Medicine - Religion - Spirituality: Global Perspectives on Traditional, Complementary, and Alternative Healing

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Veröffentlichungsversion / Published Version
Sammelwerk / collection

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transcript Verlag

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MEDICINE — RELIGION — SPIRITUALITY

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Preface and Acknowledgements

Healing is a contested field, and talking about healing from the perspective of the Study of Religion involves many risks. In our experience, studying traditional, complementary, and alternative medicines inevitably leads to accusations of partiality: one is blamed either for taking sides in favor of biomedicine and against alternative healing systems, or for advocating alternative healing systems without pointing out the alleged risks they imply. In presenting papers on the topic, we have often felt that our audience tended to prick up their ears on hearing what they feared, expecting us to take sides in either promoting or condemning biomedicine or alternative medicine. This experience, which reinforced our desire to approach this topic from an unbiased perspective, is one reason why this publication is so important to us.

This collection has benefitted from the support of many people. Laura Feldt und Gregory Alles shared our interest in not subjecting any kind of healing system to value judgements, and their comments helped us to improve the consistency of our arguments. We are also grateful to Johannes Quack for feedback on our initial drafts. Our sincerest thanks go to Robert Parkin for his linguistic proof-reading; his flexibility, patience, and feeling for language were of invaluable value. Julia Swoboda and Mirjam Aeschbach undertook the task of formatting and formally proof-reading the manuscript. Our heartfelt thanks go to them both for their academic expertise and their invariable good spirits in having to cope with complex formatting rules.

Finally, we thank all of our authors. Some of them revised their papers despite looming deadlines for their PhD theses or the challenges of pregnancy and parenthood. By happy coincidence, three children were born during the preparation of this publication.

Dorothea Lüddeckens and Monika Schrimpf, Zurich / Tuebingen, July 2018

Introduction

Observing the Entanglement of Medicine, Religion, and Spirituality through the Lens of Differentiation

Dorothea Lüddeckens and Monika Schrimpf

In the history of religions, tasks such as curing bodily ailments, treating the sick, and dealing with dying were often assigned to religious experts. Concepts such as the body, illness, and health were anchored in the world views and practices of the respective religious traditions. As Pamela Klassen (2016: 401) writes: "Medical knowledge and techniques have often emerged directly from religious traditions, making the line between these two admittedly unstable categories—religion and medicine—particularly hard to draw with any certainty." In historical contexts, the disentangling of medicine, religion, and spirituality is seemingly impossible. With regard to contemporary societies, one may take Klassen's observation a step further and ask whether it is at all possible to draw a clear line between "religion" and "medicine." Research in medical anthropology tends to emphasize that on the emic level, actors often do not distinguish between religion and medicine.[1] Besides, debates on secularization theory discuss the question of whether and in what ways the functional differentiation of modern societies that is observed in Europe and North America, including the differentiation of religion and

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1 In cases of medical pluralism, Krause et al. (2012: 17–18), for example, refer to the work of Murray Last and David Parkin, who argue against the concept of "medical systems" and point out that actors often make use of a variety of medical (and religious) traditions without differentiating between "medical" and "religious" practices and knowledge.

medicine, can also be claimed for non-European countries and cultural traditions (cp. Wohlrab-Sahr/Burchhardt 2017; for Japan cp. Rots/Teeuwen 2017; Schrimpf 2018).

Taking up these reflections, we raise the questions of whether it makes sense to refer to "religion" and "medicine" as two different realms, and whether it is acceptable for etic academic research to make use of concepts (or differentiations) that do not reflect self-perceptions and concepts on the emic level.

1 DOES IT MAKE SENSE TO DIFFERENTIATE BETWEEN RELIGION AND MEDICINE?

In contrast to the considerations sketched out above, we argue that it is important to maintain the paradigm of differentiating between "religion" and "medicine," at least in contemporary societies, for the following reasons.

1.1 The Contemporary Differentiation between "Religion" and "Medicine": A Global Paradigm

Social differentiation is a characteristic of modern societies, including the social systems denoted by "religion" and "medicine," though to different degrees. In the following, we argue that, thanks to the specific evolution of modern academic medicine (cp. Lüddeckens)[2] and the worldwide spread of biomedicine, differentiating "religion" and "medicine" has become a global paradigm. Nevertheless, there are many cases of non-differentiation or of the entangling of religion and medicine.

When we talk about the entangling or de-differentiation of "religion" and "medicine", we are not referring to cases in which religious and medical actors or actions coexist, as, for example, in a hospital where physicians deal with the physical needs of their patients and chaplains deal with their spiritual needs. Nor are we dealing with cases where a physician talks with his or her patient first about an impending operation and afterwards about the patient's fear of dying.

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2   All references without a year designation refer to contributions in this volume.

Such cases are in line with the global development of social differentiation. Our interest is rather directed at practices and concepts that involve medical and religious arguments and aims at the same time, that take medical as well as religious concepts into account, or that deal with both the physical and the transcendent aspects, including transcendent entities, thus pursuing medical and religious goals within one and the same framework.

The entangling of "medicine" and "religion" may therefore be observed in cases where religious concepts, such as spiritual development, are guiding principles for medical treatment, as in an anthroposophical hospital (cp. Zeugin et al.), or where, as in Transpersonal Psychology, religious experience is induced on purpose in order to support therapeutic aims (cp. Gripentrog), to name but two examples.

These de-differentiated entanglements can be observed especially at the margins of either "religion" or "medicine," as we will outline below. Such cases of entanglement rather confirm the global character of the paradigm of differentiated religion and medicine: even when actors do not differentiate, they often relate to this paradigm and are judged accordingly. These processes are particularly visible in the ways in which therapeutic practices and knowledge are labeled.

1.1.1 Differentiation in the Mainstream, Entanglement at the Margins?

Many scholars have discussed the differentiation of "religion" and "medicine" in the context of their respective institutions and professions, including their knowledge and techniques, with regard to "Western" societies (cp. Beyer 2012; Lüddeckens 2012; Luhmann 1983, 1990a; Parsons 2001; Vogd 2011). On the one hand, modern academic medicine, also called biomedicine,[3] does not accept religious concepts and practices as part of its biomedical framework. Due to the global spread of this kind of medicine, the disentangling of biomedicine and religion can be observed far beyond so-called "Western" societies, although in different ways and to different degrees. For example, in Japan and Tanzania, public health care supports primarily biomedical institutions.

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3   Similar terms include "conventional medicine, mainstream medicine, Western medicine, orthodox medicine," and "allopathic medicine".

However, even in modern societies, biomedicine is only one healing system among others. In many countries, officially recognized medicine also includes more or less "secularized" (and re-invented) forms of pre-modern medicine, often labeled "traditional medicine," in which religious and medical concepts are intertwined with therapeutic practices such as Siddha medicine (cp. Rageth), Ayurveda, and Unani in India, or kanpō medicine in Japan. In other cases, modern medical innovations in the field of Complementary and Alternative Medicine (CAM), such as anthroposophic medicine[4] or homeopathy, are officially acknowledged, as in the Swiss health-care system. While the religious connections or aspects of these healing systems are disputed, they often claim to be "holistic," in contrast to biomedicine. Many medical professionals trained in these therapeutic practices claim not only to address the physical and mental aspects of their patients' illnesses but also to take care of their spiritual needs.

On the other hand, religious actors, institutions, and communities that consider themselves as belonging to the "mainstream" religions often display a ready acceptance of the differentiation between religion and medicine, even though this deprives their institutions of an important social function that they have formerly fulfilled. By accepting biomedicine and its claims to medical authority and by refraining from raising their own claims of therapeutic competence beyond religious support, these religious actors and institutions present themselves as modern and as compatible with modern societies. This is the case with the European mainstream churches as well as with internationally or nationally acknowledged Islamic institutions such as the Al Azhar University in Cairo or the healthcare system in Saudi Arabia (cp. Khalil et al. 2018).

To quote Steve Bruce:

"Now only the fringes of religion—New Agers employing Amerindian cures, Jehovah's Witnesses rejecting blood transfusion in favor of prayer, US television evangelists claiming that HIV/AIDS is divine punishment for homosexuality—practice or reject medicine. The mainstream—primarily political response—can be seen in the Church of England's response to HIV/AIDS: it recommends that the government invest more in scientific research." (2016: 640)

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4   Anthroposophic medicine perceives itself as "integrated medicine".

Bruce's observation that the tendency to engage in healing practices occurs rather on the institutional margins or in non-mainstream segments of religious traditions is supported by studies of Sufi Islam (cp. Selim 2015), and charismatic Christianity (cp. Brown 2011).[5] In these cases, religious actors emphasize the superiority of religious authority over medical authority in dealing with cases of illness. Another example in the context of New Age spirituality is the intertwining of spiritual and psychotherapeutical goals (cp. Gripentrog).

1.1.2 The Paradigm of Differentiation as a Frame of Reference

Even though in cases of traditional medicine, faith healing, and so forth, the assumption that medicine and reliion are separate realms or systems that can be differentiated from each other seems absurd, this does not mean that the notion of differentiation is irrelevant. The notions of differentiation and of the subsequent hegemony of biomedicine strongly affect contemporary discourses and techniques related to the curing of illness globally. Proponents of diverse forms of medical knowledge and therapeutic practices define their own positions within this diversity by referring to the differentiation between religion and (scientific) medicine, or to the alleged authority of biomedicine, whether in affirmative, critical, or integrative ways. They react to the presumed hegemonic status of biomedicine in the society concerned and are judged accordingly.

As Schrimpf shows, for example, a contemporary Japanese Buddhist priest—that is, a religious actor—explains the medical effects of Buddhist practice by drawing analogies with scientific studies and referring to Transpersonal Psychology (cp. Schrimpf). Here, reference to a particular

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5 The distinction between mainstream religion and its margins as applied here refers only to the level of institutionalized, official religion. As Meredith McGuire has shown in her study on "lived religion" in the USA, individual religious practices and beliefs do not necessarily coincide with officially acknowledged religious knowledge and practice. Hers and other studies have analyzed cases in which members of Christian "mainstream" communities engage in non-Christian spiritual practices, some of which are attributed with healing effects (cp., for example, McGuire 2008:6–10; for Germany, cp. Bochinger et al. 2009).

image of medicine as scientific is applied to legitimize claims regarding the therapeutic authority of religion. Whereas some practitioners of CAM like Ayurveda emphasize the spiritual aspects of their therapies in order to distinguish their practice from biomedicine, others de-emphasize the metaphysical dimensions of their therapies because they want them to be acknowledged as equal to biomedical treatments.

As a consequence, the notion of differentiation and the hegemony of an allegedly non-religious biomedicine is reproduced not only by those who support it, but also by those who deny it or who claim their own superiority over it. This is often done by criticizing biomedicine as non-holistic, as lacking any spiritual or religious dimension, and as dealing only superficially with symptoms, instead of curing the (spiritual) causes of illnesses. This reproduction leads to a circular process, being reflected in discourses, terminologies, regulations, professions, social structures, and so on, which simultaneously condition forms of self-positioning and are shaped by them. In this sense, the differentiation between "religion" and "medicine" can be described as a social reality that is constantly negotiated, that is, produced and dissolved by the actors involved.

1.1.3 The Power of Words

Labeling is an important strategy in pursuing such negotiations. Terms such as faith healing, traditional medicine, CAM, biomedicine, and Western medicine are used in academic publications, as well as in emic discourses. These terms are closely interrelated, and their emergence reflects not only medical diversity, but also a hierarchical order within this diversity. According to Klassen (2016: 404), "[b]iomedicine's overwhelming social, political, and economic authority—and many would argue, its bodily efficacy—is what transforms other, non-biomedical therapeutic approaches into 'alternative' or 'complementary' therapies."

All these terms are controversial, their meaning being contested both etically and emically. In environments that display medical diversity, in which representatives of various therapeutic practices and forms of knowledge compete for medical authority and claims to power, they take on specific meanings and functions. For example, whereas the label "faith healing" may exclude religious therapeutic practices from national health-care systems, "traditional medicine" and even "complementary" or "integrative

medicine" may allow their inclusion. In this sense, again, the paradigm of differentiated "medicine" and "religion" conditions strategies of labeling which simultaneously contribute to consolidating this paradigm.

Power struggles over medical care are strongly influenced by political, legal, or economic structures. As Walter Bruchhausen demonstrates for the concept of "traditional medicine" in Tanzania, local, national, and international institutions, such as medical training institutions, health ministries, or the World Health Organization, provide official definitions of the terms mentioned above. These definitions impact upon the legal and economic conditions in which therapeutic practices are engaged, as well as upon their accessibility (cp. Bruchhausen). The possibility of offering therapies that do not comply with the biomedical paradigm of abstaining from religious claims and interpretations depends upon these basic conditions and their structural constraints. Concrete examples of how these terms are applied and interrelated in order to (re-)configure a plurality of medical practices from different perspectives and to be able to position oneself in relation to this plurality are discussed for India, Tanzania, Japan, and Europe in this volume.

1.2 Recognizing Power Relations and Self-Positionings through the Lens of Differentiation

As explained above, the global spread of this differentiation implies that the de-differentiation and entanglement of concepts and practices can be observed within the frame of "differentiated religion and medicine." Thus, we can analyze, for example, strategies of self-positioning within the entanglement of religion and medicine. This includes actors in medical institutions like an anthroposophical hospital or conventional palliative-care wards, who aim to extend their fields of competence and increase their agency by including spiritual-religious concepts and practices (such as spiritual development or aroma therapy) in their medical work (cp. Lüddeckens; Zeugin et al.). These actors frequently disguise the religious aspects of therapeutic practices by using the label "spiritual" in order to avoid possibly negative images of religion within a medical context.

Another example of de-emphasizing the religious aspects of medical practices is political actors in Tanzania, whose definitions of "traditional medicine" aim to re-establish pre-modern medical practices devoid of their religious interpretations and ritual elements (cp. Bruchhausen). Similarly,

practitioners of Ayurveda describe their activities as "spiritual" or "medical," depending on the legal conditions of health policies and the needs of patients (cp. Pattathu).

In contrast, religious actors in established traditions may call their thera- peutic knowledge and practices "traditional medicine" in order implicitly to advocate the pre-differentiation state of entangled religion and medicine, as is observable, for example, in contemporary Japanese Buddhism (cp. Schrimpf). For the same reason, "hereditary" Siddha practitioners oppose the professionalization of their medical tradition (cp. Rageth). Obviously, the phrase "traditional medicine" can be used to support strategies to both con- solidate and counteract the entanglements of religion and medicine, depend- ing on the respective social and political contexts. Not all strategies, how- ever, refer to the labeling or use of terms; others may aim to create a specific relationship between religious and medical authority.

We will conclude with some general reflections on the second question raised in the beginning: is it acceptable for etic academic research to make use of concepts (or differentiations) that do not reflect self-perceptions and concepts on the emic level?

2 ETIC APPROACHES TO EMIC PERSPECTIVES: REPRODUCING OR ANALYZING?

At the IAHR conference in Erfurt in 2015 we organized three panels on "In- novation and Tradition in the Field of Entangled Religion and Medicine." These panels were accompanied by heated discussions over the question of whether etic academic terminology needs to be aligned with the conceptual- izations and perceptions of the actual actors in the field.

One argument in favor of such an alignment can be found in a working paper by Krause et al. (2012) on medical diversity, mentioned above. In it, the authors argue that talking of systems (of medical traditions) obstructs the view of emic conceptions that are characterized by overlapping, mutual in- fluences, etc., and of activities that are guided by the appropriation of various practices to individual needs without distinguishing between religious or medical therapies (ibid: 17–18).

In contrast, we argue that it is important to maintain a distinction between etic and emic perspectives. Academic research should not stop at describing

emic self-perceptions in the field but should also provide analytical etic second- and third order observations (cp. Luhmann 1990b). [6] One question at stake is whether it is acceptable to label concepts and practices "religious" in cases where the respective actors disagree with this classification? Is it not the responsibility of the researcher to acknowledge this self-positioning and take the emic perspective seriously?

2.1 Emic Perspectives

However, what does "taking the emic perspective seriously" mean?

Every self-perception is conditioned by particular contexts, for instance by economic aspects: for example, health insurance covers the cost of medical treatments, but not religious ones. Some political contexts support self-labeling as non-religious, for example, as part of the public education system, whereas others support self-labeling as religious, for example, to obtain the benefits granted to religious institutions. Besides, prestige is an issue: what does it mean to be viewed as religious in a particular society or social milieu, and is it advantageous or not? Also, what kind of positioning does it entail? Depending on the social milieu, being "spiritual," for example, can have a higher value than being "religious."

Therefore, self-perceptions teach us a lot about the contexts in which the respective actors are engaged. Besides, the dependence of self-perceptions on these conditions illustrates their relativity—that is, perceptions may vary according to the contextual conditions of different actors.

In our opinion, this is one reason why the academic perspective of the Study of Religion should not be expected to merely reproduce emic views and self-perceptions. Apart from the relativity of emic perspectives mentioned above, which perception should be considered authoritative, that of the specialists or those of ordinary people? For the specialists, a healing practice may be imbued with "spiritual" aspects, whereas patients may perceive the same practice as purely "medical" (cp. Pattathu). Furthermore, the

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6   In many cases we find scholarly reflection in the field itself, for example, anthroposophic medicine, or scientific research on the effects of kanpō medicine or Ayurveda by their respective practitioners.

researcher must be careful not to slip into a paternalistic habitus by portray-ing him- or herself as a spokesperson for the "emic voice". [7]

2.2 Etic Perspectives

The same plurality characterizes etic academic perspectives, which are also determined by the specific contextual conditions and frames of reference pro-vided by their respective academic disciplines. For example, academics make use of reflective concepts that produce specific differentiations, such as that between "religion" and "medicine."

The Study of Religion depends upon such abstract analytical concepts in order to make statements about its topic and be able to conduct comparative research. The relevance of comparison as a basic research method in the Study of Religion has been emphasized from the beginnings of the discipline (cp. Wach 1924) to the present day (cp. Freiberger 2018). Only on the basis of comparison can generalized concepts[8] be developed and constantly re-vised (or "rectified" in Freiberger's terms) in order to make non-exemplary statements about religions.

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7   This habitus is also a critical topic in various feminist discourses. For example, Kawahashi and Kobayashi criticize a patronizing attitude towards women in con-temporary Japanese religions: "Another issue is the attitude shown by some schol-ars of taking non-Western women under their wing, as though somehow acting as those women's patron, and there is a danger that such attitudes may in effect con-stitute complicity in maintaining patriarchal religious structures." (Kawahashi and Kobayashi 2017: 3) On the other hand, there are various examples of joint author-ship on the basis of a dialogical relationship, cp. Lüddeckens and Karanjia 2011, and Ari and Jebens 2015.

8   As Mohn explains, when we use the term "generalized concepts," we must be aware that "[u]niversality is always a cultural, linguistic, and socially constructed claim on 'the general' that can be raised differently even by speakers of a shared cultural context." Original wording: "Universalität ist immer eine kulturelle, sprachliche, gesellschaftlich konstruierte Inanspruchnahme des Allgemeinen, die von vielen Sprechern selbst eines geteilten kulturellen Kontextes unterschiedlich behauptet werden kann." (Mohn 2012: 307) And, given the diversity of compared cases, it is impossible to find general terms on a meta-level that correspond to each individual case.

Another disciplinary framework in the Study of Religion results from the process in which religion as the object of its research is produced.[9] Besides, academic perspectives are strongly influenced by the respective political conditions in which research is conducted: some fields of research are better funded than others, and these trends are constantly changing. All these conditions provide framings for academic positions that are quite different from those on the emic level. Etic perspectives are therefore determined by particular contextual conditions differently from emic perspectives. Hence it is consistent to acknowledge the difference in perspectives without ascribing a higher value to one over the other.

BIBLIOGRAPHY

Ari, Alex Yapua/Jebens, Holger (2015): Storibuk Pairundu. Tales and Legends from the Kewa (Southern Highlands, Papua New Guinea), Berlin: Reimer.

Beyer, Peter (2012): "Observing Religion in a Globalized World: Late Twentieth-Century Transformations", in: Volkhard Krech/Marion Steinicke (eds.), Dynamics in the History of Religions between Asia and Europe, Leiden: Brill, pp. 413–433.

Bochinger, Christoph/Engelbrecht, Martin/Gebhardt, Winfried (2009): Die unsichtbare Religion in der sichtbaren Religion. Formen spiritueller Orientierung in der religiösen Gegenwartskultur, Stuttgart: Kohlhammer Verlag.

Brown, Candy Gunther (2011): Global Pentecostal and Charismatic Healing, Oxford: University Press.

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9 "Any heuristic approaches the 'phenomenon' religion with revisable and not ontologizing terms, a 'phenomenon' that is found or created by these movements of searching and description, and thus becomes temporarily communicable in the academic space." Original wording: "Eine Heuristik geht mit revidierbaren und nicht ontologisierenden Begriffen an das 'Phänomen' Religion heran, das genau in diesen Such- oder Beschreibungsbewegungen erst gefunden oder erzeugt und somit im Wissenschaftsraum 'vorläufig' kommunizierbar wird" (Mohn 2012:307).

Bruce, Steve (2016): "Differentiation", in: Michael Stausberg/Steven Engler (eds.), The Oxford Handbook of the Study of Religion, Oxford: Oxford University Press, pp. 635–645.

Freiberger, Oliver (2018): Elements of a Comparative Methodology in the Study of Religion, in: Religions 9(38), doi:10.3390/rel9020038

Kawahashi Noriko/Naoko Kobayashi (2017): Editors' Introduction: Gendering Religious Practices in Japan. Multiple Voices, Multiple Strategies, in: Japanese Journal of Religious Studies 44 (1), pp. 1–13.

Khalil, Mohamed K.M./Sulaiman Al-Eidi/Meshary Al-Qaed/AlSanad, Saud (2018): The Future of Integrative Health and Medicine in Saudi Arabia, in: "Integrative Medicine Research", https://doi.org/10.1016/j.imr.2018.06.004.

Klassen, Pamela (2016): "Medicine", in: Michael Stausberg/Steven Engler (eds.), The Oxford Handbook of the Study of Religion, Oxford: Oxford University Press, pp. 401–414.

Krause, Kristine/Alex, Gabriele/Parkin, David (2012): Medical knowledge, therapeutic practice and processes of diversification, MMG Working Paper 12–11, http://www.mmg.mpg.de/fileadmin/user_upload/documents/wp/WP_12-11_Concept-Paper_MEDDIV.pdf.

