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

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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).
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. 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), 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

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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.

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.” 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.”

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. Following the start of the key journal *Social

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8 See [http://www.sssrweb.org/About_cfm](http://www.sssrweb.org/About_cfm).
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.\(^\text{10}\)

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.\(^\text{11}\) 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.\(^\text{12}\)

Others criticized what they took to be an uncritical analysis of such categories as the “primi-
Jung was also charged with *Universalgedanken* (universal thought), and with claiming that archetypal symbols arise from a larger collective unconscious.\(^\text{14}\)

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.\(^\text{15}\) 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.\(^\text{16}\)

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.\(^\text{17}\)

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


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.”

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. 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.

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,

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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. 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

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?”

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?

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

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consider when exploring issues related to religion and healing.

In general, an explanatory model 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.

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?


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. As his later work demonstrated, such expressions can include the impact of social suffering relayed through bodily or affective symptoms. Sometimes illness categories appeared not to overlap at all. Such cases seem to occur only within a single culture as a “culture-bound syndrome.”

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.

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

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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


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.

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.

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.


| **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

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


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, “The 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.

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 lightning. 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.

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.

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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.
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.”

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.

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.

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.


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. 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. 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.”

Through Traditions


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

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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.

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 to medical care in the postcolonial world has been explored in various contexts.

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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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


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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{62}

\textsuperscript{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.


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 “superstitions” 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. 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.

**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 fluidity of a term that compels the religious imagination over time.

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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. 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.

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 context.


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


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

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 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.\textsuperscript{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.\textsuperscript{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

\textsuperscript{73} Gary B. Ferngren, \textit{Medicine and Health Care in Early Christianity} (Baltimore: Johns Hopkins University Press, 2009); Gerald J. Grudzen and Richard W. Bullet, \textit{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., \textit{Religion and Healing in America}.

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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{77} One approach, therefore, to the study of this tradition takes as its starting point those


\textsuperscript{77} Ibn Qayyim al-Jawziyyah and Muhammad ibn Abi Bakr, \textit{Medicine of the Prophet}, trans. Penelope Johnstone (Cambridge: Islamic Texts Society, 1998); Osman Bakar, \textit{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 ʿAli al- Ḥusayn ibn ʿAbd Allāh ibn Šīnā, or ibn Šīnā (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—some-
times 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 jīnn/djīnn, are alluded to
in the Qu’ran and can enter time and space through the possession and entrancement of individu-
als. 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

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
Culture, Medicine, and Psychiatry 15, no. 1 (1991): 19-43; Paula Schrode, “The Dynamics of Orthodoxy and
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,
“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).


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. But to avoid generalizations, it is useful to speak of a particular tradition

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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, Èlégbara, 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. Èlégbara opens the way (although he can also impose obstacles as well) through divination with the Odú Ifá.

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.

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.

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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\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{91}

\textsuperscript{88} When referring to the spirits in Africa, I refer to them as \textit{òrìsàs}; when referring to their presence abroad, I use the term \textit{orishas}.


\textsuperscript{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,” \textit{Counseling Psychology Quarterly} 23, no. 3 (2010): 267-82; Andrés Rodríguez Reyes, “Illness and the Rule of Ocha in Cuban Santería,”
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 descendents 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...
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-


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


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).

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, ceremonies 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
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.\textsuperscript{103}

\textbf{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.

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).


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. Orlowksi, 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.\textsuperscript{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.”\textsuperscript{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


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 Experience*.110

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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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{113}

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.


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.”

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.


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

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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 wide-spread 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


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

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Practical Matters

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. 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.

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 Carnegie 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.” 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

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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. 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.” 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.” 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.”

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

127 Flexner, Medical Education, 26
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
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.” 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.”

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.


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. 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

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 TM138

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


The practice had also come to the attention of Herbert Benson because its self-assigned secular nature presented a lower threshold to cross than, say, the Hare Krishna movement might have.\footnote{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.} 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.\footnote{See Jane E. Brody, “Cardiologist Offers Meditation Exercise,” \textit{New York Times}, November 8, 1974.}

Although it had become something of a commonplace to refer to “mind-body medicine,” when Benson published \textit{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.\footnote{See Herbert Benson, \textit{The Relaxation Response} (New York: Morrow, 1975); Herbert Benson, \textit{Beyond the Relaxation Response: How to Harness the Healing Power of Your Personal Beliefs} (New York: Times Books, 1984); Herbert Benson with William Proctor, \textit{Your Maximum Mind} (New York: Times Books, 1987); Herbert Benson with Marg Stark, \textit{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,” \textit{Crosscurrents} 60, no. 2 (2010): 168-84.}

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 opposed to more overtly Hindu devotional practices and setting up related temples, ISKON represented a transplanted version of Hinduism.\footnote{See Herbert Benson, \textit{The Relaxation Response} (New York: Morrow, 1975); Herbert Benson, \textit{Beyond the Relaxation Response: How to Harness the Healing Power of Your Personal Beliefs} (New York: Times Books, 1984); Herbert Benson with William Proctor, \textit{Your Maximum Mind} (New York: Times Books, 1987); Herbert Benson with Marg Stark, \textit{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,” \textit{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


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...
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.\textsuperscript{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.\textsuperscript{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.


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.\(^{150}\)


\(^{149}\) 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.

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.”

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. 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.


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


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).


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

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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.

the topic into residency education.\textsuperscript{160} A small number of programs are designed for health care professionals and for nurses.\textsuperscript{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”\textsuperscript{162} from their patients or to perform a “spiritual assessment.”


\textsuperscript{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,” \textit{Critical Care Medicine} 33, no. 12 (2005): 2733-36; Pamela Meredith et al., “Can Spirituality Be Taught to Health Care Professionals?” \textit{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,” \textit{Nurse Education Today} (2010), doi:10.1016/j.nedt.2010.11.010.

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

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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.\textsuperscript{165} One sees this progression, for example, in Harold Koenig’s writing.\textsuperscript{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.\textsuperscript{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.\textsuperscript{168} And, in a move oddly reminiscent of earlier critiques directed from within Religious Stud-


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.\textsuperscript{169} Indeed, a small number of such studies have recently been published.\textsuperscript{170}

\textbf{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.


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 States, one finds that the competencies related to cultural competence include the ability to communicate effectively and respectfully with patients, families, and the public from diverse socioeconomic and cultural backgrounds.174 These competencies are embedded within the broader domain of communication skills, and there is an emphasis on cultural humility and the ability to recognize and address one’s own biases and assumptions.

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States, the term “spiritual” currently appears only in relation to training in hospice and palliative medicine core competencies. 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”)—and to working across cultural differences, barriers generally go down. To the extent that they assume that the discussion of religiosity pertains to cultural groups

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.

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?

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.”

**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.


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. 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.

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. 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).


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

Practical Matters

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


tant examples there as well.188


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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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](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/](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.”


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:


**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-)


*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**
