or interventions were deemed necessary, and what was expected of each one? If the larger framework of Healing is

factored into the picture, then the most meaningful kinds of change — of “working” — may be understood to happen after the person’s death. The expectation of some life after death modifies the time frame of healing. Other frameworks of hope operate similarly.

Efficacy is another way of talking about the form of change that is recognized and valued. It may be assessed as the process engaged in by the healer, as discussed by Winkelman and Carr; it is also related to whatever is meant by an outcome. To grasp the different meanings of efficacy involved in a situation, we must know how both Healing and Suffering are understood, we must understand the concept of the person at work, along with which aspect of the person is viewed as having been affected, and we must know how the person and his or her family envisions all the necessary healers and interventions, in order for both healing and Healing to happen.

Systemic Contexts and Structural Violence

An ecological model encourages us to ask about how such variables as gender, race, social class, personal traits, family economies, support structures, the challenges of acculturation (for families who have relocated), and other factors constitute the systemic contexts in which each of these seven categories occurs. What happens when the parties involved occupy one or more socially targeted positions? These targeted positions can include being a woman, being someone with a minority sexual orientation, being part of a racial/ethnic minority, having a low socio-economic class status, being a recent immigrant, belonging to a religious tradition that may suffer stigmatizing in the media or in popular perception, living with the legacy of colonialism, and so on.

Such forms of targeting constitute what medical anthropologists have characterized as “structural violence.” The term refers to social structures and systems that have perpetrated and perpetuated unequal access to resources and justice for different groups. Such inequities are often buttressed by economic, political, legal, and religious influences, taking their toll on individual bodies. When therapeutic interventions focus solely on individual bodies, however, they overlook the structural and ideological underpinnings of the individual’s poor health — what are really individual expressions of social conditions.

The Essays in This Issue

The authors in this issue suggest that healing occurs in multiple domains, including personal, interpersonal, institutional, and social. It encompasses elite and popular systems, as well as the interplay between them, and the ways they are inflected by specific cultural, historical settings. Kaja Finkler suggests that the study of healing opens windows onto broader social processes, while Paula Arai posits that we examine worldviews to understand why people experience

healing, and how it occurs through the study of what they do. Crawford argues that the study of healing addresses “fundamental educational goals of the liberal arts curriculum and the goals of religious studies as a discipline more specifically.” I concur with all of them.

Selected Resources

Books

Barnes, Linda L., and Susan S. Sered, eds. *Religion and Healing in America*. New York: Oxford University Press, in press (fall 2004).

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

Numbers, Ronald L., and Darrel W. Amundsen, eds. *Caring and Curing: Health and Medicine in the Western Religious Traditions* . Baltimore: Johns Hopkins University Press, 1998.

Sullivan, Lawrence E., ed. *Healing and Restoring: Health and Medicine in the World’s Religious Traditions* . New York: Macmillan, 1989.

Kleinman, Arthur. *Patients and Healers in the Context of Culture*. Berkeley: University of California Press, 1980.

Journals

Culture, Medicine, and Psychiatry
Ethos
Medical Anthropology
Medical Anthropology Quarterly

Social Science and Medicine

Visual Images

The Image Bank , housed at the Center for the Study of World Religions (slides can be ordered)

The Boston Healing Landscape Project