Lüddeckens, Dorothea (2012): "Religion und Medizin in der europäischen Moderne", in: Michael Stausberg (ed.), Religionswissenschaft, Berlin: De Gruyter, pp. 283–297.

Lüddeckens, Dorothea/Karanjia, Ramiyar (2011): Days of Transition. The Parsi Death Rituals, Göttingen: Wallstein Verlag.

Luhmann, Niklas (1983): "Medizin und Gesellschaftstheorie", in: Medizin, Mensch, Gesellschaft 8, pp. 168–175.

Luhmann, Niklas (1990a): "Der medizinische Code", in: Soziologische Aufklärung 5: Konstruktivistische Perspektiven, Wiesbaden: VS Verlag für Sozialwissenschaften, pp. 183–195.

Luhmann, Niklas (1990b): Die Wissenschaft der Gesellschaft, Frankfurt a.M.: Suhrkamp.

McGuire, Meredith (2008): Lived Religion. Faith and Practice in Everyday Life, Oxford: Oxford University Press.

Mohn, Jürgen. (2012): Die Religion der Religionswissenschaft und die Wissenschaft der Gesellschaft: eine Replik. Erwägen, Wissen, Ethik, Jg. 23, ed2, pp. 306–320. http://edoc.unibas.ch/dok/A6031567.

Parsons, Talcott (2001): The Social System, London: Routledge.

Rots, Aike/Teeuwen, Mark (eds.) (2017): Formations of the Secular in Japan, Special Issue of Japan Review 30.

Schrimpf, Monika (2018): "Religious Responses to Secularization in Meiji Japan: The case of Inuoe Enryō", in: Michael Wachutka/Monika Schrimpf/Birgit Stämmler (eds.), Religion, Politik und Ideologie. Beiträge zu einer kritischen Kulturwissenschaft. Festschrift für Klaus Antoni zum 65. Geburtstag, München: Iudicium, pp. 59–70.

Selim, Nasima (2015): "Sufi Body Practices and Therapeutic Politics in Berlin", in: Gritt Klinkhammer/Eva Tolksdorf (eds.), Somatisierung des Religiösen: Empirische Studien zum rezenten religiösen Heilungs- und Therapiemarkt, Bremen: Universität Bremen, pp. 237–282. http://elib.suub.uni-bremen.de/edocs/00104231-1.pdf.

Vogd, Werner (2011): Zur Soziologie der organisierten Krankenbehandlung, Weilerswist: Velbrück Wissenschaft.

Wach, Joachim (1924): Religionswissenschaft. Prolegomena zu ihrer wissenschaftstheoretischen Grundlegung, Leipzig: Hinrich.

Wohlrab-Sahr, Monika/Burchhardt, Marian (2017): Revisiting the Secular—Multiple Secularities and Pathways to Modernity, Working Paper, Leipzig: Leipzig University, HCAS "Multiple Secularities—Beyond the West, Beyond Modernities", http://www.mmg.mpg.de/fileadmin/user_upload/documents/wp/WP_12-11_Concept-Paper_MEDDIV.pdf.

Medicalized Healing in East Africa

The Separation of Medicine and Religion by Politics and Science

Walter Bruchhausen

ABSTRACT

For centuries, foreign notions of religion and medicine have divided African forms of healing into religious and medical aspects. This distinction developed into an institutional separation, which has proved problematic for African patients, who expect the previous unity of religious and medical aspects from their healers but are increasingly offered a medicalized, i.e. secular version of "traditional medicine" instead. There are different factors contributing to this discrepancy. For orthodox Muslims, Christian missionaries, and colonial doctors, while the use of herbs was acceptable, rituals controlling or addressing spirits mostly was not. Following the World Health Organization and the concept of "alternative medicine," substances and experts came to be regulated by the state or scientifically researched in accordance with "biomedical" notions of efficacy and safety. Thus, elements that could be classified as religious by both functionalist and non-functionalist theories of religion were increasingly excluded, first in external perceptions and research, and later in legislation and social reality.

1 INTRODUCTION

Healing services referring to African traditions are in great demand in sub-Saharan Africa, and national as well as international bodies are trying to regulate and promote the field. This poses the question of whether the demands of the local population and activities on a political level truly refer to the same thing. The evidence presented in this article suggests that what sick people and their relatives are mostly looking for from such services, which they do not find in government health facilities, is related to what could be called "religious" in most notions of the term. However, international and governmental health policies and scientific activities are dominated by tendencies to minimize or even exclude precisely such aspects. Concepts of religion, whose "use" here is clarified below, can be regarded as one of the central criteria in distinguishing between local and national or international views of what African traditions have to offer in treating illness.

The fact that internationally and locally organized religion, especially "enchanted Christianity" in Pentecostalism and charismatic Catholicism (Gifford 2015: 13–68; 107–124), has taken over much healing in Africa is well known and has been intensively researched. Whereas my previous studies on East Africa have concentrated on the influence of local religious practices and of Christian missions on the development of traditional forms of healing (Bruchhausen 2009), the present contribution will mainly consider the national and international political factors that have changed and even created "traditional medicine" as a mainly medical activity, instead of the previous practice in which the medical and religious aspects were fused. The focus will therefore be much more on the "medicalization" of healing than on its religious reformulation. In a global perspective, the focus on medicalization is also justified by the fact that, in both national and international politics, there were far more forces turning African healing into medicine than into religion. Thus, this article offers a fresh and substantiated look at the forces that are driving the religious aspects out of the practice of "traditional healers," seeking to go beyond the master narrative of an allegedly irresistible secularization in dealing with disease.

This difference between local hopes and practices involving the religious aspects on the one hand and the political or scientific interest in minimizing such aspects on the other constitutes the starting point for this study. The argument will be substantiated through limited reference to ethnographic

findings in order to illustrate the religious functions in this context and through an extended analysis of documents from different periods and organizations in order to show the various ways in which these functions have been excluded.

After an introduction to the terms, methods and materials used, I will summarize the present practice of consulting non-biomedical experts in the region of my ethnographic fieldwork in south-eastern Tanzania.

In the following, the difference between the local and the (inter)national will be demonstrated and explained in several ways, since monocausal views must be dismissed as outdated accounts of complex social processes. In my first explanation I will refer to comparable issues surrounding non-biomedical practices in Europe. For comparison and self-reflection, and to induce an awareness of interaction in the sense of an entangled history, current European attitudes towards such practices are briefly sketched and related to the situation in East Africa. A second way of explaining the difference between local demand and the political neglect of the religious dimension in healing is to provide a historical account of how European intrusions altered perceptions and practices during colonial rule. There are different pathways to account for the impact of foreign approaches on African healing, scientific research, international health policies, and territorial legislation respectively.

Before political independence, colonial administrators and academic researchers in both the natural and the social sciences increasingly noticed and also practiced a distinction between herbal medicine and spiritual practices. After Tanzania's independence in 1960, two different new approaches emerged to regulating the development of "traditional medicine": the policies of the World Health Organization (WHO) internationally, and Tanzanian national legislation on health professions and "traditional medicine". Thus, studying the influences on healing practices in East Africa must include colonial and current legislation, international and national health policies, scientific research and neoliberal commodification. Although these globalized and globalizing influences point towards the increasing functional differentiation of such distinct systems as medicine, law, science, education, politics, and religion (Luhmann 1999), these influences have encountered local resistance, often inspired by global movements, against the strict functional separation of healing and religion, like mystical Sufism in Islam and Pentecostalism and other charismatic movements within the mainstream Christian churches.

The final section before the conclusion returns to the present, to the recent Traditional and Alternative Medicines Act in Tanzania, and its impact on the religious aspects of healing.

2 CONCEPTS, METHODS AND DATA

Applying terms of European origin and highly contested meanings such as "religion" or "medicine" to African social phenomena is a major challenge that has long been debated in anthropology, theology, and missionary studies (Dilger et al. 2004). This is especially the case where the impact of complex European terms, in this case religion and medicine, constitutes the object of study, as in this article. The only meaningful solution to this epistemic problem seems to be an understanding informed by social constructivism: medicine and religion are what they are for the participants in the particular social construction of reality. This implies that, before the introduction of terms expressing the Muslim distinction between *tiba* and *dini* (two Swahili words of Arabic origin) or the European distinction between "medicine" and "religion," there might not have been anything like such differences for the inhabitants of the East African coast. However, it would excessively ethnocentric and arrogant to deny that Africans had what European observers called religion and medicine, as in the work of certain theological and scientific authors in the early colonial period (Bruchhausen/Roelcke 2000), before the debates emerged over concepts like "primitive religion" (Evans-Pritchard 1965) and "primitive medicine" (Ackerknecht 1942). The dilemma is obvious: subjecting African practices to European definitions could ultimately lead to one endorsing the neo-colonialist statement that they do not have such institutions, whereas using only the terms of the particular tradition would make translation and, especially, cooperation between the representatives of different societies or cultural traditions impossible. Therefore, the path to more shared, globally applicable definitions must be taken, even though it always risks introducing distinctions not yet known to the society in question. The debates between universalism and particularism, between liberalism and communitarianism, in political and moral philosophy revolve precisely around this dilemma.

One of the solutions to this dilemma is to use notions that carry as broad a meaning as possible in the case in question. Thus, in such contexts

"medicine" is not only defined by what medical doctors or the practice taught at university does, for which the term "biomedicine" has been introduced in anthropology (Bruchhausen 2011a)—it may also refer to any activity that deals explicitly or mainly with preventing, diagnosing, and treating illness. Although food, physical and mental exercises, and a clean environment might be even more important in preventing illness or recovering from it, they are not regarded as medical in this sense, but rather as related to "health". First of all, whether practices like those of East African ritual experts are called "medicine" or not depends on the broadness or narrowness of the definition of "medicine," but in the long run the definition itself may have effects on these practices. For mere reasons of convenience, rather than to emphasize any claim to supposedly proven efficacy, any foundation in biology or any static notion of tradition, the conventional, broadly established terms "medicine," "biomedicine," and "traditional medicine" and their adjectives will be used in this article. We must be aware, however, that "medicine" and today also "traditional medicine" are used by the respective proponents of these categories and the clients and politicians involved themselves, whereas "biomedicine" mostly remains a term used by external academic observers. What is meant by "traditional medicine" in the different discourses will remain one of the central questions. "Healing" is also occasionally used as a term indicating the broader functions of originally African activities.

Concerning the term "religion," taking a similar approach would mean that some of the classical debates between, for example, functionalist and non-functionalist theories (Stausberg 2009; Luhmann 1992: 9–71) or between definitions of religion as personal conviction, faith or experience and as social institution and doctrine (Taylor 2002), are left aside as far as possible. In some beliefs and practices in African healing, relating to the spirits is a subjective experience, as well as a social event and institution. Even if dealing with disease—the fundamental task of medical systems in functionalist definitions—were the primary concern or function of a practice, the tasks of assisting the patient to cope with contingency and of reassuring him or her of the existence of a meaningful, trustworthy world could fulfill the functionalist criteria for religion. It could, of course, be argued that any medical practice, including secular biomedicine, entails coping with contingency and reassures by means of rituals and symbols (such as white coats or stethoscopes), as several proponents of medical anthropology do indeed argue

(Helman 2007: 227). Yet these practices lack the open reference to a transcendent dimension which is a basic aspect of the concept of religion as applied in this article. Contacting invisible personal forces, praying for their assistance and making sacrifices to them, as established in most kinds of African healing (Magesa 1998: 188–198), would constitute religious activities in the understanding of most scholars of religion and probably most people in the world. The fact that early Christian missionaries and scholars called some African practices "magic," "witchcraft," "superstition," or "paganism," and thus denied them the status of religion, no longer prevents the present-day use of the term "religion:" indeed "African religion" is a well-established concept (Mbiti 1969). Nevertheless, such phenomena as sorcery, divination or spirit possession might still, by definition, be excluded from the term "religion" by some monotheistic theologians. In African theology (Magesa 1998: 13–35) and religious studies, however, a less dogmatic and narrow notion of what belongs to religion seems to be common. It is precisely this notion that will be applied here.

The article starts with a very condensed account of my findings from three years (2000–2003) spent studying the situation of medical pluralism in south-east Tanzania ethnographically, which I have described in detail previously (Bruchhausen 2006: 143–295). Interviews and participant observation in consultations and rituals were conducted in the premises of about ninety "traditional healers" identified for me by personal recommendation, the registration lists of the district office and the healers' association, the list of participating healers in the workshops of a mission hospital, and finally by inquiring in villages. The same methods were also followed in four government and three mission hospitals, as well as some health centers and dispensaries. Focus-group discussions in a hospital and on a healer's premises and a final survey of more than a hundred households validated the findings. The major research questions were how the experts and patients understood these services and where they saw their strengths and those of others, including possible reference to other experts. Ethnography forms a suitable starting point in attempts to understand all the forces that determine the religious and medical aspects of healing in East Africa. This descriptive approach, which aims at establishing the "emic" understanding, takes into account the fact that classification into either medical or religious traits is, from a certain perspective, a European categorical obsession rather than an identification of elements in an ontological sense (Krause, Alex/Parkin 2012). Looking at actual

practices provides an understanding of the local interests and foreign influences that make possible a deeper study of the dynamics that produce and determine the present situation. It allows us to ask why such close relationships between needs classified as religious and medical respectively were deeply changed by the encounter with the overwhelming secularizing modernity of the Global North.

Studying international and national impacts on African healing is different in kind. Doing so has involved the analysis of recent research literature and documents produced by political and administrative authorities, including the relevant public records in archives in Dar es Salaam, Oxford, Kew Gardens (London), and Berlin, as well as contemporary medical and scientific journals and international organizations, especially the WHO.

3 MEDICAL AND RELIGIOUS TRAITS OF HEALING IN CONTEMPORARY TANZANIA: ETHNOGRAPHIC FINDINGS

The social reality of health-related behavior, probably in most of sub-Saharan Africa, and certainly in south-east Tanzania, consists in an enormous variety of options. The majority of experts who can be consulted outside biomedicine are referred to as *waganga wa jadi* in Swahili. *Waganga* derives from a Bantu verb originally meaning "connecting," but here denoting the performance of special rituals for positive outcomes. The functions of the priest in offering sacrifices and relating to invisible personal powers, of the magician in divining and protecting against evil forces, and of the healer in caring for the sick were not separated in this concept, which is common to large parts of Bantu-speaking Africa and beyond. Today the term *waganga* on its own can be used for practitioners of both "traditional" and "modern" medicine, that is, healers on the one hand and doctors, nurses or other biomedical specialists on the other. *Waganga wa jadi* refers to the "traditional sector" only and is usually translated as "traditional healer," as *wa jadi* means literally "of yesterday" or "of the past" more generally.[1] In particular, as *waganga* is also used for biomedical practitioners, it has taken on the medical meaning of "healer." The abstract noun *uganga* still refers to the previous

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1   A word like *desturi* would rather have the connotations of "tradition" or "custom."

broad range of functions. The Arabic term *tiba* is used for "medicine" in a narrow, rather European sense. *Tiba ya asili*, "medicine of the origin" or "of nature," is translated as "traditional medicine", while *tiba ya kisasa*, "medicine of today," or *tiba ya hospitali*, "hospital medicine," are used for "modern medicine," that is, "biomedicine".

Thus, if one demands to speak to a *mganga* [singular of *waganga*] *wa jadi*, one will be probably taken to somebody who practices a type of healing. Yet the variety of experts that fall under this name is broad. Some of them, all male, behave in several ways similar to a biomedical doctor, wearing a white coat, using a stethoscope, and selling pharmaceuticals, although their diagnostics do not follow the principles of a clinical examination and laboratory tests. If these *waganga* use herbal medicine, it tends to be already pulverized and issued in small bottles originally used for injections or large containers for tablets, a further reference to biomedicine. Such preparations can also be bought in small shops in towns, where long lists of diseases and other misfortunes, like problems in marriage, at school or in business, promise remedies against them.

However, the majority of the *waganga wa jadi* in southeast Tanzania are female spirit mediums, who, through an initial illness, have been called by their spirit(s) to serve, especially in healing. With this type of healer, the use of roots and herbs is embedded in contact with spirits: the spirit gives the diagnosis and shows which remedies are the correct ones. Often these healers become leaders in a kind of religious group in which variations of the traditional night-long drum dances are performed as major rituals intended to satisfy the spirit(s). These groups may exhibit different cultural or religious characteristics, some of which, like half-naked dress, the colors of red and black, drum rhythms, songs, and the names of spirits, belong to the African heritage. Under the influence of Islam, others resemble Sufi brotherhoods, with full white dress (*galabia* and head scarf), a flag of the prophet, a Koran, *dhikr* (rhythmic breathing) as incantation, songs without drumming, and sacrifices without alcohol. The reference to Islamic spirits supposedly renders the originally "pagan" practice lawful for Muslim healers, although for orthodox Muslims any dealing with spirits is *shirk*, religiously forbidden. In the mostly Christian regions, the function of such groups has been taken over by independent African churches in which the prophets are healers who also lead long rituals with dancing, trances and glossolalia.

Regardless of religious affiliation—whether originally African, Islamized or Christianized—these consultations and rituals obviously function both as religious services in the sense of contact with spiritual forces and as medical treatment by concentrating simultaneously on health problems. Yet what health problems do they address? At the end of my field research in southeast Tanzania, a questionnaire I had circulated, answered by a hundred households, clearly revealed local perceptions of the strengths and weaknesses of the different services. The results indicated an informal but factual division of labor between biomedicine and "traditional medicine," the former being more appropriate to the somatic aspect, especially through the impact of chemical substances and surgery, the latter to the more psychic aspect. Yet interestingly enough, scientific and political support for "traditional medicine" points in a quite different direction that favors the bioactive substances of medicinal herbs, not coping or healing through rituals. In order to explain this tendency, we must first look at non-biomedical practices of healing in a global and historical perspective.

4 "TRADITIONAL" AND "COMPLEMENTARY AND ALTERNATIVE" MEDICINE: AFRICA AND THE GLOBAL NORTH

4.1 Non-biomedical Healing in Africa and Europe

Equating African healing with European "folk medicine" or "naturopathy," as various discourses have done since the late nineteenth century, produced ambiguous results regarding the religious dimension. The obvious reason is that it repeats the variety of Europe's reactions and interpretations concerning its own healing traditions (Ernst 2000). Conceptions of the foreign mirror one's own preoccupations, in this case negotiating the relationship between religion and medicine in the Global North (Bruchhausen 2011b).

The broad current interest in "traditional medicine" in Africa would have been quite a surprise to Western observers in previous times. When Europeans' descriptions of African health care reached Europe during the colonial period, the general direction of medicine in Europe seemed to be inevitable, a matter of course, to many of the educated: medical science would increasingly govern peoples' health-related behavior, as older practices came to be

regarded as "medical superstitions" or existed only in new fringe areas such as naturopathy and spiritual healing, in opposition to the sort of medicine represented in the universities (Jütte 1996). Thus, African healing practices were categorized similarly, that is, as an irrational way of dealing with disease that would soon disappear, or, in some more sympathetic minds, as a possibly more natural and less materialistic way of healing (Bruchhausen/Roelcke 2000).

Yet in Africa as in Europe, the biomedical approach, despite its undeniable successes in many areas, did not conquer all areas of health care equally. The partitioning of the domain of biomedical practitioners and other forms of medical treatment and their experts, called "traditional" for countries outside Europe and "alternative" for Europe, seems to have converged in most parts of the world: the diagnosis, treatment, and prevention of severe infectious diseases, as well as major surgery, are mostly pursued in hospitals and pharmacies; patients with chronic or psychosomatic conditions quite often prefer to consult practitioners with a less scientific reputation.

Given the numbers of patients and the gravity of the health problems concerned, "traditional medicine" in African countries is a far more important issue than "complementary and alternative medicine" (CAM), as it tends to be called today in the industrialized nations (Moeti 2015). Due to its central role in African societies and to the longer tradition of ethnographic work on non-European situations, academic interest in the non-scientific aspects of healing developed in Africa much earlier and more widely than interest in the "folk healing" of Europe. But in asking how formal state control influences non-biomedical practices, industrialized societies, with their fully implemented administrative structures, may offer some fruitful entry points to the study of regulatory activities in a globalized world.

The term CAM itself—despite its reference to "medicine"—does not necessarily imply a preference for either secular notions of scientifically explainable effects or a utilization of religious elements such as reference to a "spiritual world". As governmental recognition of CAM is a concession to that variously large and heterogeneous part of the population that does not accept biomedical monopolism, the academic debate on CAM asks quite different questions (Sharma 1992). Is it rather a sign of post-modern "anything goes", of disappointment at the unfulfilled promises of biomedicine, of the "re-enchantment" of a secularized world, of the new consumer sovereignty, or of the increasing market-place ideology of health care? All these factors,

of course, play their role to different degrees. Although the dimensions that refer to spiritual or psychological needs i.e. those discourses that address questions of ultimate causation and meaning of illness, will be at the center of this study the more economic and political factors underlying the popularity of CAM must also be considered. On the whole, these factors create an opportunity for interpretations of CAM in terms of both secular methods based on nature and religious activities. Under the umbrella term CAM, we find anatomy-based practices like osteopathy, the pharmaceutically sophisticated system of homeopathy, the "neo-pagan" rituals of Wicca, and the Catholic approaches to healing of the mediaeval nun Hildegard of Bingen. Dissatisfaction and liberalization can lead in quite opposite directions. On the part of the patients or consumers, there does not seem to be a strong need to distinguish or even separate the material and spiritual components of CAM practices, i.e. the scientifically proven biological effects of substances and procedures on the one hand and the mobilization of healing forces beyond the causality of the sciences.

A major aspect of a secular notion, however, is the growing demand for scientific research into CAM's effects that is being sponsored currently by pharmaceutical enterprises specialized in phytotherapy, foundations devoted to such therapies, and even public sick funds and private health insurance companies. Despite its much lower funding compared to research into other pharmaceuticals or into molecular and cell biology, such studies are a publicly visible part of medical research. The economic interest in traditional medicine and CAM is quite obvious and no longer concealed by reference to public service alone, as in earlier WHO documents and ethnographic studies. On the relevant WHO fact sheet for 2008, one of five "key facts" about "traditional medicine" is: "Herbal medicines are the most lucrative form of traditional medicine, generating billions of dollars in revenue" (WHO 2008). The explanation given later in the text is: "Herbal treatments are the most popular form of traditional medicine and are highly lucrative in the international marketplace. Annual revenues in Western Europe reached US$ 5 billion in 2003-2004. In China, sales of products totaled US$ 14 billion in 2005. Herbal medicine revenue in Brazil was US$ 160 million in 2007." Before the WHO turned its emphasis in this way from saving to making money from "traditional medicine," already in the 1990s in the United States the Eisenberg studies showed the high percentage of out-of-pocket expenditure flowing into so-called unconventional or alternative medicine (Eisenberg 1993,

1998). National and international bodies, like the European Union or the WHO, try to regulate the production, distribution, and application of herbal remedies. Yet so far, no African international organization, and only a single African state, Ghana, has joined the WHO's organization in this project, the International Regulatory Cooperation for Herbal Medicines (WHO 2010). There is no WHO collaboration center for traditional medicine in sub-Saharan Africa, the only one on the continent being in Khartoum. New national legislation for traditional medicine is growing in several African countries, and its effect on healing practices will be studied at the end of this article.

The overall effect of equating African healing with CAM in industrialized nations as implied by, for example, the WHO unit for Traditional and Complementary Medicine in Geneva is its construction and classification as herbal medicine. Even when "traditional" health-related practices that do not involve substances are studied in clinical trials, African practices are not included. Whereas acupuncture from the Chinese tradition, yoga from the Ayurveda, the mindfulness exercises of Buddhism, or even trances in shamanism and Caribbean cults are investigated for their impacts on health, making a scientific distinction between potentially useful plants and rituals not worth clinical study seems to be general when it comes to African healing. The religious or spiritual functions of African healing, such as the integration of experiences into an overall world view, the resulting motivations to serve others and accept misfortune, are not emphasized by its international and national supporters.

Having looked at contemporary situations and tendencies in the non-biomedical healing practices of Africa and Europe, we now need to see how they can be explained by reference to the various historical influences which used to favor a biomedical interpretation and the suppression of the religious aspects and functions.

4.2 The Impact of Colonialism on the Practice and Perception of African Healing

4.2.1 The Distinction between the Physical and the Spiritual or Religious Aspects of Healing

The way healing practices develop in our case—whether they are tied to or are removed from religion—is, of course, largely determined by the social

institutions that control the field. Both before and during early colonial rule, these institutions worked more closely to the traditions of the local population than under the later nation state. Control was exerted in condensed settlements among ethnic or social groups where functional differentiation was low, even in places where centralized kingdoms, colonial administrations or national governments exerted some political control over a larger territory. Before the colonial and later the independent state attempted to assume the regulation of healing—and in many instances long after this, even up until today—communities both large and small ruled such issues. They decided how ill-health had to be approached, what standards of health were acceptable or unacceptable, and which kinds of healing should be chosen. Religious features such as contacts with spirits, sacrifices, and reconciliation were indispensable aspects of such healing practices (Sempebwa 1983).

The modern state, both colonial and independent, did not feel responsible for African healing traditions in the same way as it did for biomedical services. This left traditional health expertise in a peculiar situation, with less control but also less recognition. But the colonial conquest, accompanied as it was by more Christian missions, ethnographic studies, and preventive as well as curative medical activities, had changed African healing by introducing fundamental European distinctions: science versus humanities, natural versus supernatural. Some practices, especially the use of herbs, were regarded as acceptable by Christian theology and by doctors, while others were denounced as mere "belief" or as "superstition." In doing so, the encounter with Europe established a marked difference between those aspects of African healing practices that are researched in socio-cultural studies like anthropology and those aspects that are evaluated by scientific investigation. This distinction affected politics and administration, criminal law, and the population concerned in both early and more recent settings. Thus, this difference must be considered central to all the discourses being examined here, even though—or perhaps because—it is certainly a product of colonial categorization.

This distinction between the physical and spiritual or religious aspects is also essential for a nuanced assessment of present-day claims in Tanzania that "traditional medicine" had been forbidden under colonial rule but has now been legalized. This prompts us to ask which parts and aspects had been opposed then but are being promoted today, a differentiation in which the separation between the physically effective and more religious constituents

of African healing has the central function. The common view of semi-official statements and published opinion is that it is only since 1968 that "traditional medicine" has been politically accepted in Tanzania, that it had been suppressed earlier, and that official recognition of the potential of "traditional medicine" is a necessary compensation for colonial injustice (Goergen et al. 2001: 4). This poses the question of how much of this generalizing statement is due to the African nationalist rhetoric that has dominated public discourses for several decades, and how much of it can be substantiated by evidence. What did colonial rule want to do, and what did it do to African ways of healing? Here the definition of what counts as "traditional medicine" becomes crucial.

If one takes the broad meaning of an anthropological approach—that is, attempts to arrive at an "emic" view referring to the notions and functions of the traditional experts in their own society—colonial rule has been certainly disastrous for the African population's ability to cope with all kinds of affliction, including ill-health. The role of these experts went far beyond private problems: they also judged certain general developments within their community to be dangerous and initiated counter-measures, such as the exclusion or reconciliation of allegedly harmful individuals ("witches") and even uprisings against the colonial rulers in cases of unbearable colonial burdens like new taxes or other orders. Motivating or even leading resistance by means of prophetic messages such as liberation from the evil of colonialism with the assistance of spiritual forces, especially in the Maji Maji war, brought these ritual experts into violent conflict with the colonial rulers and led to their persecution, including even their execution by hanging (Beez 2005). How and how deeply colonial agents and actions destroyed the traditional ways of preserving and restoring health have been demonstrated by Steven Feierman (1986: 206-210) with interesting examples showing that many health-related functions of the pre-colonial authorities among the Shambalaa-speaking people in northeast Tanganyika were forcibly brought to an end without relevant substitutes being made available.

If, however, one starts from the much narrower, biomedical notion of "traditional medicine" that most African politicians and officials also refer to today, the extent of the colonial-era destruction must necessarily be judged differently. In this perspective on the treatment and prevention of disease, one would have to distinguish—as both colonial and modern legislation does—therapeutic practices related to medicinal plants from the use of spirits

and the fighting of "witchcraft," as colonial discourses constructed practices of controlling evil (Langwick 2011: 46–57; Bruchhausen 2007). In this perspective, the colonial and post-colonial impacts on the spiritual-psychotherapeutic and herbalist aspects of the healers' activities were both quite different. When *waganga* were banned and persecuted, it was their function as political or religious authorities that was the issue of concern, especially their social, moral, and religious importance as experts in the management of affliction by detecting the guilty; that is, by "witch-finding," which was forbidden by the Witchcraft Ordinance of 1928, still in force today (Mesaki 2009, Tanzania 1998). Yet how did the Witchcraft Ordinance affect traditional healing? Was it meant to suppress all "supernatural" activities indiscriminately, or was it applied to troubles only?

At least in southeast Tanganyika, the British administration tried to apply the Witchcraft Ordinance in accordance with local public opinion. Initially, it did not feel that punishing witch-finders was absolutely necessary in order to prevent the exploitation of what they regarded as a credulous population. Some years later, in the 1930s, and contrary to the wording of the Witchcraft Ordinance (Cole/Denison 1964: 254–255), the Provincial Commissioners were inclined to distinguish between "benevolent witchcraft" or the "benevolent removal of witchcraft" or *"uganga"* on the one hand and *"uchawi"* as "black art" on the other (Guise Williams 1933; Kitching 1937). In 1933 an Assistant District Officer in Liwale requested that therapeutically acting "witch doctors" should not be imprisoned, even if a lethal outcome could be attributed to their practice, as long as they did not cause any social trouble (Beck 1970: 140). Some years later, even the Colonial Office in London raised the necessity of distinguishing between allegedly benevolent and destructive "witchcraft" (Keith 1938: 2). This attitude seems to have become the prevailing British policy in the south of Tanganyika, as can be seen in the recently published autobiography of a former district officer in Lindi and Masasi in the late 1950s. He notes major differences between the wording of the ordinance and the local administrative practice of its application:

"The official view of witchcraft was embodied in the Witchcraft Ordinance; I do not recollect whether it was the law itself or the practical interpretation thereof which was curiously ambiguous and liberal, but it was one or the other. White magic or *uganga*, in effect "traditional medicine" employing herbal remedies and psychology, tended to be beneficial and therapeutic even though accompanied by a great deal of mumbo-

jumbo and theatre, and was acceptable. *[Then he gives examples of its use by British officers, including the famous police investigations by Nguvumali.]* Witchcraft or *uchawi* however was another matter, and anyone who purported to practice it or who maliciously accused others of doing so, was liable to severe penalties in addition to almost certain banishment to a remote part of the country; such was the strength of superstition—or belief." (Barton 2004: 142)

Concerning the restricted European or biomedical notion of "medicine," according to which "medicine" comprises measures intended for the good of an individual only, the British administration was guided by the approbation of the local population and tolerated the practice of "employing herbal remedies and psychology." However, when it came to the much broader African concept of what ritual experts are responsible for, which includes accusing and fighting witches, local support for counter-magic was not recognized by the representatives of the colonial state. Therefore, it can be concluded that the general destruction of "traditional medicine" had obviously not been the intention of colonial officers who had to enforce the Witchcraft Ordinance in the south of Tanganyika: it was only directed against witch-finding, not against the treatment of the sick. Nevertheless, this ordinance has certainly destroyed much of what anthropologists would consider the previous cultural or social system related to health. It marked the transition from a pre-colonial system in which traditional authorities fought all those who were perceived as threatening the well-being of the community to a colonial system that made distinctions according to the functional systems of modern Western societies, here "law" and "medicine".

Given this separation of the "medical" aspect from the other previous functions of ritual experts, it could be argued that the effects of the Witchcraft Ordinances did not destroy "traditional medicine" but actually created it by medicalizing it. Rituals for treating the sick were acceptable to the administration, but rituals leading to accusations against others were not. Beyond the administration's acceptance of herbal medicine, the application of the Witchcraft Ordinances declared even rituals referring to the "supernatural" lawful as long as the purpose was restoring or preserving health—and doing so without causing social conflict. At least some of the religious functions of traditional healing, like placating sacrifices and incantations to angry ancestors or other spirits, although not previous practices like fighting evil human beings, could be allowed to survive in the eyes of the colonial rulers.

4.2.2 The Impact of Scientific Interest in the Tanzanian Context

Regarding those activities of *waganga wa jadi*, the "traditional healers," that the Tanzanian state seeks to promote and legalize today, mainly the application of herbal knowledge, there have never been any government attempts to prohibit them. This is even one area where the institutions imported from Europe showed more than just tolerance for African healing, one where herbal medicines were also actively promoted, reflecting a marked preference for the material over the spiritual aspects. During and after German colonial rule such knowledge was investigated with government support and regarded as potentially valuable (Bruchhausen/Roelcke 2000: 78–83). As far back as 1895, the director of health services in German East Africa, Dr Alexander Becker, had called on his widely dispersed medical officers to study native healing methods, including "devil dances," but mainly for them to send in specimens of medicinal plants (Becker 1896: 647–48). In 1969, in a similar circular to the Regional Medical Officers, the Tanzanian Chief Medical Officer in the Ministry of Health requested "research into indigenous methods of therapeutics" to be conducted (Institute of Traditional Medicine ca. 2002: 2), thus following the model of his first colonial predecessor, probably without realizing it. Only an initiative of the medical faculty of the national university five years later led to the permanent institutionalization of such research through the establishment of a Traditional Medicine Research Unit divided into the five sections of botany, chemistry, pharmacology, social anthropology, and clinical evaluation. As can be seen from the labels for these sections, the major tasks of this institution were the collection and scientific or medical investigation of medicinal plants and the study of other functions of "traditional healers". Whereas, after the unit's promotion to an institute in 1991, "Botany and Agronomy," "Pharmacology and Toxicology," and "Chemistry of Natural Products" became departments of their own, social anthropology remained something of an appendix. The scientific reason for this focus seemed obvious in the East African discourse, as one Kenyan pharmacist succinctly expressed it: "Traditional medicine, whether involving the supernatural or not, depends very much on the use of plants" (Tessema 1980: 48–54). The WHO African Regional Office in Congo Brazzaville is especially keen on reformulating African healing as herbal medicine within the WHO's Traditional Medicine Strategy.

Whereas national research and the promotion of "traditional medicine" both focus on herbal medicine, the ritual dimension did not remain completely unconsidered. Here, however, the main approach was to define this area as involving a cultural, and neither a medical nor a religious heritage. Thus, at the beginning of the 1980s the Tanzanian Ministry of Culture promoted the relevant drumming rituals in public by organizing competitions and studying songs and dances (Janzen 1992: 25). This was facilitated by the fact that the drum dances overlap to a certain degree, whether for pleasure, celebrations, or protection and healing. Not only do they have the general name of *ngoma* in common, which can be qualified by adding phrases like *ya majini* (for spirits) or *ya kutibu* (for healing) as religious or medical. The kind of music and dance and the musicians involved can also be regarded as largely similar and/or even as the same. The only elements specific to healing were the shape of the drums, the costumes, and other symbols, and of course the texts and the individual melodies and rhythms. Yet not only *ngoma*, but also *waganga* were in principle officially assigned to the government's cultural sector instead of to medicine or religion. Up until the recent legal change, their registration was with the District Cultural Officer (*Afisa utumaduni*), not the District Health Officer (*Afisa afya*), or else they were registered as religious congregations. Until 2002, too, it was the Cultural Office that issued permits to practice as a *mganga* after payment of the obligatory annual fee.

Summing up our findings on the influence of colonial as well as postcolonial administration and research, what today the WHO and national politicians call "traditional medicine"—mostly a kind of naturopathy—has not been administratively suppressed in East African countries, but in light of public demand it has been tolerated and even promoted. Yet, regarded as a whole, the precolonial sociocultural and religious function of healing has certainly been disrupted, especially by the activities of colonial states and Christian missions against those ritual experts who acted as political leaders, witch-finders or traditional priests. The difference between speaking of a whole social institution, such as the public protection of well-being, and looking at different kinds of healing practices is decisive in judging the destructive effects of the clash between African societies and the colonial state. The pre-colonial social system, where notions of the common good (including health and good relations with spirits) were widely shared between the general population and the authorities, had to give way to the rule of a

government with functional systems (including public health and medicine) whose experts tried to convince people of the validity of their relevant messages and institutions. Thus, this transition from a purely African, often ethnically restricted healing and health maintenance system, which was an inseparable part of a religiously constituted social order and world view, to the situation in the colonial and independent state characterized by massive European influence was not just a matter of a change in the ruling elite. Regulating healing experts and health was no longer just a local matter of clans, villages or ethnic groups—it acquired a geographically and socially much wider, though more focused dimension which had to deal with nationwide or even global functional systems like science, medicine, and law. The national and international agendas on health entered local choices and decision-making even in a field such as this that touched on questions of cultural and religious identity.

4.3   The Impact of International and National Health Policies

4.3.1 WHO Policies on Traditional Healers and Medicine: Using Healers or Integrating Indigenous Knowledge?

Whereas for the colonial and post-colonial state the main reason for tolerating African healing, including its religious components, had been political expediency—namely respecting the wishes of the population—the WHO had a different motivation that resulted in yet another concept of "traditional medicine." And, as in the case of the questionable colonial suppression of "traditional medicine," the usual narrative concerning the WHO's relationship with "traditional medicine" must also be questioned, or at least distinguished. This common view of the WHO's policy on "traditional medicine" seems to be that, since the Alma Ata Declaration of 1978 proclaiming "Health for all—by the Year 2000" (WHO and UNICEF 1978), "traditional medicine" should be integrated into national programs of primary health care (PHC). A closer reading of the declaration, however, tells a different story, as it speaks of the use of "traditional practitioners" within biomedically conceived programs only, not of the use of "traditional medicine" as a potential healing resource. While the first suggests complete subjection to

biomedicine, the second could entail religious functions such as the incantation of personal invisible forces as well.

The only section in the Declaration of Alma Ata that mentions the traditional sector argues that "traditional medical practitioners and birth attendants" should be recruited as "important allies" or even as "community health workers" through relevant "training" (WHO and UNICEF 1978: 63). It explicitly argues that the "high social standing" and "considerable local influence" of these persons—that is, the esteem they enjoy among the general public—could be used in PHC. This was in accordance with a previous resolution of the World Health Assembly (WHA) of 1976, which encouraged "the development of health teams trained to meet the health needs of populations, including health workers for primary health care, and taking into account, where appropriate, the manpower reserve constituted by those practicing traditional medicine" (WHA 1976). Related to this medical attempt to integrate healers are some studies in medical anthropology that tried to distinguish two types of healing (Foster/Anderson 1978: 53–65; Young 1983). One, the "internalizing" or "naturalistic" type that recognized the relevant pathological processes within the body and treated them accordingly—for example, with herbal medicines—was judged compatible with state medicine. The other, the "externalizing" or "personalistic" type, identified evil forces outside the individual as causing the illness and sought to counter them by means of magical objects, rituals and prayers. The practitioners of such forms of healing were to be left outside the governmental healthcare system, as their world view did not recommend them for co-operation. In anthropology, it could still be debated whether pure examples of each type exist at all, but the distinction as such was certainly influential—not only in health policies—and it contributed to the dichotomy between medicine and religion in academic, political, and public perceptions. As the anthropologist Robert Pool noted, this anthropological conceptualization was part of a major shift from religion to medicine: the same experts, rituals, and objects that had earlier been studied by the anthropology of religion were now often investigated by medical anthropologists (Dilger et al. 2004).

However, the attempt to use traditional practitioners as mainly preventive health-workers without government pay proved illusory. These plans on the part of the biomedical experts who dominated the Alma Ata Declaration mostly failed since communities were not ready to respect and pay healers for biomedically designed preventive medicine, and in any case the majority

of healers rejected being placed at the bottom of a hierarchical national healthcare system in place of their former independent authority and were thus saved from being incorporated into a completely medicalized setting. Such incorporation would have probably meant the end of any ritual activity, whereas avoiding close supervision by biomedical functionaries preserved spaces for religious functions.

At about the same time, politicians from countries with strong political concepts and institutions of "traditional medicine" that entered into their national identities, especially China and India, convinced the WHO to adopt a policy on "traditional medicine" itself. This policy was not related to health policies in general, nor to other health programs, and therefore the important spiritual or religious dimension could have been accepted. However, the opposite tendency became quite influential instead, that is, the definition of traditional medicine as the administration of substances. The first relevant document of the WHA on traditional medicine, dated 1978, focused on medicinal plants (WHA 31.33). In 1989, another resolution on "traditional medicine" elaborated research into medicinal plants and their regulation (WHA 1989). Two years later, the WHA demanded a "substantial increase in national and international funding and support […] to enable 'traditional medicine' to take its rightful place in health care," as well as "the use of scientifically proven, safe and effective traditional remedies to reduce national drug costs" (WHA 1991). Medicinal plants were at the heart of the strategy on "traditional medicine."

When, in the mid-1990s, the two strands, namely the use of traditional healers in a strongly preventive biomedical healthcare system and the use of "traditional medicine" as a curative resource, merged, the role of herbal medicine in programs was strengthened further. The revitalization of training schedules for "traditional practitioners," promoted by the WHO in the 1990s and still referring to their use as "primary health care workers" (WHO 1991), demonstrates a characteristic shift in the curriculum: those aspects that refer directly to traditional herbal medicine, such as the secure identification and hygienic storage of herbal remedies, receive attention first. Actions such as referral to hospital or supervising the construction and use of latrines—that is, the classic tasks of the village health-worker—come last in the list of subjects on training courses (WHO 1995: 64–65). In the WHO's "traditional medicine strategy 2002–2005" (WHO 2005), it was the aim of promoting

"traditional medicine" as a therapeutic resource for natural remedies, not of using its manpower in PHC, that received the most visible expression.

Thus, it can be said that the turn to the PHC policy since the 1970s certainly did not promote African healing in all its aspects, as it favored those elements that were regarded as compatible with science-based medicine and ignored those others that were regarded as depending on thinking attributed to the realm of religion. Therefore, medical development experts even warned that integration into the national healthcare system would lead to the "destruction of traditional medicine" (Diesfeld 1989: 90–91). If one wanted to save African healing from losing its overall importance for the population, the option of leaving "traditional medicine" as far as possible out of the administrative and judicial system and trusting local mechanisms of social control instead had much to commend it.

4.3.2 East African Legislation: Local and National Control of "Traditional Medicine"

Given the importance of local criteria for local practice, the way the colonial and later the independent state regulated African healing combined control at the local and governmental levels. In doing so, at least in theory, the interest of the population in services close to their own religious traditions could be made compatible with the obligation of the state to protect its citizens against harmful practices. Following the example of Western countries from medieval or early modern times, government responsibility for health was especially a matter of the legal status of health practitioners.[2] The relevant measures were introduced in the British mandated territory in 1937 with the Medical Practitioners and Dentist Ordinance Act, the first legal regulation of the health professions, modelled after European legislation. This Act forbade any medical practice without registration or license, but explicitly exempted such persons whose expertise in healing was acknowledged by their respective communities and whose healing activities were confined to their communities (Tanganyika Territory 1937: 409). Thus, the Act did not qualify the method of healing as natural or "supernatural," but took the assessment of the local community as the decisive criterion regarding the qualification of practitioners. In 1963, the legislation of the independent state did not alter

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2   For the same aspect in the context of India see Rageth, this volume.

the section on local medicine and merely changed the reference to colonial institutions such as "the Crown," "Director of Medical Services," and "registers of health professionals" (Tanganyika 1963). Yet there is substantial reason to doubt whether this official "restriction on traditional healing," which confined it to a local practice, had been enforced in all the decades that followed up until new legislation was passed in 2002 (Harrington 1999: 226).

In 1976 the regional Africa office of the WHO in Brazzaville also defined a traditional healer as "a person who is recognized by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background" (WHO 1978: 9). The reference to practices that do not rely on substances and physical intervention is remarkable but remained without consequence for WHO policies on Africa. The special legal arrangement for "a system of therapeutics according to local methods […] in a bona fide practice" was also set out in Tanzania's Pharmaceutical and Poisons Act of 1978 (Tanzania 1978, Part VI, 68 [1]). The following regulation, however, emphasized explicitly that it does not give permission to produce and/or distribute substances to persons outside the respective community, to sell or supply lethal quantities or preparations, or to add self-manufactured substances to any preparations of other systems of treatment. Thus, the goal was still that traditional remedies should only be accepted as local practices subject to the immediate judgement of local civil society.

Only after the launch of these WHO programs for "traditional medicine" (WHO 1987: 149–51) did this rather defensive legislative approach change slightly, culminating in Tanzania's Traditional and Alternative Medicines Act of 2002, which paved the way to the active promotion and regulation of "traditional medicine." The old rule that there has to be a relationship with a local public was partly maintained in as much as under this new law a "traditional health practitioner" is defined as "a person who is recognized by the community in which he lives as competent to provide health care" (Tanzania 2002: 3). This also allows such practitioners to practice religious ways of healing if the community regards this as adequate. However, the old restriction on practicing healing in one's own community alone is now omitted as long as the other regulations are respected. For like the so-called "alternative health practitioner" (with formal training in the respective therapeutic system), now the "traditional health practitioner" is also allowed (i.e. without

formally recognized training) to practice country-wide and in all groups, provided the appropriate official permission has been granted (Tanzania 2002: 21). Where there are strong ties to local religion—perhaps in the forms of ethnically bound spirits—shrines fixed to a grave or prayers in a local language, these forms are likely to disappear in cases of healing far from home. The old practice of healing outside one's own ethnic and religious group, which rapidly increased with urbanization and growing mobility, is now encouraged even by law.

The official governmental view, as expressed by the person responsible in the Ministry of Health, is that the new law of 2002 has taken the "traditional healer" and visits to him or her out of the "underground," from being "most […] an illegal thing" (Langwick 2011: 74). In contrast to this view "from above," the local population's experience—as a subaltern perspective—was somewhat different, as even before the new Act healers' activities and consultations had been quite public, especially for those who had paid their registration fee to the district office, but also for most others, far from the feeling of doing anything illegal. Especially in the case of drumming and dancing performed as a group in order to please certain spirits as part of healing rituals, there is no evidence that it was ever felt to be illegal.

In addition to legalizing the existing tendencies towards even more spatial mobility within traditional medicine, the legal and administrative regulation of "traditional medicine" also continues changes that had already been taking place for some decades.

The aspect of biomedicalization has been already dealt with. Professionalization is the final topic to be discussed here. As Feierman (1986: 205–6, 210–12) noted, the professionalization of "traditional medicine" strengthens the importance of such healers, who mainly treat strangers for material gain as a business, while at the same time reducing the role of those "care-givers" for "altruistic healing," who mostly treat relatives and neighbors free of charge as a kind of religious service and who used to carry out the greatest part of health care. In southeast Tanzania, the composition of the members of the healers' association, *CHAWATIATA* (*Chama cha Waganga wa Tiba Asilia Tanzania*), according to a list of 1053 names, does not at all reflect the actual care given (Nampyali, 16. 11. 2001).[3] Thus, the *wagariba*, the experts

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3   Interview with B. M. Nampyali, Secretary of CHAWATIATA (Chama cha Waganga wa Tiba Asilia Tanzania).

in circumcision who themselves say that they do not heal and are not sought for healing, form a considerable proportion of the members' list, whereas female spirit mediums, who are more than 80% of those who are called *waganga wa jadi* or *waganga wa kienyeji* by the people, are found in the list less often.

Unregistered healers of this sort who have a rather spiritual focus will increasingly be excluded from any informal network of healers, as § 36 (1) of the Act says that registered traditional health practitioners must not "allow, associate or otherwise cause a person who is not registered as such to practice as traditional or alternative health practitioner" (apart from aides). Thereby, the once common referral of patients to those experts who are regarded as better or even exclusively suited to a specific problem, such as possession of the patient by a certain spirit, is no longer allowed if these healers are not registered. At this point, the national public interest that the democratically elected government claims to represent is at odds with a religious practice approved by local publics in the interests of the individuals concerned. The orderly professionalization of healing is not compatible with the motivation and practice of most spirit mediums who regard their call by a spirit, their initiation into rituals and secrets involving spirits, as well as their service to a community believing in these spirits, rather in religious terms.

Finally, it can be asked how the recent Tanzanian Traditional and Alternative Medicines Act of 2002 should be qualified—as accepting all aspects of healing, including the religious dimension, or as a further medicalization of it? Here the role of the market becomes central. As the Tanzanian Minister of Health, Anna Margareth Abdallah, mentioned in her 2002/2003 budget speech, the health sector reforms of the 1990s had among their goals "public/private mix reforms such as encouragement of private sector to complement public health services" (Abdallah 2002). There was no hint in the official texts at that time that "traditional medicine" should be one of these private services complementing the public sector, yet the new climate was certainly favorable to the idea of greater freedoms for traditional healers. Some expected that legal acknowledgement would give such healers greater independence from biomedicine, which could provide opportunities to increase the visibility of the religious dimension in healing. The actual development, however, seems to point in another direction, namely towards even greater similarity with biomedical practitioners. There is the desire that in East Africa traditional healers should be given professional biomedical privileges

that non-biomedical practitioners in other regions have already achieved, such as being financed by private health insurance and sometimes even by public sick funds, as in some European countries, or being able to certify the need for sick leave, as in South Africa. It would be the material rather than the symbolic power that would be strengthened by such achievements.

This new status of "traditional medicine" as a modern private practice rather than a traditional public service certainly also changes the healer's relationship with his or her patients and the spirit world. Moreover, it has an impact on the less professionalized ways of and experts in traditional healing who still practice without substantial financial gain and within the community of a quasi-religious cult group. At this point, the approach that treats "traditional healers" as a liberal profession might come into conflict with other, quite different arguments in favor of traditional healing. For, on the other side of the dialectics of "glocalization," those who advocate traditional healing as part of an African revival—as a constituent of a truly African identity—are usually not in favor of neoliberal globalization but emphasize rather the local, social and cultural integration of healing, not its autonomy from public administration. For such "traditionalists," the new professional opportunities for "traditional medicine" may further loosen their last ties with a former understanding of healing that saw illness often caused by invisible personal forces and treatment as negotiation with these forces.

Both these approaches to enhancing the "traditional" by giving it professional autonomy, as well as through its social (re-)integration, returns us to the question of the social practices separating those functions that are covered by the two functional systems of medicine and religion in more functionally differentiated societies. How should healing be approached legally—by applying the criterion of scientific and professional knowledge, or by referring to pure consumer choice? In fact, the public regulation and empowerment of traditional health practitioners according to the new Tanzanian Act does not go much beyond the colonial legislation, which already left the decisive role to local publics. This kind of social control leaves a space for versions of religious healing within "traditional medicine." Hospitals built by successful traditional healers for their clients,[4] where communal prayers, rituals with the healer or meditation in a holy place occupy the day for the temporary residents, rather resemble or even constitute the sorts of

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4   An example for such a hospital is that in Mwera, southeast Tanzania.

congregations or monasteries that are known from old or new religions in several parts of the world. The spirit mediums can combine their roles as cult leaders and healers without much interference from the political administration. But, as a pure herbalist without any reference to a religious world view falls under the same Act as the keeper of a holy place or a spirit medium of the sort just mentioned, they are all officially labeled "medical." While earlier colonial and national legislation merely exempted them all from medical registration, the new legislation requires that they all be registered with the medical office.

5 CONCLUSION

Practices like the incantation of spirits, sacrifices to them or explaining illness with reference to their activities—practices that would be classified by most observers of today as "religious" in other contexts—constitute the probably most important part of what is consulted as "traditional medicine" in present-day Tanzania, but not of what, under this term, is regulated by national or international health authorities and investigated by scientific research. This equivocal use of the term led to the question of how this present relationship between the functions of medicine and religion was shaped by the various influences of encounters with people and powers from outside Africa. Nearly all these influences favored a separation of healing practices from their religious contexts and understanding. Doctors and scientists were mainly interested in bioactive substances, colonial and post-independence administrators were concerned to suppress possible social unrest arising from ritual practices, and Islamic and Christian experts tried to free healing from allegedly "pagan" ideas.

In this study, two common notions about the foreign treatment of "traditional medicine" have been questioned and disproved by means of further differentiation of what is meant by "traditional medicine": its alleged colonial suppression, and its supposed acknowledgment in the Declaration of Alma Ata on Primary Health Care of WHO and UNICEF. By distinguishing the social, mental, and religious functions from the physically effective means and practices, the commonalities between the attitudes of colonial administrations, Christian missions, the WHO, and independent governments are shown to be more marked than the differences: none of them

wholeheartedly embraced the ritual and symbolic side of "traditional medicine", but at best tolerated it, whereas they all expressed a much greater interest in the bioactive substances of herbal remedies.

It was the less orthodox versions of cosmopolitan religion, the Sufi or *tariqat* traditions of Islam and Pentecostal, Zionist, or charismatic Christianity, that opened up spaces for the adaptive survival of healing practices related to spirits and the countering of evil forces. Other healing experts organized their adapted rituals without obvious ties to a monotheistic religion. In either way, local wishes to keep the experience of ill health related to the experience of an invisible world of helpful and hostile beings find their satisfaction in new groups that have replaced the former ritual community of clans or settlements. Religious connotations of healing are now also present in many of the more commercialized and individualized encounters between healers and clients. But the very facts that all these experts are now registered with the district medical offices in accordance with national legislation on "traditional and alternative medicine," are being investigated by scientific researchers interested in herbal medicine and are being contacted by biomedical institutions for cooperation on certain health issues indicate and strengthen their overriding inclination towards medicine.

BIBLIOGRAPHY

Abdallah, Anna M. (2002): Hotuba ya Waziri wa Afya [...] kuhusu makadiro ya matumizi ya fedha kwa mwaka 2002/2003 (Speech of the Minister of Health [...] on expenses for the year 2002/2003). Retrieved from www.bunge.go.tz, July 1, 2003.

Ackerknecht, Erwin H. (1942): "Problems of primitive medicine", in: Bulletin of the History of Medicine, 11, pp. 503–521.

Barton, Donald (2004): An Affair with Africa: Tanganyika Remembered, Hertford/England: Authors Online.

Beck, Ann (1970): A History of the British Medical Administration in East Africa, Cambridge/MA: Harvard University Press.

Becker, Alexander (1896): "Rundschreiben vom 13.10.1895: An sämmtliche Herren Aerzte!", in: Arbeiten aus dem Kaiserlichen Gesundheitsamte, 14, pp. 647–648.

Beez, Jigal (2005): "Mit Wasser gegen Gewehre: Die Maji-Maji-Botschaft des Propheten Kinjikitile", in: Felicitas Becker/Jigal Beez (eds.), Der Maji-Maji-Krieg in Deutsch-Ostafrika 1905–1907, Berlin: Ch. Links, pp. 61–73.

Bruchhausen, Walter (2006): Medizin zwischen den Welten. Vergangenheit und Gegenwart des medizinischen Pluralismus im südöstlichen Tansania, Göttingen: v&r University Press/Bonn University Press.

Bruchhausen, Walter (2007): "Repelling and Cleansing 'Bad People': The Fight against Witchcraft in Southeast Tanzania since Colonial Times", in: Schmidt, Burghart/Rainer Schulte (eds.), Witchcraft in Modern Africa: Witches, Witch-Hunts and Magical Imaginaries, Hamburg: DOBU, pp. 130–152.

Bruchhausen, Walter (2009): "Medicine between religious worlds: The mission hospitals of South-East Tanzania during the 20th century", in: Mark Harrison et al. (eds.), From Western Medicine to Global Medicine: The Hospital Beyond the West, Hyderabad: Orient Black Swan, pp. 172–197.

Bruchhausen, Walter (2011a): "'Biomedizin' in sozial- und kulturwissenschaftlichen Beiträgen. Eine Begriffskarriere zwischen Analyse und Polemik", in: NTM. Zeitschrift für Geschichte der Wissenschaften, Technik und Medizin, 18, pp. 497–522.

Bruchhausen, Walter (2011b): "Beziehungen zwischen Gesundheit und Religion von der Frühgeschichte bis zur Frühen Neuzeit", in: Constantin Klein/Hendrik Berth/Friedrich Balck (ed.), Gesundheit – Religion – Spiritualität. Konzepte, Befunde und Erklärungsansätze, Weinheim: Juventa, pp. 93–111.

Bruchhausen, Walter/Roelcke, Volker (2000): "Categorising 'African Medicine'. The German Discourse on East African Healing Practices, 1885–1918", in: Waltraud Ernst (ed.), Plural Medicine, Tradition and Modernity, 1800–2000, London: Routledge, pp. 76–94.

Cole, John Sydney R./Denison, William Neil (1964): Tanganyika: The Development of its Laws and Constitution, London: Stevens.

Diesfeld, Hans Jochen (1989): Gesundheitsproblematik der Dritten Welt, Darmstadt: Wissenschaftliche Buchgesellschaft.

Dilger, Hansjörg/Obrist, Brigit/Bruchhausen, Walter (2004): "Kranksein, Heilen und Gesundbleiben im Schnittpunkt von Religion und Medizin", in: curare. Zeitschrift für Ethnomedizin 27, pp. 27–39.

Eisenberg, D.M./Kessler, R.C./Foster, C./Norlock, F.E./Calkins, D.R./Delbanco, T.L. (1993): "Unconventional Medicine in the United States. Prevalence, Costs, and Patterns of Use", in: New England Journal of Medicine 328, pp. 246–252.

Eisenberg, D.M./Davis, R.B./Ettner, S.L. (1998): "Trends in Alternative Medicine Use in the United States, 1990–1997. Results of a Follow-up National Survey", in: Journal of the American Medical Association 280, pp. 1569–1575.

Ernst, Waltraud (2000): "Plural medicine, tradition and modernity. Historical and contemporary perspectives: views from below and from above", in: Waltraud Ernst (ed.), Plural Medicine, Tradition and Modernity, 1800–2000, London: Routledge, pp. 1–18.

Evans-Pritchard Edward Evan (1965): Theories of primitive religion, Oxford: Clarendon Press.

Feierman, Steven (1986): "Popular control over the institutions of health: a historical study", in: Murray Last/Gordon L. Chavunduka (eds.), The Professionalization of African medicine, Manchester: Manchester University Press in association with the International African Institute, pp. 205–220.

Foster, George M./Anderson, Barbara G. (1978): Medical Anthropology, New York: John Wiley & Sons.

Gifford, Paul (2015): Christianity, Development and Modernity in Africa, London: C. Hurst & Co.

Goergen, Helmut/Kuelker, Kirsten/Bruchhausen, Walter (2001): History of Health Care in Tanzania: An Exhibition on the Development of the Health Sector in more than 100 years, Dar es Salaam: GTZ and National Museum of Tanzania.

Guise Williams, O. (1933): "Letter to Chief Secretary, 25 September 1933, in Witchcraft, Correspondence between Provincial Commisioner and District Officers 1933–44", in: National Archives of Tanzania 16/5/7, pp. 229.

Harrington, John A. (1999): "Between the State and Civil Society: Medical Discipline in Tanzania", in: Journal of Modern African Studies, 37, pp. 207–239.

Helman, Cecil G. (2007): Culture, Health and Illness, Fifth edition, London: Hodder Arnold.

Institute of Traditional Medicine, Muhimbili University College of Health Sciences (2002/2003): Analysis of the Current Position of the Institute and Proposals for the Needs and Future Direction, unpublished manuscript: Dar es Salaam.

Janzen, John. M. (1992): Ngoma: Discourses of Healing in Central and Southern Africa, Berkeley: University of California Press.

Jütte, Robert (1996): Geschichte der alternativen Medizin. Von der Volksmedizin zu den unkonventionellen Therapien von heute, München: C.H. Beck.

Keith, John L. (1938): "Memorandum, 21 November 1939", in: Laws relating to witchcraft, Public Record Office in Kew/London CO 847/13/11 (today: British National Archives).

Kitching A. E. (1937): "Report to Chief Secretary, Lindi, 22 July 1937", in: Witchcraft, Correspondence between Provincial Commisioner and District Officers 1933–44 National Archives of Tanzania 16/5/7, p. 284.

Krause, Kristine/Alex, Gabriele/Parkin, David (2012): Medical knowledge, therapeutic practice and processes of diversification, MMG Working Paper 12–11.

Langwick, Stacey (2011): Bodies, Politics and African Healing: The Matter of Maladies in Tanzania, Bloomington Indiana: University Press.

Luhmann, Niklas (1992): Funktion der Religion, 3rd edition, Frankfurt/M.: Suhrkamp.

Luhmann, Niklas (1999): Social Systems, Stanford: Stanford University Press.

Magesa, Laurenti (1998): African Religion: The Moral Traditions of Abundant Life, Nairobi: Paulines Publications Africa.

Mbiti, John S. (1969): African Religions and Philosophy, London: Heinemann.

Mesaki, Simeon (2009): "Witchcraft and the law in Tanzania", in: International Journal of Sociology and Anthropology Vol. 1(8), December, 2009, pp. 132–138.

Moeti, Matshidiso (2015): Message of WHO Regional Director for Africa, Dr Matshidiso Moeti, on the Occasion of African Traditional Medicine Day 2015, Published Online, http://www.afro.who.int/regional-director/speeches-messages/message-who-regional-director-africa-dr-matshidiso-moeti-8.

Sempebwa, Joshua W. (1983): "Religiosity and Health Behaviour in Africa", in: Peter Oberender/Hans Jochen Diesfeld/Wolfgang Gitter (eds.), Health and Development in Africa, Frankfurt/M.: Peter Lang, pp. 34–44.

Sharma, Ursula (1992): Complementary Medicine Today: Practitioners and Patients, London: Tavistock/Routledge.

Stausberg, Michael (ed.) (2009): Contemporary Theories of Religion: A Critical Companion, London: Routledge.

Tanganyika (1963): An Act to amend the Medical Practitioners and Dentist Ordinance, Published Online, http://www.saflii.org/tz/legis/num_act/mpadoa1963487.pdf, July 4, 2018.

Tanganyika Territory (1937): Medical Practitioners and Dentist Ordinance Act.

Tanzania, United Republic of (1978): The Pharmaceutical and Poisons Act, 1978, Published Online, http://www.vertic.org/media/National%20Legislation/Tanzania/TZ_Pharmaceutical_and_Poisons_Act.pdf, July 4, 2018.

Tanzania, United Republic of (1998): The Witchcraft Act, 1998, http://www.icla.up.ac.za/images/un/use-of-force/africa/Tanzania/The%20Witchcraft%20Act.pdf, July 4, 2018.

Tanzania, United Republic of (2002): The Traditional and Alternative Medicines Act, 2002, http://www.wipo.int/edocs/lexdocs/laws/en/tz/tz029en.pdf, July 4, 2018.

Taylor, Charles (2002): Varities of Religion Today: William James Revisited, Cambridge/Mass.: Harvard University Press.

Tessema, S. S. (1980): "Traditional Medicine: Past Growth and Future Development in East Africa", in: East African Medical Journal, 57, pp. 48–54.

WHA (1976): 29th World Health Assembly Geneva, 3–21 May 1976, WHA29.72 Health manpower development.

WHA (1989): 42nd World Health Assembly Geneva, 8–19 May 1989, WHA42.43 Traditional medicine and modern health care.

WHA (1991): 44th World Health Assembly Geneva, 6–16 May 1991, WHA44.34 Traditional medicine and modern health care.

WHO and UNICEF (1978): Primary Health Care: Report of the International Conference on Primary Health Care Alma-Ata, USSR, 6–12 September 1978. Geneva: WHO, http://apps.who.int/iris/handle/10665/39228.

WHO (1978): The Promotion and Development of Traditional Medicine: Report of a WHO Meeting", in: Technical Report Series 622. Geneva: WHO.

WHO (1987): 8th Programme of Work 1990–1995. Geneva: WHO, http://apps.who.int/iris/bitstream/handle/10665/39340/9241800100_eng.pdf?sequence=17, July 4, 2018.

WHO (1991): Traditional Healers and Community Health. WHO/SHS/DHS/91.6, Geneva: WHO.

WHO (1995): Traditional Practitioners as Primary Health Care Workers, WHO/SHS/DHS/TRM/95.6. Geneva: WHO.

WHO (2005): Traditional Medicine Strategy 2002–2005, Geneva: WHO, http://www.wpro.who.int/health_technology/book_who_traditional_medicine_strategy_2002_2005.pdf, July 4, 2018.

WHO (2008): Fact sheet No. 134, Traditional medicine, December 2008, Published Online, http://www.siav-itvas.org/images/stories/doc/agopuntura_scientifica/WHO_Traditional_medicine_2008.pdf, July 4, 2018.

WHO (2010): International Regulatory Cooperation for Herbal Medicines (IRCH), January 2010, Published Online, http://www.who.int/traditional-complementary-integrative-medicine/collabo ration/IRCH/en/, July 4, 2018.

The Witchcraft Act [Principle Legislation], http://www.icla.up.ac.za/images/un/use-offorce/africa/Tanzania/The%20Witchcraft%20Act.pdf, July 4, 2018.

Young, Allan (1983): "The Relevance of Traditional Medical Cultures to Modern Primary Health Care", in: Social Science & Medicine 17, pp. 1205–121.

Medical Discourses and Practices in Contemporary Japanese Religions

Monika Schrimpf

ABSTRACT

In contemporary Japan, many religious actors engage in therapeutic practices with the intention of curing or preventing disease, whether in new religious movements and the Japanese New Age, in folk religion or in "established religions" (*kisei shūkyō*). Notwithstanding the prominent role of Buddhist scriptures, temples, and priests in medical practice and knowledge in premodern Japan, the introduction of a public healthcare system in the Meiji era (1868–1912) based on German medicine resulted in a functional and institutional differentiation between medicine and religion. Therefore, the question arises how contemporary religious actors offering therapeutic practices can legitimize their actions and position themselves in Japanese society. By choosing the example of a Nichiren-Buddhist priest's concepts of Buddhist medicine and Buddhism as medicine, as well as healing practices in a new religion called Perfect Liberty Kyōdan, two strategies of legitimizing and positioning therapeutic practices in the religious field will be described: the scientification of religious practice, and code-switching between the semantic fields of medicine and religion.

1   INTRODUCTION

This article explores possible ways in which contemporary religious actors whose religious traditions used to comprise medical or therapeutical techniques, react to a social and political environment in which religions are—at

least on a political level—deprived of medical authority. How can they legitimize engaging in therapeutical activities intended to cure or prevent disease, and how do they position themselves in a society where religion and medicine are functionally and institutionally differentiated? More specifically, the strategies introduced here illustrate religious responses to the relevance assigned to science in the process of medicalization,[1] i.e., to the replacement of religious views of man, body and illness by scientific models of physiological processes and conceptualizations of the human body as a multipartite organism. These strategies are not representative of Japanese religions in general; rather, they serve to illustrate possible ways in which religious actors make use of the alleged superiority of science-based medicine in order to legitimize their therapeutical activities and consolidate the social status of their religious community.

Although in premodern Japan, medical knowledge and practice were an indispensable part of Japanese Buddhism, public healthcare in contemporary Japan is provided primarily by biomedical institutions and experts whose scientific training and licensing is regulated by secular law. This medical system rests not only on the development of biomedical knowledge, practices, and institutions since the introduction of German medicine in the Meiji era (1868–1912), it also includes *kanpō* medicine or "Japanese traditional herbal medicine", the Japanese adaptation of Chinese medical traditions.[2] Whereas in the late Edo (1603–1868) and early Meiji eras *kanpō* medicine was the main rival of so-called Western medicine (*seiyō ijutsu*) (Oberländer 1995:

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1   For the concept of "medicalization" cp., for example, Conrad 2007; Foucault 1973. Conrad provides a short definition of the term: "'Mecicalization' describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders." (2007: 4).

2   Literally, *kanpō* means "methods from Han-China" (206 BC–220 AD). Chinese medicine was introduced to Japan in the fifth century in the wake of the spread of Buddhism to the country. *Kanpō* medicine developed its specifically Japanese form during the Edo period (1603–1868), when the number of crude drugs used in decoctions was reduced to approximately 250 herbal plants and formulae, and Yoshimasu Tōdō (1702–1773) developed a particular abdominal palpation method (*fukushin*) for diagnosis. He also emphasized the practical, symptom-oriented focus of medical practice and de-emphasized the underlying theoretical concepts of the five phases, Yin and Yang etc. (Watanabe et al. 2010).

51), today it has been smoothly integrated into the medical system as a complementary herbal drug treatment.[3]

Notwithstanding the dominance of biomedicine and its incorporation of *kanpō*, other types of medical techniques, such as acupuncture and moxibustion (*shinkyū*) and massage therapy (*anma*), are also acknowledged as part of the public healthcare system and are subject to a training and licensing system regulated by the Ministry of Health, Labor and Welfare (MHLW).[4]

Outside the realm of officially recognized medical practices, religious actors, especially in the field of "new religions" (*shinshūkyō*) and the "new spirituality culture" (*shin reisei bunka*),[5] but also in folk religion or the so-called established religions (*kisei shūkyō*), provide alternative explanations for what causes illnesses and offer corresponding practices designed to heal[6] them. These forms of religious therapeutic knowledge and practice must be analyzed against the backdrop of a functionally differentiated society.

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3   Therefore, a critical juxtaposition of these two as representing (reductionist) Western vs. (holistic) "traditional" or indigenous medicine, as suggested by Margaret Lock under the labels "cosmopolitan medical system" and "East Asian medical system" (1980: 3), is questionable for present-day Japan. Still, her study provides valuable insights into medical views and attitudes of contemporary *kanpō* doctors and patients.

4   For information on the licensing system for acupuncturists, moxibustionists and *anma* massage therapists, see the website of the Japanese Society for Acupuncture and Moxibustion (JSAM): http://en.jsam.jp/contents.php/020000RNSXjD/, July 4, 2018. Acupuncture, moxibustion, and *anma* massage or acupressure therapy are partly covered by national health insurance (http://apps.who.int/medicinedocs/en/d/Jh2943e/9.6.html#Jh2943e.9.6, July 4, 2018).

5   The term as coined by Shimazono Susumu designates the New Age culture of Japan as comprising imported elements of Western New Age, as well as specifically Japanese notions of spirituality and related activities, networks, i.e., the so-called "spiritual world" (*seishin sekai*) (2007: 46–57).

6   The term "healing" (*iyashi* as noun, *iyasu* as verb) as applied in the context of religions and the new spirituality culture goes beyond the meaning of physical curing. As Yumiyama Tatsuya states with regard to contemporary Japanese new religions: "Thus religious people speak not only of diseases that are cured through faith but of diseases that, uncured, occasion the realization of the true meaning of life or the perception of erroneous ways of thought." (Yumiyama 1995: 269).

Despite the historical relevance of therapeutic services in the Buddhist or new religious traditions, propagating them today requires legitimizing the religious claims of an authority that is assigned to medical institutions, knowledge and social practices.

2 TERMINOLOGICAL REFLECTIONS

The term biomedicine is applied here to denote a conceptualization of medicine based on the principles of the natural sciences, in particular biology. Notwithstanding multi-layered criticisms of the term as both a research perspective and a medical concept (Bruchhausen 2010), I prefer "biomedicine" to the alternative terms "Western medicine" and "modern medicine," which are often used in literature about Japanese medical history. Not only does "Western medicine" disguise the plurality of medical traditions in Europe and North America, it also ignores the developments that took place in Japanese biomedicine after its introduction in the Meiji era. Besides, both "Western medicine" and "modern medicine" are used as counter-terms in the realm of traditional, complementary, and alternative medicine, where they denote a symptom-oriented, science-based kind of medicine originating in the "West" that does not take the mental and spiritual aspects of illness into account. For example, on the website of the Japanese Society for Integrative Medicine, the basic distinction between symptomatic treatment (*taishō ryōhō*) and causal treatment (*gen'in ryōhō*) is used to characterize the differences between modern Western medicine (*kindai seiyō igaku*) and traditional, complementary, and alternative medicine (*dentō igaku, sōho daitai iryō*). "The kind of medicine practised in many medical institutions today builds on modern Western medicine with its focus on the treatment of symptoms" (http://imj.or.jp/intro, July 4, 2018).[7]

In contrast, the concepts of oriental medicine (*tōyō iryō*)[8], East Asian medicine (Lock 1980), and traditional medicine (*dentō igaku*) are often

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7   This and all following English quotations from Japanese sources are my own translations.

8   See, for example, the website of the Japan Society for Oriental Medicine, which is dedicated exclusively to *kanpō* medicine (http://www.jsom.or.jp/index.html, January 29, 2018).

qualified as representing a holistic, individualistic, and natural approach to health and wellbeing. The Japan Holistic Medical Society explains the main principles of holistic medicine (*horisutikku igaku*) as a "holistic (wholesome) view of health" (*horisutikku (zenteki) kenkōkan*), reliance on "the therapeutic powers of nature as the source of healing," trust in self-healing powers, the combining of various medical methods to create the appropriate treatment for each case, and the conviction that realizing the inherent meaning of illness contributes to individual self-realization (http://www.holistic-medicine.or.jp/holistic/definition/, July 4, 2018). Traditional medicine is described by the Japanese Society for Integrative Medicine in terms of juxtaposing culture with science:

"There are specific styles based on regional characteristics such as climate, food, ethnos, customs etc., and they have evolved as traditional medicine and folk medicine. In this sense, traditional medicine is clearly more of a culture than a science, and given this background it can be viewed as a medicine tailored to the patients' and clients' individuality." (http://imj.or.jp/intro/qa, January 29, 2017)

However, both societies advocate the combined use of biomedicine, Japanese traditional medicine, and CAM (Complementary and Alternative Medicine). This discourse also provides an important frame for proponents of Buddhist medicine.

3 DIFFERENTIATION OF RELIGION AND MEDICINE IN JAPAN

From ancient times, health care in Japan was provided by either officially trained physicians or Buddhist "priest-doctors" (*sōi*).[9] In ancient Japan, Chinese medical literature and the knowledge transmitted by Korean physicians provided the main basis for medical practice. From the ninth century, these writings were complemented by Japanese medical literature, starting with the *Daidōruijuhō* (806–810) and the *Ishinpō* (982–984) (Rosner 1989: 12–33). In addition, Buddhist priests relied upon Chinese (and to a lesser degree Indian) medical knowledge as passed on in Buddhist scriptures such as the *Sutra of Golden Light* (Jp. *Konkōmyōkyō*; Skt. *Suvarṇaprabhāsottama-sūtra*), the meditation manuals *Tendai shōshikan* ("Shorter Treatise on śamatha and vipaśyanā") and *Maka shikan* ("The Great Calming and Insight") by the Chinese monk Zhiyi (Chigi; 538–597), founder of Tian'tai Buddhism and many more.[10] From the Heian era (794–1185), Buddhist temples became places where commoners could find medical help. Paul Demiévielle's classification of three types of Buddhist healing practices corresponds to Buddhist medicine as practiced throughout Japanese history: Buddhist healing comprised "religious therapeutics (good works, and practices of worship, expiation; meditation etc.), magical therapeutics (mantras, incantations, esoteric ritual), and medical therapeutics proper (dietetics, pharmacy, surgery etc.). The lines demarcating these fields are not at all distinct" (Démieville 1985: 6).[11]

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9   For general overviews of Japanese medical history, cp. Fujikawa 1911, Kuriyama and Yamada 1997, Rosner 1989, and the historical chapters in Siary and Benhamou 1994.

10 Beside Paul Démieville's fundamental article on Buddhism and healing (1985 in English, original 1937), Pierce Salguero has written extensively on the transmission of Indian and Chinese medicine in Chinese Buddhist scriptures (2013, 2012, 2010–11, 2009). See also Katja Triplett's introduction to Buddhist medical scriptures used in early and medieval Japanese Buddhism (2012).

11 Various authors have contributed to the study of Buddhist medical history in Japan: For early and medieval Japan see Cristoph Kleine (2012), Juhn Ahn (2008), Edward Drott (2010), Katja Triplett (2012), and Andrew Goble (2011). Pamela Winfield (2005) and Jason Ananda Josephson (2013) focus on the medieval and early modern Buddhist practice of "empowering prayers" (*kaji*) and their re-

From the late sixteenth century, Buddhist priest-doctors were challenged and complemented by medical professionals trained in *kanpō* medicine and frequently also in the Confucian and neo-Confucian classics (Josephson 2013: 125; Rosner 1989: 63–72). Starting with the arrival of European missionaries in the sixteenth and seventeenth centuries, both traditions were confronted with the gradual spread of European medical thought. With the publication in 1774 of Sugita Genpaku's (1733–1817) *Kaitai Shinsho* ("A New Book on Anatomy"), a Japanese translation of the Dutch translation of Johann Adam Kulmus' *Anatomische Tabellen* (1725),[12] European anatomical knowledge became increasingly known in Japan. In the Meiji era, concepts of the human body as a kind of independent organism gradually started to supersede hitherto prevalent views of the body as being influenced by the flow of *ki*, the relevance of its balance, and its effects on the internal organs.

In the wake of modernization, the new Meiji government installed a system of public healthcare that shifted responsibility for health from the individual to the state. Starting in 1874, a standardized system of medical examination was established, and from 1876 anyone aspiring to acquire a license as a physician had to study biomedicine as imported from Germany. The first decree issued in 1874 by the Ministry of Education regulated the training and licensing examination of physicians and pharmacists, as well as the control of pharmaceuticals (Oberländer 1995: 61). It was followed by various regulations (*kisoku*) and codified as a law (*fukoku*) in 1883 (Oberländer 1995: 61–62, 140). Medical ideologists like the physician and politician Gōtō Shinpei (1857–1929) denounced premodern medical practices, such as *kanpō* or Buddhist healing prayers, as useless, obstructing modern medicine, and damaging the national body. In addition, in 1874 the Ministry of Doctrine (Kyōbushō) issued an ordinance specifically prohibiting religious healing practices: "Healing by means of magical rituals and the like are obstructing the government and are henceforth prohibited." (Josephson 2013:129–131, quote 131; Shinmura 2013: 283)

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interpretation in the modern era. For the early modern period see Duncan Ryūken Williams' study on the medical activities of Sōtō temples in Tokugawa Japan (2005: 83–116), and Juhn Ahn on the relation between Zen, medicine and sword fighting (2012). See also Nihonyanagi's study on medicine in esoteric Buddhism (1997) and Shinmura's (2013) overview of Buddhist medical history in Japan.

12 The *Ontleedkundige Tafelen* or "Anatomical Tables", 1734.

The gradual implementation of this policy[13] was a blow especially to *kanpō* doctors, who in 1873 made up about eighty percent of Japanese physicians, and to Buddhist temples offering medical services. A Westernization of medicine took place, in which medicine was differentiated from religion as a separate sphere, regulated by the state authorities, and conceptualized as pursuing different goals.

As a result of these processes, biomedical institutions and practices have become the dominant form of medicine in contemporary Japan. Yet ever since the revival of *kanpō* medicine in postwar Japan, starting with the foundation of the Japan Society for Oriental Medicine (*Nihon tōyō igakkai*) in 1950, *kanpō* has become an integral part of the contemporary healthcare system.[14] It should be noted, however, that this integrated form of *kanpō* differs substantially from premodern *kanpō*: most conventional physicians do not practice the *kanpō*-specific type of diagnosis (*shō*)[15] but prescribe herbal drugs on the basis of conventional medical diagnoses. Moreover, most *kanpō* drugs are produced using industrialized techniques in which spray-dried granulate extracts have replaced the former decoction of crude drugs

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13 Takeda Dōshō points out that the implementation of the health policy of licensing physicians and hospitals was slow and that the lower social classes had limited access to them. For him, the coincidence of this failure of public healthcare with numerous cholera epidemics in the 1880s and 1890s supported the popularity of religious healing practices offered by new religions such as Renmonkyō (Takeda Dōshō 1991; http://www2.kokugakuin.ac.jp/ijcc/wp/cpjr/newreligions/takeda. html, January 29, 2018).

14 For a detailed reconstruction of the *kanpō* revival movement in the twentieth century, cp. Oberländer 1995 and Hattori 2014. See also Margaret Lock's fieldwork study (1980) of the activities and conceptualizations of *kanpō* doctors and patients in the 1980s. Since 2001, *kanpō* has been included in the curriculum of obligatory medical studies, and conventional physicians are allowed to prescribe *kanpō* drugs, 148 of which are covered by national health insurance (Watanabe et al. 2011).

15 The typical *kanpō* diagnosis comprises "[…] investigation of the complaints and symptoms of the patient, including taking their temperature, examining sensation, weakness or sweating […]. The physical examination includes abdominal palpation, tongue inspection and pulse diagnosis." (Watanabe et al. 2011, 1.3 "Background of Kampo").

(Watanabe et al. 2011, 1.2, "Usage and Integration into Modern Medicine"). Notwithstanding these changes, *kanpō* is extremely popular in contemporary Japan.[16]

"While Chinese medicine and acupuncture are looked on with doubt by some and there is certainly room for debate as to whether or not these therapies are seen by most as viable means of treating serious illness, as an overall trend, current attitudes towards *kanpō* and acupuncture are perhaps more positive than any time since the Meiji period." (Hattori 2014: 18)

Although *kanpō* is based on premodern medical practices which were a full-fledged alternative to biomedicine, today *kanpō* physicians and the Japan Society for Oriental Medicine tend to characterize it as a complementary form of medicine which compensates for the limits and deficiencies of biomedicine. In doing so, they have adopted the critical stance and semantics of Complementary and Alternative Medicine (CAM), emphasizing the holistic approach and the naturalness of *kanpō* medicine, its reliance on the patient's own self-healing powers, and its effectiveness in cases of chronic diseases (where biomedicine fails) (Oberländer 1995: 217–219). Oberländer explains this re-interpretation as resulting from the new educational system established since the Meiji era, which requires all *kanpō* specialists to be trained doctors of conventional medicine (1995: 219).[17] Thus, contemporary *kanpō* is an "invented tradition" (cp. Hobsbawm/Ranger 1983) which is semantically much closer to CAM than to its Japanese premodern predecessors.

Adding to the plurality of medical practices are the healing practices offered in religious communities and by agents of the "spiritual world" (*seishin*

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16 In 2011, the Japan Society for Oriental Medicine counted 2,150 certified *kanpō* specialists practising in Japan, as well as 152,049 licensed acupuncturists and 150,812 moxibustionists (Hattori 2014: 18).

17 Besides, Osamu Hattori reconstructs the strong stimulus that postwar Japanese *kanpō* doctors and acupuncturists received from European movements in complementary and alternative medicine. Hattori diligently reconstructs how the mutual visit of a German physician (Heribert Schmidt) studying *kanpō* and acupuncture in Japan, and the subsequent visit of a Japanese *kanpō* doctor (Hiroshi Sakaguchi) to Germany in the 1950s influenced the *kanpō* and acupuncturist movements and the self-perceptions of their supporters in Japan (cp. 2014).

sekai).[18] Whereas healing services provided in networks or so-called "client religions" are open to everybody, rituals specific to the new religions are usually accessible only to their members. In addition, recent initiatives propagate Buddhist places and practices as contributing to individual wellbeing, such as temple yoga or meditation as a means of stress-reduction (e.g. http://www.tera-buddha.net/project/spilit_body/, January 29, 2018).

4 TWO CASE STUDIES

The following two case studies are situated in the contexts of (1) traditional, complementary, and alternative medicine in a Buddhist setting, and (2) religious healing practices in new religions. The examples of the Nichiren Buddhist priest Kageyama Kyōshun and the new religion Perfect Liberty Kyōdan provide insights into two possible legitimation strategies used by contemporary religious actors offering therapeutic practices. They were chosen because they illustrate significant ways of relating religious and medical or scientific authority and not because they represent the main advocates of therapeutic practices in established Buddhism, TCAM or new religions in Japan. In accordance with Steve Bruce's observation that nowadays "only the fringes of religion" (2016: 640) propagate (or reject) therapeutic practices, both examples illustrate these fringes: Perfect Liberty Kyōdan as a new religion and Kageyama Kyōshun as a non-mainstream Buddhist priest, as we shall see below.

4.1 Buddhist Medicine: Kageyama Kyōshun

Despite the long history of Buddhist medical practice in Japan, contemporary advocates of Buddhism as a medical tradition are comparatively rare. Instead, Buddhist schools and individuals have recently become actively engaged in providing spiritual care or grief care,[19] especially for terminally ill

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18 Cp., for example, Araya et al. 1995; Kubotera 2011; Tanabe/Shimazono 2002; Shimazono 2003.

19 Cp., e.g., the Vihara Movement and concepts of Buddhist counseling as developed in Jōdo Shinshū (Tomohisa 2010, 2013), or the cross-denominational Institute for Engaged Buddhism (Risshō Bukkyō Kenkyūsho; http://www.zenseikyo.

patients or in the aftermath of the triple disaster in Tōhoku in 2011.[20] In addition, the role of Buddhism in the contemporary Japanese healthcare system was the topic of a research project (1999–2001) headed by the Research Institute of Bukkyō University and entitled "Contemporary Problems of Modern Medicine—from a Buddhistic [sic] Point of View—" (Bukkyō Daigaku Sōgō Kenkyūsho 2013). The research adopted a critical stance towards biomedicine because of its alleged tendencies towards objectification, dehumanization, and superficial doctor-patient relations. In contrast, Buddhist medicine was advocated as a means to add a holistic and humanistic perspective to contemporary healthcare (Muraoka 2003: 4–5). In defining Buddhist medicine, Muraoka Kiyoshi, head of the research group, referred to a contemporary interpretation of the sixth century meditation manual *Maka shikan*, mentioned above, thus contributing to the construction of an "invented tradition" of Buddhist medicine.[21]

The same critical attitude towards biomedicine and the characterization of Buddhist medicine in accordance with the rhetoric of CAM is expressed in a recent publication on "Medicine and Buddhism" (*iryō to bukkyō*) in the Buddhist journal *Samgha Japan* (2018). Here, the depiction of Western medicine (*seiyō igaku*) in opposition to Eastern medicine (*tōyō igaku*), namely *kanpō*, acupuncture, moxibustion, and other *ki*-based healing techniques, is intertwined with a fundamental cultural critique of "the values of Europe and America" (*ōbei no kachikan*) as manifested in materialistic thought and an

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or.jp/rinbutsuken/index.html, January 29, 2018). Practical examples in the Tōhoku area include the training of "Japanese-style chaplains" (*rinshō shūkyōshi*) at Tōhoku University (http://www2.sal.tohoku.ac.jp/p-religion/2017/cn8/pg37.html, July 4, 2018) and the Café de Monk run by Sōtō Zen monk Kaneta Taiō. On spiritual care, cp. Kamata 2014.

20 E.g. the earthquake and *tsunami* that hit the East coast of Japan on March 11th, 2011, and the subsequent meltdown at the nuclear power plant in Fukushima.

21 More precisely, he relies on Nagura Michitaka's rather selective summary of Chigi's medical approach in five guidelines: (1) care concerning clothes, food, accomodation, human relationships, and guidance; (2) overcoming emotions aroused by the five senses; (3) refraining from greed, hatred, anger, laziness, arrogance, and jealousy; (4) regulating food, sleep, exercise, breathing, and mental attitude; and (5) cultivating virtues such as positive thinking, perseverance, trust, wisdom, and a unified mind (Muraoka 2003: 6).

approach to medicine that objectifies the human being. In contrast, Eastern medicine is described as activating the person's own self-healing powers and striving for the harmonization of mind and body (Iryō to Bukkyō 2018: 4–5).

This way of combining the evaluation of different medical traditions with a critique of "Western" culture as opposed to conceptualizations of a superior Japanese or Asian culture is also characteristic of the writings of Kageyama Kyōshun (born 1951), the Nichiren-Buddhist head priest of the temple Shakaji in Kamogawa in Chiba prefecture. Kageyama is a graduate of Nichiren-Buddhist Risshō University (Buddhist Studies) and obtained his Ph.D. in Behavioral Sciences from the California Institute for Human Science (CIHS)[22] with a thesis about the psychological and physiological aspects of the Chinese Tendai monk Zhiyi's (538–597) meditation manual *Tendai shōshikan*. He has completed and guided the severe hundred-day ascetic practice of Nichirenshū (*aragyō*), is the vice-director of the Nichirenshū Research Center on Contemporary Religions (Nichirenshū Gendai Shūkyō Kenkyūsho) and has published several books directed at the public. The following analysis is based on three of his publications: *Buddhist Body Techniques: Relating "Calming the Mind and Insight" [Meditation] to Psychotherapy and Buddhist Medicine* (2007), *Healing Illness by Prayer* (2010), and *A Buddhist Life awakening to Spirituality: Contemporary Buddhism as Meditation Techniques* (2013).23 Whereas *Healing Illness by Prayer* is written in a rather simple style to advocate the healing effects of Buddhist

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22 This institute in Encinitas, California, has been founded by Motoyama Hiroshi (1925–2015), parapsychologist and second head of the religious group Tamamitsu Jinja. It offers degree programs on BA, MA, and PhD level in "Psychology, Integral Health, Life Physics and Comparative Religion and Philosophy". Its academic interest is expressed in Motoyama's "President's message": "[…] conducting research on the healing applications of subtle energy by integrating science with spirituality. […] By experiencing the body-mind-spirit interconnection, as well as integrating science with spirituality, people can gain a deeper insight into the nature of reality, which will hopefully empower them to contribute to the improvement of society at large." (http://www.cihs.edu/index.php/about-cihs/presidents-message/, July 4, 2018) Motoyama Hiroshi also founded the International Association for Religion and Parapsychology (IARP, 1972).

23 These are my translations of the originally Japanese titles (see Bibliography).

practices, the other two books combine elaborate depictions of Indian and Chinese medical concepts transmitted in Buddhist writings with physiological explanations of the effects of Buddhist meditation techniques. In both his temple activities and his publications, Kageyama propagates Buddhism as a salutogenetic medical tradition and a Buddhist way of living as a guarantor of a healthy life. He argues (1) that Buddhist practice is simultaneously therapeutical practice, and (2) that "traditional" Buddhist medicine[24] represents the premodern "medicine of nourishing life" (*yōjō iryō*)[25] as a countermodel to modern "Western medicine" (*seiyō igaku*). For both arguments, he relies primarily on Zhiyi's meditation manuals, whether with regard to their explanations of the causes, types, and treatments of diseases, or as the ultimate authority for East Asian meditation techniques. For reasons of space, I will focus here on his second argument.

Kageyama defines Buddhism as meditation techniques (*meisō gijutsu*) that enable us "to live in a healthy way and face death in a healthy way" (2013: 300). In his understanding, meditation includes various forms of religious practice (*shugyō*), such as sitting meditation (*zazen*), walking meditation, sutra recitation, invocations of the Lotus Sutra's title (*daimoku*) or Amida Buddha's name (*nenbutsu*), or service to others (Kageyama 2010: 105; 2013: 28). He advocates Buddhist meditation as the appropriate way of overcoming the separation of mind and body as prevalent in modern, competitive societies: "As mentioned before, the main need of societies in which

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24 Buddhist medicine for Kageyama denotes the transmission of Ayurvedic and Chinese medicine in Buddhist scriptures and its reception by Japanese Buddhists such as Nichiren (1222–1282).

25 *Yōjō* (Chin. *yangsheng*) denotes "a broad array of practices aimed at nourishing and prolonging life, including breathing exercises, dietetics (especially abstention from grains), sexual practices, meditation and visualization exercises, pharmaceutical prescriptions, and methods of 'guiding and pulling' (導引) vital pneuma or *qi* 氣 (Jp. *ki*)" (Drott 2010: 254). Originating in China, *yangsheng* theories and practices spread in Japan through Chinese medical writings. They were adopted and complemented by Buddhist and other authors, such as Myōan Eisai (1141–1215), Kaibara Ekken (1630–1714), and many more. See Drott's (2010) analysis of *Kissayōjōki* (1211) and *Chōseiryōyōhō* (1184), and Ahn's (2008) study of Kaibara Ekken's *Yōjōkun*. For Kageyama, *yōjō* medicine was transmitted by Buddhism, and its core is the medical chapter in Zhiyi's *Maka shikan* (2013: 169).

mind and body are separated is liberation from stress, and this can be realized by means of meditation techniques which unite mind and body" (2013: 4). Accordingly, Kageyama calls his temple a Buddhist Meditation Center (*Buk-kyō meisō sentā*) and offers not only the usual ritual services, but also yoga classes, meditation and consultation sessions. In addition, his wife provides Ayurvedic treatment and macrobiotic meals.[26]

By means of these services and this self-representation, Kageyama's temple differs from most other Nichiren Buddhist temples. Given his strong criticisms of temple priests who restrict their activities to funerary rites rather than thinking of ways in which they can be helpful to contemporary Japanese,[27] one can easily imagine that he is a contested figure in contemporary temple Buddhism. Therefore, Kageyama could be said to exemplify religious advocates of medicine at the margins of mainstream religion.

4.2 Healing in New Religions: Perfect Liberty (PL) Kyōdan

Starting with the earliest new religions, such as Tenrikyō, Ōmoto, Konkōkyō etc., healing has been an important element in the practices of Japanese new religions. Nagai Mikiko distinguishes between forms of "magical healing" (*jujutsuteki na iyashi*), which are based on the performance of rituals or rely on supernatural powers, and "healing by self-cultivation" (*shūyōteki na iyashi*) (Nagai 1995: 97–98). Robert Kisala adds the category of "social healing" (*shakaiteki iyashi*), which refers to social engagement, i.e., "[…] to put it in strong terms, what we can see is the intention to heal the maladies of society as a whole" (Kisala 1995: 112). Like Yumiyama, Nagai emphasizes that healing in this context refers to individual perceptions of being saved, irrespective of whether physical curing has taken place or not (Nagai 1995: 97).

Healing practices in the new religion Perfect Liberty Kyōdan are an example of how magical healing and healing by self-cultivation overlap. Its followers are encouraged to engage in guided moral self-cultivation as a means to overcome disease, injuries, and other forms of misfortune.

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26 http://temple.nichiren.or.jp/1031159-syakazi/; http://sunwork.her.jp/ayurveda/in-dex.html, July 4, 2018.

27 Private conversation, September 2016.

Guidance, however, relies on god's saving powers as transmitted by the head of the group or its religious teachers (*kyōshi*).

Perfect Liberty Kyōdan (cp. Schrimpf 2018) has existed in its present form since 1946, but it goes back to the pre-war community of Hitonomichi Kyōdan (founded by Miki Tokuharu (1871–1938) in 1925) and its predecessor Mikatekyō Tokumitsu Daikyōkai (founded in 1912, renamed in Shintō Tokumintsu Daikyōkai in 1917). Already the pre-war religious movements had a strong focus on self-cultivation and healing, centering on the practice ofurikae as the temporary transference of illness to the head of the group (Serikawa 1972: 1–27). Although in Hitonomichi Kyōdan veneration of the emperor was strongly emphasized, in 1937 Miki Tokuharu and his son Tokuchika (1900–1983) were accused of lèse majesté and the group was ordered to dissolve (Serikawa 1972: 280–281; Kojima 2008). It was refounded as Perfect Liberty Kyōdan in 1946 by Miki Tokuchika.

PL Kyōdan has approximately 1.2 million members and is headed by Miki Takahito, the third "parent of the teaching" (*oshieoya*), whose uncle was Miki Tokuchika (http://www.perfect-liberty.or.jp/html/name-pl/kyuoso .html, January 29, 2018). The doctrinal core consists of 21 "rules of living" (*shoseikun*) as guidelines for the moral conduct of life. As summarized in the slogan "Life is Art" (*jinsei wa geijutsu de aru*), salvation is conceptualized as perfecting moral self-cultivation. With its concepts of divine notices (*mishirase*) and divine instructions (*mioshie*) as essential tools of salvation, PL Kyōdan offers a religious interpretation of illness, and its religious teachers direct the believers in overcoming it. Illness, injuries, and misfortune are seen as divine notices (*mishirase*) indicating distortions of one's self-expression as manifest in inappropriate habitual behaviour or bad habits (*kokoroguse*) such as greed, obstinacy, arrogance, hurry etc. In order to reveal these distortions, so-called divine instructions (*mioshie*) are granted by god to the head of the group, the oshieoya, as someone who is in a "purely objective state" (*junsui kyakkan no kyōchi*) and "one with heaven" (*tenjin gōitsu*) (Miki 1979: 118).

These two examples differ in type of actor—Kageyama as an individual actor, PL religious teachers as collective actors—and data. In the case of Kageyama, analysis relies mainly on his publications. In the case of PL Kyōdan, the main data are the group's publications and instructions directed at the religious teachers (Pāfekuto Ribatī Kyōdan Bunkyōka 1991). In the following, the focus will be on the level of semantics, that is, on the ways in

which elements of the semantic field of medicine are blended into the semantic field of religion.

5 RELIGION AND MEDICINE AS STRATEGIC ACTION FIELDS[28]

Strategic action fields are social orders that provide a conceptual and practical frame for the interaction of individual or collective actors. This term, coined by Neil Fligstein and Douglas McAdam, designates "a constructed mesolevel social order in which actors (who can be individual or collective) are attuned to and interact with one another on the basis of shared (which is not to say consensual) understandings about the purposes of the field, relationships to others in the field (including who has power and why), and the rules governing legitimate action in the field" (Fligstein/McAdam 2012: 9). The "shared" but not necessarily consensual understandings refer to (1) "what is going on in the field, i.e. what's at stake"; (2) the existence of a set of actors possessing more or less power; (3) the nature of the rules governing possible, legitimate and interpretable actions; and (4) interpretive frames applied to the actions of others" (Fligstein/McAdam 2012: 10–11).

In our cases, both types of actors clearly position themselves within a subfield of religion, either Japanese Buddhism or PL Kyōdan. Both act according to their perceptions of the rules governing legitimate action in their respective fields. Neither Kageyama's nor PL Kyōdan's religious teachers perform medical practices in a technical sense. Kageyama propagates religious practices such as meditation techniques, prayers, recitation of the Lotus Sutra or invocation of its title (*namu myōhō rengekyō*), as well as moral practice and body practices, such as breathing exercises, physical exercises, dietetics, hygienic routines etc. (Kageyama 2010: 156–173). PL religious teachers guide their believers toward a moral conduct to which they ascribe healing effects. In PL Kyōdan, acceptance of the differentiation between the two fields is also manifest in the clear distinction between the practice of moral guidance on the one hand and medical activities in the PL Hospital

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28 I thank Nina Rageth for inspiring me to apply Fligstein and McAdam's concept of the strategic action field (2012). As a consequence, these authors figure prominently in both our articles.

(http://www.plhospital.or.jp, July 4, 2018) and the health centers in Tokyo (the PL Tokyo Kenkō Kanri Sentā; http://www.pl-tokyo-kenkan.gr.jp, July 4, 2018) and Osaka on the other hand. These institutions rely completely on biomedical expertise and modern medical technology. Accordingly, religious teachers who accept and forward requests for *mioshie* are urged to emphasize that *mioshie* does not primarily have curing functions but is a means to realize moral conduct in accordance with one's nature (Pāfekuto Ribatī Kyōdan Bunkyōka 1991: 184–185).

In sum, since both types of actor propagate religious or moral practices based on the authority of their religious status (Buddhist priest, religious teacher, head of PL Kyōdan) and act in religious spaces (Buddhist temple or PL church), they can be said to position themselves as actors in their respective fields, namely Japanese Buddhism and PL Kyōdan, or in the wider field of religion.

From this position, however, they claim that their religious or moral practice has therapeutic effects in a practical, not a metaphorical sense. In Kageyama's case, this claim is clearly aimed to redefine the purpose of the field of Buddhism and to (re-)establish Buddhism as a medical tradition, hence integrating medical functions into the religious field. In contrast, PL Kyōdan publications emphasize that healing is just a side effect, not the intended goal of moral practice. In both cases, however, therapeutic claims are supported on the level of semantics. Kageyama's writings and PL Kyōdan's communicative practices are both characterized by particular ways of switching between "religious language" and "medical language", understood here as the vocabulary, idioms, or linguistic registers (i.e. ways of talking and writing) of the respective semantic fields of medicine and religion. Based on these observations, I will introduce two forms of strategic action that aim to legitimize claims to therapeutic authority: (1) Scientification and (2) Code-switching between the religious and medical semantic fields.

5.1 Forms of Strategic Action: Scientification

5.1.1 Kageyama Kyōshun

Scientification here denotes reference to scientific knowledge, institutions, and practices by religious actors in order to legitimize religious knowledge and practices. This strategy is a main characteristic of Kageyama Kyōshun's

writings. His justification for a scientific explanation of Buddhist practice contains a harsh critique of the forced separation of medicine and Buddhism in Japan's early Meiji era and of the prevalent mode of knowledge as represented in the academic culture. Due to the Westernization of Japan in early modern times, he argues, the emotional culture (*kansei no bunka*) of Japan as manifest in the premodern medical tradition of "nourishing life" (*yōjō iryō*) has been replaced by the rational culture (*risei no bunka*) of the "West" as represented in modern biomedicine. For him, emotional cultures are characterized by a mode of knowledge in which tradition is transmitted via emotion: "How are matters of tradition felt, how are they reflected in oneself?" (Kageyama 2007: 24). In constrast, in a rational culture, the dominant mode of knowledge rests on intellectual understanding and explanation, as well as on empirical knowledge (Kageyama 2007: 21–23). As a consequence, although Buddhist culture represents the original emotional culture of Japan, nowadays it is perceived as a primarily textual tradition—Buddhism has lost its "physicality" (*shintaisei*) (Kageyama 2007: 24). Therefore, although Buddhist truth can only be grasped through experience, Kageyama must refer to the language of the sciences in order to explain the essence of Buddhism (Kageyama 2007: 31).

In considering the appropriate science, Kageyama argues that Buddhism was originally not a scholarly tradition, but a form of psychotherapy. "At present, Buddhism is approached as philosophy, but considering that Buddhism actually aims at resolving people's sorrows and sufferings, it is not philosophy but rather psychotherapy." (Kageyama 2013: 19) The psychotherapeutic and general medical quality he ascribes to Buddhist practice results from the fact that, at its core, Buddhism is practice (*shugyō*) and experience, rather than a tradition of scholarship. It must therefore be approached through mental and physical experience, that is, by means of sensory perception and the emotions aroused by it.[29] Consequently, a science which provides appropriate tools to explain Buddhist practice must consider both the physical and the intellectual aspects:

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29 "Emotional cultures such as Buddhism must be approached via a mode of knowledge in which someone knows by experience; by means of one's body, i.e. one's senses, someone knows how he feels and what mood arises" (Kageyama 2007: 24).

"Because in this sense Buddhist practice is the attempt to master (*taitoku*) true knowledge by means of mind and body, physiological-psychological research into methods of Buddhist practice represents a research attitude in accordance with the metaphysical particularities of Buddhist thought." (Kageyama 2007: 35)

For example, he introduces Hans Selye's (1907–1982) theory of stress reactions and the concept of homeostasis as developed by physiologist Walter Bradford Cannon (1871–1945) to clarify the physiological conditions of stress before explaining how the methods of "calming the mind and insight meditation" (*shikan*, Skt. *śamatha* and *vipaśyanā*) impact upon them by calming the body, the mind, and breathing (Kageyama 2013: 28–48). He also compares these meditation techniques to autogenic training as expounded by psychiatrists Johannes Schultz (1884–1970) and Wolfgang Luthe (1922–1985) (Kageyama 2013: 93–117). In more concrete terms, Kageyama explains and graphically illustrates the measured correlation of time spent in meditation with the frequency of brain waves and heart rates and links it to four temporal phases in autogenic training (2013: 118–123). In this argument, the slowing down of the heart rate and brain waves measured ten minutes after starting meditation is said to coincide with inducement of the meditative state of *zenna* (Skt. *dhyāna*), in which one sits in quiet observation of one's own self-reflection (Kageyama 2013: 156). Finally, the changed self-perception (the expansion of consciousness) in *shikan* meditation is compared to Stanislav Grof's notion of transpersonal experiences and Abraham Maslow's concept of self-actualization (Kageyama 2013: 134–139)[30].

Similar to Mikael Rothstein's observation concerning how and why new religions emphasize their scientific character, Kageyama's choice of the "physiological-psychological" sciences reflects his agenda of supporting religious authority vis-à-vis scientifically based authority claims in the field of medicine. "It is, as we shall see, religion, not science, which defines the standards in the interaction between the two systems: Science, in the scientific sense of the word, has been largely substituted by a mythological rendering of the same concept." (Rothstein 2004: 101) Although Kageyama's concept of science is by no means mythological, his choice of scientists, including proponents of transpersonal psychology, serves his aim of providing

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30 See Stephanie Gripentrog's analysis of religious elements in Maslow's and Grof's contribution to Transpersonal Psychology in this volume.

scientific proof of the physical, psychological, and ultimately medical impact of Buddhist practice very well.

This interpretation of Buddhism brings Kageyama's concept of "Buddhism as meditation techniques" close to what Lorne Dawson calls "the new religious consciousness" (2006: 183)[31] as a kind of "cultural […] resource pool" (Robbins/Bromley as cited in Dawson 2006: 186), parts of which are actualized in different social settings. Similar to this notion of an individualistic, experience-based religiosity resting on a holistic worldview, Kageyama emphasizes experience as the only way of grasping the essence of Buddhism and advocates Buddhist practice as a means to re-establish the unity of mind and body. This topos of mind-body unity is a basic concept in the associations of integrative or holistic medicine mentioned above, as well as in the context of the California Institute for Human Science: its basic principles include "To Understand Human Existence from the Total Perspective of Body, Mind and Spirit".[32] As such, mind-body unity is a modern rhetoric projected back on to premodern forms of medicine. Neither in Buddhist medicine nor in Japanese kanpō does the juxtaposition of mind and body play any role.

In sum, Kageyama's strategy of scientification serves a double aim: (1) to legitimize his claim that Buddhist practices have medico-therapeutical effects by expressing them in scientific terms; and (2) as a consequence, to upgrade Buddhism as a tradition serving not only the religious goal of awakening, but also the physical goal of a healthy body and mind. His concept of Buddhism as a religion serving "this-worldly" interests, such as a healthy life, creates a counterimage to the negative image of Buddhism in Japanese public; the widely used term "funeral Buddhism" (*sōshiki Bukkyō*) implies that many priests see their main function in providing expensive funerary

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31 Dawson describes this kind of contemporary religiosity as a cultural resource manifest for example in new religious movements, new religious networks, client religions etc. To him, it is characterized by religious individualism, emphasis on experience, i.e., "intense experiences of themselves and the sacred" (2006: 183), authority based on "skill development" rather than scriptures or revelation, tolerance of other religious perspectives, a holistic worldview, and "organizational openness" (2006: 184).

32 http://www.cihs.edu/index.php/about-cihs/principles-of-cihs/, July 4, 2018.

rituals to increase their wealth.[33] Therefore, the use of scientific language is applied here as a means to advocate and legitimize a new concept of Buddhism that defies its public image. As noted by Rothstein, it is a kind of legitimization that no modern religion can avoid: "No religion of the modern world will successfully be able to claim authority without some kind of scientific legitimization." (Rothstein 2004: 102)

5.1.2 Perfect Liberty Kyōdan

For the same reason, I argue, the value of science, especially of the medical and natural sciences, is strongly emphasized in the case of Perfect Liberty Kyōdan. As explained in its introductory guidebook for believers, "the unity of religion and science" (*shūkyō to kagaku wa itchi suru*) is a basic conviction propagated in the community. Accordingly, PL Kyōdan runs several scientific and medical institutions; a General Research Center (*PL sōgō kenkyūsho*), the PL Hospital (*PL byōin*), and two PL health centers (*PL kenkō kanri sentā*) in Tokyo and Osaka. The tasks of the General Research Center comprise "analysing psychic sources of injuries and illness, providing a database concerning doctrines and propagation, [and] rationalizing and increasing the efficiency of office work" (Pāfekuto Ribatī Kyōdan Bunkyōbu 2008: 27). At the same time, its aim to scientifically prove doctrinal statements is emphasized:

"In the field of medicine, we conduct research on the topic of bad habits and illness (*kokoroguse to byōki*), based on the truth of divine notices (*mishirase*) and divine instructions (*mioshie*); and in the field of education, we conduct research on the topic of parent-child relations and human relations, based on the teaching that children are a mirror of their parents." (Pāfekuto Ribatī Kyōdan Bunkyōbu 2008: 27)

As these quotes indicate, scientific institutions and scientific knowledge are highly valued both as a means to support the religious organization and to prove its truth claims, and they are said to rest ultimately on religious truths. This linking of religious and scientific truth is also reflected in the short text introducing the PL hospital:

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33 For an analysis of the role scholarship has played in the emergence of the popular image of a corrupt, degenerate temple Buddhism, see Covell 2005: 11–22.

"No matter how well we are equipped with excellent technical devices, and how much we improve medical techniques, since we are human beings we cannot avoid mistakes. Therefore, those in a position to take care of other peoples' lives cannot but conduct medical treatment with the following praying mind: 'We do our best to make sure, and we do what is humanly possible, but beyond this we rely on god with all our hearts.'" (Pāfekuto Ribatī Kyōdan Bunkyōbu 2008: 27)

Obviously, in this introductory guidebook, the relationship between science and religion is evaluated from a religious perspective. By addressing a religious audience, emphasizing the superiority of god's actions over human actions, and stressing the scientific truth of their religious doctrines, the authors are acting in accordance with the rules of legitimate action in the religious field. Relating science to religion in this way is a communicative strategy with the intention to strengthen the authority of religion by and in relation to science. By means of this strategy, an ambiguous relationship between the two fields is created. On the one hand, the legitimizing power of science is accepted; on the other hand, the superiority of divine action over human action is claimed, thus reversing the relationship.

This strategy is not applied in the context of medical institutions. The website of the PL Hospital addresses potential patients rather than PL members or the religious in general. The language of the website conforms to the norms of communication in the field of medicine with regard to both, its contents and its use of medical terminology. As on any other hospital website, the hospital units and their recent activities, the technological equipment they use, their medical services, ethics in dealing with patients etc. are described. The only reference to religious concepts is made in the section on "Hospital guidelines," where one finds not only an extended version of the PL motto "Life is Art", namely "Life is Art—So is Medicine" and a commitment to the ultimate reliance on god when men reach their limits, but also the statement that "medical treatment rests on PL principles" (http://www. plhospital.or.jp/contents/gNavi4/hosin.html, July 4, 2018). Although the connection with PL Kyōdan as a religious group is clearly stated, the actual meaning of the "PL principles" and their relevance for the hospital remain vague. In this institutional context, the purpose of the medical field is acknowledged and its rules are applied with regard to medical practice as well as language use.

Both cases show that religious actors pursue a strategy of scientifically validating therapeutical claims, thus supporting Mikael Rothstein's judgement, mentioned above, that every modern religion needs scientific legitimization in order to claim authority for itself. In the case of PL Kyōdan, scientification as a means of legitimization is complemented by its attempt to establish itself institutionally in the medical field. However, representatives of these institutions act as medical actors, thus complying with the semantics of the medical field.

5.2 Forms of Strategic Action: Code-switching between the Religious and Medical Semantic Fields

Another strategy I observed among religious actors is a kind of code-switching between the semantic fields of religion and medicine in order to create a functional hierarchy. Although linguistically code-switching denotes "the juxtaposition of elements from two (or more) languages or dialects" (McCormick 1994: 581), it is used here in a wider sense as switching between semantic fields. By semantic field, I refer to specific vocabulary, idiomatic expressions, and linguistic registers, such as special terminology, as well as codified ways of speaking or writing, for example, between doctor and patient, religious expert and believer etc.

Semantic fields in this sense are understood as part of the tool kits of the strategic action field of religion or the subfields of Japanese Buddhism and PL Kyōdan, and medicine. Tool kits are defined by Ann Swidler (1986) as habits, skills, meanings, linguistic repertoires etc. that are available to actors in their respective social contexts. Individual and collective actors develop strategies of action by selecting from these cultural repertoires and by interpreting their actions in specific ways (Swidler 1986: 281–283).

In the two cases discussed here, the question arises why religious actors select from the linguistic tools of the semantic field of medicine and combine them with elements of their own religious linguistic repertoires. Do they want to position themselves as actors in the medical field? I argue that, rather than positioning themselves in another field, they apply this strategy as a means of strengthening the position of their own field in relation to that of medicine.

Let us look first at the case of Perfect Liberty Kyōdan. The procedures of asking for divine instruction (*mioshie*) concerning a disease, injury or other

physical affliction involve religious semantics as well as medical semantics. If a member asks for *mioshie*, he or she hands over a standardized "plea for *mioshie*" to the local church. Beforehand, he or she will have prayed in a ritualized way and promised to apply the contents of the divine instruction in his or her daily life. The religious teacher who receives this plea inquires diligently about the member's marital status, family members, job, duration of membership etc., and describes the symptoms and course of the disease in great detail (Pāfekuto Ribatī Kyōdan Bunkyōka 1991:183–186, 195–279).

This comprehensive information is then sent to the headquarters in Tondabayashi, where Miki Takahito, the head of PL Kyōdan, or those religious teachers who are able to receive *mioshie*, write down the specific divine instruction and send it back to the local church. Again, the member has to pray in formalized words before receiving the envelope with the *mioshie* from a local religious teacher. After three days of reflecting about the meaning and the individual application of the *mioshie*, the member visits a religious teacher to ask him for his assessment (*kaisetsu*) and to discuss possible ways of realizing the *mioshie* in everyday life (Pāfekuto Ribatī Kyōdan Bunkyōka 1991: 186–189).

Notwithstanding the ritualistic language register manifest in prayers and formalized phrases when receiving the plea and handing over the *mioshie*, code-switching to medical language occurs in the religious teacher's detailed recording of the symptoms, the course of the disease, the diagnosis by a physician, and the prescribed treatment. The manual for religious teachers illustrates how the symptoms of various diseases are to be described in great detail and how their location is to be marked on a drawing of the human body. For example, in the case of a rash, the person is asked whether she or he experiences hot flushes at night, and whether the symptoms increase when the person is exposed to cold wind; in case of sinusitis the believer is asked how the nasal mucus smells, how it affects the sense of smell, and whether it causes headaches; in case of an accident, the course of events must be described precisely etc. (Pāfekuto Ribatī Kyōdan Bunkyōka 1991: 231–239).

In this communication, religious teacher and believer imitate a conversation between a doctor and a patient. Whereas previously their communication was in line with the linguistic registers of religious believer and teacher, they now switch into the communicative mode of a medical anamnesis performed by a doctor with a patient (Pāfekuto Ribatī Kyōdan Bunkyōka 1991: 183–185). By using this kind of medical communication in order to document the

symptoms of a disease or injury and by framing it using religious concepts that explain the occurence of the symptoms, different functions are assigned to medical and religious language respectively: medical language serves to label and locate the symptoms physically, whereas religious language serves to explain the actual causes of the disease and to indicate ways of healing it. Thus, a hierarchical relationship is constructed, in which religious concepts are assigned a superior position.

A similar strategy is followed by Kageyama in his explanations for actual diseases. On the general level, he ascribes the increase of so-called lifestyle diseases such as metabolic syndrome, diabetes, cerebrovascular diseases, heart diseases, cancer, allergies, rashes, high blood pressure, eating disorders etc. to the separation of mind and body as characteristic of contemporary "competitive societies" (2013: 36). This separation creates stress, the main cause of all the diseases mentioned above, and can be countered by meditation techniques which reinstate the unity of mind and body (Kageyama 2013: 28–36). In explaining actual diseases, he sometimes blends religious concepts with physiological effects in a way that assigns them different functions. The following is part of his explanation for what causes chronic rheumatism and rheumatic arthritis, a disease that afflicts mostly women in the second half of their lives.

"In the minds of women who suffer from rheumatic arthritis, suppressed contradictory emotions are hidden. In Buddhism we call these "dust accumulating passions"; this expression describes a state in which the mind, which is originally as pure as the Buddha nature, in the process of its development has been polluted by dirt. This aggressive karma (gō), in neurophysiological terms, stimulates the sympathetic nervous system and manifests itself in a muscular tension. By suppressing this strong impulse in order to stop it, the tension of the adversary muscle which is connected to the originally tense muscle is also intensified. As a consequence, the contraction caused by the tension of the adversary muscle group damages the joints, and the physical basis causing rheumatism is revealed." (Kageyama 2010: 111)

In this example, medical terminology and explanations are used to describe a disease as a physiological process, whereas religious terminology—the concepts of passion (bonnō), Buddha nature (busshō) and karma (gō)—are applied to explain its real cause. To Kageyama, a woman's contradictory urges to dominate and to protect cause aggressive karma. Buddhist prayers

(*kitō*) and invoking the title of the Lotus Sutra are advocated as means to purify this negative karma, resulting in a relaxation of the muscles and a stabilization of the vegetative nervous system (Kageyama 2010: 114).

As in the case of PL Kyōdan, medical terminology is incorporated here and assigned the inferior function of explaining organic processes and relationships, in which it is framed by religious concepts which provide an explanation for what causes these physical effects in the context of a Buddhist notion of man and fate. In this way, religious knowledge and practice, whether Buddhist or new religious, is depicted as superior when it comes to understanding the causes of diseases.

6 CONCLUSION

Neither Kageyama nor the religious teachers in PL Kyōdan make use of the linguistic tool kit of the field of medicine or apply scientific reasoning in order to compete with medical actors in their respective field. Kageyama does not challenge medical experts by setting up an institution of alternative medical practice or by actually becoming involved in contemporary medical-scientific discourses. PL Kyōdan does have its own medical institutions, but they operate according to the rules of the medical field. Here, the specifically religious interpretation and subsequent treatment of illness are considered to be complementary practices.

Rather, Kageyama and PL Kyōdan's religious teachers use medical or allegedly scientific language to legitimize, within the religious field, their claims that religious practice also fulfills therapeutical functions. In this sense, Kageyama and PL Kyōdan both represent one way of bridging the gap between scientific medicine and their own therapeutic practices. They advocate an understanding of "the purposes of the field" (Fligstein/McAdam 2012: 9), which includes the goal of a healthy body and mind in the literal sense. By doing so, they re-claim a premodern or 'pre-differentiated' understanding of religions and their "purposes" in which medical care was a fundamental task of their respective religious communities. However, they do not propagate to simply return to this previous state and replace scientific medical authority by religious medical authority. Instead, they qualify their therapeutical techniques as compatible with science, thus acknowledging the

superiority of scientific medicine, while at the same time dissolving the boundaries between it and their own activities.

In this sense, scientification and code-switching between medical and religious language are used to strengthen the position and influence of religions in contemporary Japanese society. They aim to re-establish the relevance of religious traditions as (complementary) medical traditions via illustrating their compatibility with scientific-medical knowledge and the superiority of religious over medical explanatory models.

The strategies of scientific legitimization and code-switching applied in the two examples also shed light on possible ways in which religious actors may conceptualize the relationship between the two fields. On the one hand, the religious field—assuming it includes medical functions—is seen as being in a dependent relationship (Fligstein/McAdam 2012: 18–19) with the medical field. Although Kageyama extensively describes premodern Buddhist medical knowledge in times when medicine and religion were not yet differentiated, this traditional knowledge gains relevance for the present only if it is validated by contemporary medical-scientific knowledge. This conceptualization clearly reflects the relationship on the social level, where medical experts do not require religious legitimization, but religious actors cannot claim medical authority without referring to the tool kit of medicine. Or, in Rothstein's terms: "Religion has the ability to transform science into something useful for its purpose, while science usually is deprived of the possibility of transforming religion into something scientifically meaningful" (2004: 102).

On the other hand, in the internal discourse, an interdependent relationship is conceptualized by means of functional hierarchization according to which religious doctrines are claimed to provide the ultimate explanation of what causes illness. In this way, the one-sided dependence of religion on the social level is counteracted.

BIBLIOGRAPHY

Ahn, Juhn Y. (2008): "Zen and the Art of Nourishing Life: Labor, Exhaustion, and the Malady of Meditation", in: Japanese Journal of Religious Studies 35 (2), pp. 177–229.

Ahn, Juhn Y. (2012): "Worms, Germs, and Technologies of the Self: Religion, Sword Fighting, and Medicine in Early Modern Japan", in: Japanese Religions 37 (1&2), pp. 93–114.

Araya, Shigehiko新屋 重彦/Shimazono, Susumu島薗 進/Tanabe, Shintarō田邉 信太郎/Yumiyama, Tatsuya 弓山 達也 (eds.) (1995): Iyashi to wakai—Gendai ni okeru CARE no shosō癒しと和解―現代におけるCAREの諸相, Tokyo: Hābesutoshaハーベスト者.

Bruce, Steve (2016): "Differentiation", in: Michael Stausberg/Steven Engler (eds.), The Oxford Handbook of the Study of Religion, Oxford: Oxford University Press, pp. 635–645.

Bruchhausen, Walter (2010): "'Biomedizin' in sozial- und kulturwissenschaftlichen Beiträgen. Eine Begriffskarriere zwischen Analyse und Polemik", in: NTM: Zeitschrift für Geschichte der Wissenschaften, Technik und Medizin 18, pp. 497–522.

Bukkyō Daigaku Sōgō Kenkyūsho 仏教大学総合研究所 (2003): Gendai iryō no sho mondai—Bukkyō herusukea no shiten kara 現代医療の諸問題—仏教ヘルスケアの視点から. Contemporary Problems of the Modern Medicine—From a Buddhistic Point of View, Kyōto: Bukkyō Daigaku Sōgō Kenkyūsho 仏教大学総合研究所.

Conrad, Peter (2007): The Medicalization of Society. On the Transformation of Human Conditions into Treatable Disorders, Baltimore: The Johns Hopkins University.

Covell, Stephen G. (2005): Japanese Temple Buddhism: Worldliness in a Religion of Renunciation, Honolulu: University of Hawaii Press.

Dawson, Lorne (2006): Comprehending Cults: The Sociology of New Religious Movements, Oxford: Oxford University Press.

Démieville, Paul (1985): Buddhism and Healing. Démieville's Article on "Byō" in Hōbōgirin. Translated by Mark Tatz, Boston: University Press of America.

Drott, Edward R. (2010): "Gods, Buddhas, and Organs: Buddhist Physicians and Theories of Longevity in Early Modern Japan", in: Japanese Journal of Religious Studies 37 (2), pp. 247–273.

Fligstein, Neil/McAdam, Doug (2012): A Theory of Fields, Oxford: Oxford University Press.

Foucault, Michel (1973): Die Geburt der Klinik. Eine Archäologie des ärztlichen Blicks, München: Carl Hanser Verlag.

Fujikawa, Yu (1911): Geschichte der Medizin in Japan. Kurzgefasste Darstellung der Entwicklung der Japanischen Medizin mit besonderer Berücksichtigung der Einführung der Europäischen Heilkunde in Japan, Tokyo: Kaiserlich-Japanisches Unterrichtsministerium (reprint).

Goble, Andrew Edmund (2011): Confluences of Medicine in Medieval Japan: Buddhist Healing, Chinese Knowledge, Islamic Formulas, and Wounds of War, Honolulu: University of Hawaii Press.

Hattori, Osamu (2014): "European Homeopathic Medicine and the Rise of Kanpō in Postwar Japan", in: Nanami Suzuki (ed.), Healing Alternatives: Care and Education as a Cultural Lifestyle. Senri Ethnological Report 120, pp. 17–52.

Hobsbawm, Eric/Ranger, Terence (1983): The Invention of Tradition, Cambridge: Cambridge University Press.

Iryō to bukkyō 医療と仏教. Medicine and Buddhism (2018), Special Issue of Samgha Japan サンガジャパン Vol. 28 (2018–1), Tokyo: Sanga サンガ.

Josephson, Jason Ananda (2013): "An Empowered World: Buddhist Medicine and the Potency of Prayer in Japan", in: Jeremy Stolow (ed.), Deus in Machina: Religion, Technology, and the Things in Between, New York: Fordham University Press, pp. 117–141.

Kageyama, Kyōshun 影山教俊 (2007): Bukkyō no shintai gihō—Shikan to shinriryōhō, bukkyō igaku 仏教の身体技法—止観と心理療法、仏教医学, Tokyo: Kokusho Kankōkai国書刊行会.

Kageyama, Kyōshun 影山教俊 (2010): Inori de byōki ga naoru 祈りで病気が治る, Tokyo: Kokusho Kankōkai 国書刊行会.

Kageyama, Kyōshun 影山教俊 (2013): Supirichuaritī ni mezameru bukkyō seikatsu meisō gijutsu toshite no gendai bukkyō スピリチュアリティーにめざめる仏教生活—瞑想技術としての現代仏教, Tokyo: Kokusho Kankōkai 国書刊行会.

Kamata, Tōji 鎌田東二 (2014): Supirichuaru kea スピリチュアルケア, Sagamihara: Bingu Netto Puresuビイング・ネット・プレス.

Kisala, Robert (1995) "Shinshūkyō no shakaiteki iyashi" 新宗教の社会的癒し, in: Shigehiko Araya新屋重彦/Susumu Shimazono島薗進/Shintarō Tanabe田邊信太朗/Tatsuya Yumiyama弓矢達也 (eds.), Iyashi to wakai—Gendai ni okeru CARE no shosō 癒しと和解—現代におけるCARE の諸相, Tokyo: Hābesutoshaハーベスト者, pp. 111–128.

Kleine, Christoph (2012): "Buddhist Monks as Healers in Early and Medieval Japan", in: Japanese Religions 37 (1&2), pp.13–38.

Kojima, Nobuyuki 小島伸之(2008): "Tokubetsu Kōtō Keisatsu ni yoru shinkyō jiyū seigen no ronri—Kōdō Ōmoto to Hitonomichi Kyōdan 'fukei jiken' no haigo ni aru mono—" 特別高等警察による信教自由制限の論理—皇道大本とひとのみち教団「不敬事件」の背後にあるもの, in: Shūkyō to shakai 宗教と社会14, pp. 69–86.

Kubotera, Toshiyuki 窪寺俊之 (ed.). 2011. Iyashi wo motomeru tamashii no kawaki—Supirichuariti to wa nani ka 癒しを求める魂の渇きースピリチュアリティとは何か, Ageo: Seigakuin Daigaku Shuppankai聖学院大学出版会.

Kuriyama, Shigehisa栗山茂久/Yamada, Takako 山田慶兒 (eds.) (1997): Rekishi no naka no yamai to igaku 歴史の中の病と医学, Kyoto: Shibunkaku shuppan思文閣出版.

Lock, Margaret (1980): East Asian Medicine in Urban Japan: Varieties of Medical Experience, Berkeley and Los Angeles: University of California Press.

McCormick, Kilian (1994): "Code-switching and Mixing." In R. E. Asher (ed.), The Encyclopedia of Language and Linguistics, Vol. 2, Oxford and New York: Pergamon Press, 581–587.

Miki, Tokuchika 御木徳近 (1979): Watashi no rirekisho 私の履歴書, Tokyo: Nihon keizai shinbunsha日本経済新聞社.

Muraoka, Kiyoshi 村岡潔 (2003): "Bukkyō herusukea—Gendai iryō hihan no hitotsu kanōtai toshite" 仏教ヘルスケア～現代医療批判の一可能態として, in: Bukkyō Daigaku Sōgō Kenkyūsho佛教大学総合研究所, Gendai iryō no sho mondai—Bukkyō herusukea no shiten kara 現代医療の諸問題―仏教ヘルスケアの諸点から, Kyōto: Bukkyō Daigaku Sōgō Kenkyūsho仏教大学総合研究所, pp. 3–16.

Nagai, Mikiko永井美紀子 (1995): "Shinshūkyō ni okeru shūyōteki na iyashi to jujutsuteki na iyashi" 新宗教における修養的な癒しと呪術的な癒し, in: Shigehiko Araya新屋重彦/Susumu Shimazono島薗進/Shintarō Tanabe田邊信太朗/Tatsuya Yumiyama弓矢達也 (eds.), Iyashi to wakai—Gendai ni okeru CARE no shosō 癒しと和解―現代におけるCAREの諸相, Tokyo: Hābesutosha ハーベスト者, pp. 89–110.

Nihonyanagi, Kenji 二本柳賢司(1997): "Nihon mikkyō igaku to yakubutsugaku" 日本密教医学と薬物学, in: Shigehisa Kuriyama栗山茂久/Yamada, Takako 山田慶兒 (eds.), Rekishi no naka no yamai to igaku 歴史の中の病と医学, Kyoto: Shibunkaku shuppan思文閣出版, pp. 545–566.

Oberländer, Christian (1995): Zwischen Tradition und Moderne: Die Bewegung für den Fortbestand der Kanpō-Medizin in Japan, Stuttgart: Franz Steiner Verlag.

Pāfekuto Ribatī Kyōdan Bunkyōka パーフェクト リバティ教団文教課 (1991): Hokyōshi hikkei補教師必携, Tokyo: Pāfekuto Ribatī Kyōdan Bunkyōka パーフェクト リバティ教団文教課.

Pāfekuto Ribatī Kyōdan Bunkyōbu パーフェクト リバティ教団文教部 (2008): PL Gaido bukku PLガイドブック, Tokyo: Geijutsu seikatsusha 芸術生活社.

Rosner, Eberhard (1989): Medizingeschichte Japans, Leiden: Brill.

Rothstein, Mikael (2004): "Science and Religion in the New Religions", in: James R. Lewis (ed.), The Oxford Handbook of New Religious Movements, Oxford: Oxford University Press, pp. 99–118.

Salguero, Pierce C. (2009): "The Buddhist Medicine King in Literary Context: Reconsidering an Early Medieval Example of Indian Influence on Chinese Medicine and Surgery", in: History of Religions 48 (3), pp. 183–201.

Salguero, Pierce C. (2010–2011): "Mixing Metaphors: Translating the Indian Medical Doctrine *Tridosa* in Chinese Buddhist Sources", in: Asian Medicine 6, pp. 55–74.

Salguero, Pierce C. (2012): "'Treating Illness': Translation of a Chapter from a Medieval Chinese Buddhist Meditation Manual by Zhiyi (538–597)", in: Asian Medicine 7, pp. 461–473.

Salguero, Pierce C. (2013): "'On Eliminating Disease': Translations of the Medical Chapter from the Chinese Versions of the *Sutra of Golden Light*", in: eJournal of Indian Medicine 6, pp. 21–43.

Schrimpf, Monika (2018): "Perfect Liberty Kyōdan", in: Lukas Pokorny/ Franz Winter (eds.), Handbook of East Asian New Religious Movements, Leiden: Brill, pp. 68–87.

Serikawa, Tei 芹川定 (1972 [1939]): Hitonomichi Kyōdan jiken no kenkyū ひとのみち教団教事件の研究, Kyōto: Tōyō bunkasha 東洋文化社.

Shimazono, Susumu 島薗進 (2003): 'Iyasu chi' no keifu—kagaku to shūkyō no hazama <癒す知>の系譜―科学と宗教のはざま, Tokyo: Yoshikawa Kōbunkan 吉川弘文館.

Shimazono, Susumu 島薗進 (2007): Supirichuariti no kōryū. Shin reisei bunka to sono shūhen スピリチュアリティの興隆: 新霊性文化とその周辺, Tokyo: Iwanami Shoten岩波書店.

Shinmura, Taku 新村拓 (2013): Nihon bukkyō no iryōshi 日本仏教の医療史, Tokyo: Hōsei Daigaku Shuppankyoku 法政大学出版局.

Siary, Gérard/Benhamou, Hervé (eds.) (1994): Médecine et Société au Japon, Paris: Éditions L'Harmattan.

Swidler, Anne (1986): "Culture in Action: Symbols and Strategies", in: American Sociological Review 51/2, pp. 273–286.

Takeda, Dōshō (1991): "The Fall of Renmonkyô and Its Place in the History of Meiji-Period Religions", in: Inoue Nobutaka (ed.), New Religions, Tokyo: Institute for Japanese Culture and Classics, Kokugakuin University. http://www2.kokugakuin.ac.jp/ijcc/wp/cpjr/newreligions/takeda.html, January 27, 2017.

Tanabe, Shintarō 田邊信太朗/Shimazono, Susumu 島薗進 (2002): Tsunagari no naka no iyashi—Serapī bunka no tenkai つながりのなかの癒し―セラピィー文化の展開, Tokyo: Senshū Daigaku Shuppankyoku 専修大学出版局.

Tomohisa, Hisao 友久久雄 (2010): Bukkyō to kaunseringu 仏教とカウンセリング, Kyoto: Hōzōkan 法藏館.

Tomohisa, Hisao 友久久雄 (2013): Bukkyō to kaunseringu no riron to jissen—Bukkyō no oshie to kokoro no iyashi 仏教とカウンセリングの理論と実践―仏教の教えと心の癒し, Kyoto: Jishōsha Shuppan 自照社出版.

Triplett, Katja (2012): "Magical Medicine? Japanese Buddhist Medical Knowledge and Ritual Instruction for Healing the Physical Body", in: Japanese Religions 37 (1&2), pp. 63–92.

Watanabe, Kenji/Matsuura, Keiko/Gao, Pengfei/Hottenbacher, Lydia/Tokunaga, Hideaki/Nishimura, Kō/Imazu, Yoshihiru/Reissenweber, Heidrun/Witt, Claudia M. (2011): "Traditional Japanese Kampo Medicine: Clinical Research between Modernity and Traditional Medicine: The State of Research and Methodological Suggestions for the Future", in: Evidence-Based Complementary and Alternative Medicine, Published Online. https://www.ncbi.nlm.nih.gov/pubmed/21687585, June 22, 2018. doi:10.1093/ecam/neq067.

Williams, Duncan Ryūken (2005): The Other Side of Zen: A Social History of Sōtō Zen Buddhism in Tokugawa Japan, Princeton: Princeton University Press.

Winfield, Pamela (2005): "Curing with Kaji: Healing and Esoteric Empowerment in Japan", in: Japanese Journal of Religious Studies 32/1, pp. 107–130.

Yumiyama, Tatsuya (1995): "Varieties of Healing in Present-Day Japan", in: Japanese Journal of Religious Studies 22 (3–4), pp. 267–282.

LINKS

http://en.jsam.jp/contents.php/020000RNSXjD/, January 29, 2017.

http://apps.who.int/medicinedocs/en/d/Jh2943e/9.6.html#Jh2943e.9.6, January 29, 2017.

http://imj.or.jp/intro, January 29, 2017.

http://imj.or.jp/intro/qa, January 29, 2017.

http://www.holistic-medicine.or.jp/holistic/definition/, January 29, 2017.

http://www.jsom.or.jp/index.html, January 29, 2017.

http://www.tera-buddha.net/project/spilit_body/, January 29, 2017.

http://www2.sal.tohoku.ac.jp/p-religion/2017/cn8/pg37.html, June 15, 2018.

http://www.cihs.edu/index.php/about-cihs/presidents-message/, January 29, 2017.

http://temple.nichiren.or.jp/1031159-syakazi/, January 29, 2017.

http://sunwork.her.jp/ayurveda/index.html, January 29, 2017.

http://www.perfect-liberty.or.jp/html/name-pl/kyouso.html, January 29, 2017.

http://www.plhospital.or.jp, January 29, 2017.

http://www.pl-tokyo-kenkan.gr.jp, January 29, 2017.

http://www.cihs.edu/index.php/about-cihs/principles-of-cihs/, January 29, 2017.

http://www.plhospital.or.jp/contents/gNavi4/hosin.html, January 29, 2017.

Self-fashioning of the Hereditary Siddha Practitioner

Semantic Structure and Structuring Conditions

Nina Rageth

ABSTRACT

This article examines issues related to competition within the domain of Siddha medicine (*citta maruttuvam*), that is, Tamil medicine. It focuses on the tension and co-constitution of the figure of the hereditary Siddha practitioner and the college-educated Siddha practitioner. Based on ethnographic interviews conducted in South India, it analyzes how the figure of the hereditary Siddha practitioner is semantically delineated in the aftermath of the formal professionalization of Siddha medicine. Based on the assumption that practices of self-representation and broader social structures form a constitutive relationship, it discusses the interlocutors' accounts as semantic positionings in a 'strategic action field' (Fligstein/McAdam 2012). Accordingly, the article suggests that the interlocutors' distinct self-fashioning, especially their appropriation and fusion of religious and scientific semantics, be conceptualized as a strategic improvisation that establishes and ensures them a favorable position in this particular social field.

1 INTRODUCTION

Siddha medicine (*citta maruttuvam*) is a medical system mainly practiced in the Tamil-speaking areas of South India.[1] According to emic accounts by contemporary Siddha practitioners, the medical system is of divine provenance, having been discovered by the god Śiva and revealed by him to the siddhars (*cittarkaḷ*), "the ancient supernatural spiritual saints of India"[2], who in turn introduced the Siddha knowledge to the human realm.[3] Today, Siddha medicine is recognized by the Indian government as a traditional Indian medical system and has been integrated into the public health service. In the late colonial period and in the context of the policy of "state-sponsored medical pluralism" (Sujatha/Abraham 2009: 35), Siddha medicine underwent a process of formal professionalization along "modernist lines" (Habib/Raina 2005: 74). This process entailed the introduction of a standardized college education modelled on the biomedical paradigm, the reworking of Siddha medical knowledge in accordance with scientific principles, a differentiation between qualified and non-qualified practitioners through registration and official certificates such as the Bachelor's in Siddha Medicine and Surgery (BSMS), and the regulation of Siddha medical practices, especially in the production of pharmaceuticals (cp. Hausman 1996; Sébastia 2012a, 2012b;

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1   In accordance with the convention in English academic publications, I use the Sanskrit term *siddha* rather than Tamil *citta* to refer to the medical tradition. Furthermore, following conventions in English publications, I use *siddhar* and not the Sanskrit *siddha* or Tamil *cittar* to refer to the alleged authors of the Siddha literature and the founders of Siddha medicine. A further note on transliteration: Tamil terms are transliterated according to their Tamil forms. However, terms which are more commonly used in their Sanskrit versions, I have transliterated according to the Sanskrit spelling (e.g. *gurukula* instead of *kurukulam*, *doṣa* instead of *tōcam*, *śāstra* instead of *cāstiram*, *śiva* instead of *civaṉ*). Plural forms of Indian terms are marked by the suffix –s instead of the Tamil plural suffix -*kaḷ* (e.g. *pañcapūta*s instead of *pañcapūtaṅkaḷ)*. I render place names and personal names in their usual English spellings.

2   http://www.siddhavaidyam.com/Origin_of_SiddhaMedicine.html, August 18, 2017.

3   For scholarly work on the Siddhars, see White 1996; Venkatraman 1990; Zvelebil 1973, 1974, 1996.

Sieler 2015; Weiss 2009). The formal professionalization of Siddha medicine led to the establishment of a secularized institution, which I refer to in this article as "the college institution." This professionalization also led to the appearance of a new figure in the medical field, whom in this article I call "the college-trained practitioner." The college institution is sufficiently powerful to sanction what constitutes genuine Siddha medical knowledge and Siddha medical practice and to define the criteria for occupational closure. Moreover, it is in a position to undermine the authority of the previous authoritative institution, which I call "the *gurukula* institution."[4]

This article looks at a particular figure that has emerged under these changing social conditions and that has become effective in opposition to the college-trained practitioner. I refer to this figure as "the hereditary Siddha practitioner." Hereditary Siddha practitioners depict themselves as representatives of the gurukula institution, which, they claim, has preserved the "real" Siddha knowledge, the "divine science"[5], and which has transmitted this knowledge within lineages (paramparai) of physicians from teachers to initiated students until the recent establishment of college education and the mainstreaming of an altered version of the siddhars' original knowledge. On the basis of self-descriptive accounts of seven contemporary Siddha practitioners who identify with the figure of the hereditary practitioner, the article analyzes how my interlocutors frame the figure of the hereditary practitioner.[6] The article examines the self-fashioning of the hereditary practitioner in the current medical landscape, as well as the fashioning of the traditional Siddha medicine, that is, following Habib and Raina (2005: 76), of the "contemporary practitioners' traditional medicine." The term "self-fashioning" has been chosen to emphasize the strategic orchestration involved in the construction of the figure of the hereditary Siddha practitioner. In adopting the term, I aim to highlight the proposition that my interlocutors' self-

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4 A *gurukula* is traditionally a school where the disciples live together with their teacher.

5 http://www.devavidya.com/vision.html, September 29, 2016.

6 The term "framing" features prominently in the social sciences in areas as different as ritual theories (Goffman 1974) and media theories (Gamson 1985). However, I use the term in its everyday meaning of "delineating," "describing," or "laying out," without reference to any particular academic debate.

representations are consciously fabricated within the structuring framework of their social position.[7]

The first part of the article describes how the figure of the hereditary Siddha practitioner is semantically fashioned by examining the construction of the symbolic boundaries between this figure and its "constitutive outside" (Hall 2003: 17, emphasis in the original). Special attention is given to the application of religious semantics and the emphasis on tradition in the self-descriptive accounts of my interlocutors. In the second part, the article discusses the social structures within which the figure emerges and suggests interpreting the specific self-fashioning as a semantic positioning in a "strategic action field" (Fligstein/McAdam 2012). The article engages with Bourdieu's stance that the "construction [of social reality] is not carried out in a social vacuum but subjected to structural constraints" (Bourdieu 1989: 18). It argues that the figure of the hereditary Siddha practitioner emerges within the contextual conditions of the professionalization of Siddha medicine and that the college-trained practitioner creates the foil against which this figure becomes meaningful. Consequently, the article does not focus on the competition between Siddha medicine and biomedicine, but examines issues related to competition within the domain of Siddha medicine itself. In doing so, it fills a gap identified by the historian of religion, Richard Weiss (2009: 201). The article argues that, under conditions of the professionalization of Siddha medicine, the religious semantics and the emphasis on tradition appear as a mode of cultural production which becomes effective in the self-fashioning of the position of the hereditary Siddha practitioner. The replacement of the gurukula institution by the secularized college institution favors, so to speak, the appropriation of religious argumentation and the rhetoric of tradition as a means whereby a distinct social group attempts to provide its knowledge with authority and to attain a different status in the social field.

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7   The term "self-fashioning" loosely reflects the term "objective self-fashioning" coined by the medical anthropologist Joseph Dumit. While Dumit uses the latter term to analyze how the understanding of the biological self, the "person, body, brain, and mind" (2010: 368), are actively and continually produced, I use the term "self-fashioning" to point to the ways in which a position in a social field is produced.

2 ETHNOGRAPHIC MATERIAL: SAMPLE AND ANALYSIS

This article is based on material generated in the exploratory phase of my PhD project, which stretched over a period of four years (2014 to 2018).[8] The main sources for this article are informal conversations and ethnographic interviews with Siddha practitioners conducted between December 2014 and February 2015. Ethnographic interviews are unstructured and open interviews which do not follow a set pattern but respond to the particular situation in which they take place. Also, they typically resemble an everyday conversation, yet without the back and forth characteristic of this type of social interaction (Schlehe 2003: 72). A further source are the webpage texts of my interlocutors. Furthermore, the tool of ethnographic observation was used during fieldwork in order to see what people do and what kind of infrastructure they use for their actions (cp. Bernard 2011). However, since this article is mainly concerned with semantics rather than practice, the data I generated through observational techniques come into play only marginally in the present article.

The sample consists of Siddha practitioners who present themselves as hereditary Siddha practitioners. "Hereditary Siddha practitioner" is a term I introduce to capture and subsume the emic terminology I encountered in the field, such as "traditional *vaittiyar* (physician)" (Anbarasi), "traditional experts" (Prem Nath), "traditional practitioner" (Prem Nath), "*pārampariya* (traditional) doctors" (Surendran), "*paramparaiyāṉa vaittiyar* (hereditary practitioner)" (Kapilan) or "the real Siddha doctor" (Devanesan). I conducted ethnographic interviews with seven practitioners, six men and one woman (Anbarasi), one in Tamil (Kapilan), the others in English, or more precisely with English as the foundational language interwoven with Tamil, which proved to be the most convenient mode for conducting the interviews for everybody involved. All the interviews were conducted in the clinics of my interlocutors. The interlocutors share some basic socio-demographics. They are all around forty years old and live in towns in the southern Indian state

of Tamil Nadu. The exception is Prem Nath, who lives in Kerala in an area populated by both Malayalis and Tamils. Prem Nath comes from a Tamil family, and the circumstance that he lives in Kerala does not make his situation different from those of the other interlocutors.[9] My interlocutors also share similarities with regard to their medical practice. They all run their own clinics (*vaittiyacālai*), and they all produce medical drugs (*maruntu*), which, as they state, are based on formulas inherited from their gurus. The clinics are small-scale settings, and my interlocutors cater to as many as forty patients a day. In all the settings, consultation is free of charge, but the costs of the drugs have to be covered by the patients. Apart from two practitioners (Anbarasi and Surendran) who run a business selling drugs to retailers, the drugs are exclusively dispensed to the practitioners' own patients. Moreover, my interlocutors share themes in their self-representation. They all state that they see their work as their duty to keep Siddha medicine from vanishing. They argue that the Indian government's recognition of their medical system and its integration into the public health sector has not benefitted Siddha medicine but rather has had adverse effects on it. The most important shared element in their self-representation for the argument I develop in this article is that they all identify with the hereditary Siddha practitioners and strongly distinguish themselves from college-trained practitioners. While they describe themselves as practicing Siddha medicine "the traditional way" (Devanesan), applying "the traditional method" (Surendran), and having "traditional knowledge" (Prem Nath), they describe the college-trained practitioners as practicing "modern" (Devanesan) or "regular" (Anbarasi, Surendran) Siddha medicine, and as going the "academic way" and following the "university model" or the "educational system" (Prem Nath). My interlocutors claim that they, on the contrary, learnt the "real" Siddha medicine outside modern college institutions with a guru. Three of my interlocutors (Prem Nath, Avalok, Rubendran) stated that they hail from Siddha physician families and that they studied with their grandfathers and fathers, whereas the other four interlocutors learnt Siddha medicine with a guru outside their family. One of my interlocutors (Kapilan) framed this distinction in terms of *karuvaḻi* and *kuruvaḻi*, that is, entering a *gurukula* by birth (*karuvaḻi*, the way of the embryo) or by initiation (*kuruvaḻi*, the way of the guru).

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9   Prem Nath did not wish to be anonymized. The other interlocutors have been given pseudonyms.

It should be noted, however, that, in addition to their training with a guru, my interlocutors have also earned certified medical degrees, a prerequisite to practicing medicine legally in contemporary India.[10] From an analytical point of view, the fact that my interlocutors earned certified diplomas makes their self-representation as non-college-trained practitioners appear contradictory. However, what is important for the argument I develop in this article is that, regardless of the certified diplomas which they hold, they fashion themselves as hereditary Siddha practitioners and distance themselves from practitioners who only learnt Siddha medicine in college and who do not have access to any other source of medical knowledge.

The method used in analyzing the data follows the paradigm of *theoretical coding* and the analytical method of *grounded theory* (cp. Glaser 1978). *Theoretical coding* is a reconstructive method that aims to identify concepts in the material from which more abstract categories are developed. These abstract categories serve as a tool with which to organize the material and present it analytically. The categories are derived from the analysis of the material obtained during fieldwork. The dominant categories in the material serve as the basis for the construction of the ideal type of the hereditary Siddha practitioner I discuss in this article. The ideal type is not identical with empirical types; rather, it is to be understood as a generalization of the dominant features that are present in my interlocutors' accounts.[11] My interlocutors show these features to varying degrees, which will be indicated in the analysis. As should become clear with regard to the limited size of the sample, this study is conceptualized as a case study which does not speak for a larger whole, yet which is a valuable means of exploring trends in a specific group and thus of diversifying the existing academic discourse. However,

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10 Two of my interlocutors (Anbarasi and Surendran) have Bachelor's degrees in Siddha medicine (BSMS), one (Prem Nath) a Diploma in Siddha medicine (the older equivalent of the BSMS), one a Bachelor's degree in Ayurveda (Rubendran), and one a Bachelor's degree in homeopathy (Avalok). Two other practitioners have certificates issued by different Siddha associations, which do not count as legal documents allowing one to practice legally (Devanesan, Kapilan).

11 For a discussion of the ideal type versus the empirical type, cp. Kuckartz 1991. It would be revealing to test the ideal type that was developed on the basis of the seven cases in a next step using a larger sample in order to refine or confirm it.

one should bear in mind that the conclusions are provisional and more research is needed to strengthen the arguments and make them more nuanced.

3 THE PROTAGONISTS: AN EMANATION OF THE FIELD

I conceptualize the figure of the hereditary practitioner not as my interlocutors' individual creation or *ad hoc* improvisation, but as a figure that emerges in a distinct social configuration. This view is expressed in Bourdieu and Wacquant's famous statement: "And we could say, following the formula of a famous German physicist, that the individual, like the electron, is an *Ausgeburt des Feldes*: he or she is in a sense an emanation of the field." (1992: 107, emphasis in the original) On this note, I suggest that the articulations of my interlocutors follow certain rules which are linked to the dynamics of their social field (Bourdieu/Wacquant 1992: 98). Furthermore, I understand the figure of the hereditary Siddha practitioner as a collective figure, the collective dimension resting on the construction of a sense of a larger community of hereditary practitioners, both synchronically and diachronically. This sense of community is established and reproduced by my interlocutors through the *articulation* of tradition. The synchronic community is expressed in the individual practitioner's identification with other, contemporary practitioners. The diachronic community is expressed in the linking of the individual practitioners with previous practitioners and in their self-locating in a lineage of hereditary practitioners. The crucial point is that the articulation of community allows multiple subjects to identify with the figure of the hereditary Siddha practitioner, a collective figure that transcends the interests and identity of the individual. This stance brings to the fore a pressing question: Which social configurations are constitutive for the emergence of the figure of the hereditary Siddha practitioner? What are the characteristics of the field from which this figure emanates?

The field in which my interlocutors are situated underwent far-reaching transformations in the late nineteenth and twentieth centuries that are still reflected in its current arrangement. Those transformations are too complex to meaningfully outline in a short synopsis. In the following, I will limit my attention to one distinct component of those transformations, namely the process of the formal professionalization of the medical profession. Broadly

speaking, professionalization means turning an occupation into a profes-sion[12], a process observable in many different occupational domains, medi-cine being just one among them, though it is often held out as "the canonical example" of professionalization (Ranganathan 2013: 903). Needless to say, the professionalization of Siddha medicine is a complex process that can only be sketched out in broad strokes here.[13] The process can be traced back to the late colonial period, and it continued into India's independence. The colonial administration and later the Indian government both took on a leading role in this process, yet it should be realized that associations of what were then called ISMs (Indian Systems of Medicine) and individual practitioners of ISM were also decisive actors (cp. Sébastia 2012b; Sujatha/Abraham 2009, who strongly emphasise this point). I will limit the following remarks to one scholarly position arguing that it is no historical coincidence that the profes-sionalization of Indian medical systems coincided with the emergence of re-sistance to British colonialism.[14] This position is reflected in Last's statement that the professionalization of Indian medical systems was carried out "to rival those [medical institutions; NR] set up for 'cosmopolitan' (or 'West-ern') medicine by the imperial regime" (Last 1996: 385).[15] The development of professionalized Indian medical systems, be it Siddha medicine or others, reflects, so to speak, a dominated society's strategy to "establish parity with the hegemon" (Habib/Raina 2005: 69). Indian medical systems emerged as standardized, professionalized forms of medicine in a period in which India

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12   Broman lists six criteria for a profession: "(1) specialized and advanced educa-tion, (2) a code of conduct or ethics, (3) competency tests leading to licensing, (4) high social prestige in comparison to manual labor, (5) monopolization of the market in services, and (6) considerable autonomy in conduct of professional af-fairs" (1995: 835).

13   I am not referring here to what Engler (2003: 450), with regard to Ayurveda, calls "rudimentary professionalization" at its very inception, but to professionalization which is closely linked to the development of a modern college institution.

14   There is a rich literature on the connections between nationalism, the construction of identities, and medicine; see, for example, Brass 1972, Hausman 1996, Lang-ford 2002, Leslie 1976, Weiss 2009, Wujastyk/Smith 2008.

15   Another interpretation prioritizes the role of practitioners and students of IMS who wanted to improve their reputations and economic opportunities and thus aspired to adapt IMS to the dominant biomedicine.

was engaged in what Weiss calls a "struggle to counter cultural imperialism" (2005: 175) and was forming a "national-cultural imaginary" (Langford 2002: 17) of the emerging nation state. Through the process of professionalization, Indian medicine was reified as a series of distinct medical systems, making it possible for them to challenge Western claims of superiority in general and to oppose the particular Western medical knowledge system to which the colonial state subscribed (Sujatha/Abraham 2009: 37).[16] While Ayurveda featured most prominently as the Indian counterpart to Western medicine and has received the greatest attention in both emic and academic debates, other Indian medical systems also emerged and were presented as superior alternatives to Western medicine.[17] These dynamics found expression in the "state-sponsored medical pluralism" (Sujatha/Abraham 2009: 35), which, at least normatively, recognizes and advocates non-biomedical systems and integrates them into the public health sector. The positive evaluation of Indian medical systems has continued and is visible in India's present medical landscape in the form of the Ministry of AYUSH (an acronym for Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy), which promotes medical pluralism and is tasked with the role of protecting AYUSH medical systems.[18]

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16 The term "Siddha medicine" appears for the first time in a government report of 1923, the so-called Usman Report. Before that, it was known as Tamil Medicine or Tamil Ayurveda (Sébastia 2012a: 166). Krishnamurthy (1984) also shows that Siddha and Ayurveda have only been treated as two distinct medical systems relatively recently.

17 On Ayurveda, cp. Langford 2002; on Siddha medicine, cp. Weiss 2009; for naturopathy in India, cp. Jansen 2016.

18 The Ministry of AYUSH dates back to the establishment of the Department of Indian Systems of Medicine (ISM) in 1969, to which homeopathy was added in 1995, when it became the Department of Indian Systems of Medicine & Homeopathy (ISM&H). It was renamed the AYUSH Department in 2003, and in 2009 Tibetan medicine was included. In 2014 it was given the status of an independent ministry. However, in spite of the promotion of medical pluralism, AYUSH medicines still receive only marginal support. This leads Priya to speak of "undemocratic pluralism" (2012: 104) and Naraindas, Quack and Sax (2014) of "asymmetrical conversations" between different medical systems. For the issue of inequality in accessing these medical services, cp. Broom et al. 2009.

As Broman (1995: 835) points out, "specialized and advanced education" is one of the key criteria for distinguishing professions from other occupations. Professionalization involves a process of setting up a formalized and standardized education and training system. Retrospectively, the establishment of the School of Indian Medicine in Chennai in 1924 can be described as the starting point of this process, since it was the first college to teach Indian medicine (Ayurveda, Unani and Siddha) independently of Western medicine (e.g. Arnold 2000: 185; Bala 2007: 103).[19] The first college where Siddha medicine could be studied as a separate degree was only opened in 1964 in Palayamkottai, a town in Tamil Nadu (Sébastia 2012b: 4f).[20] The creation of what Broman calls "specialized and advanced education" (1995: 835) also involved the definition of an orthodox body of knowledge. This meant sanctioning what is considered valid and excluding what is considered invalid knowledge, a process which obviously led to the alteration of the knowledge base of the respective occupation (Ranganathan 2013: 925).

In the process of the professionalization of Siddha medicine, the teaching and transmission of medical knowledge was turned into a college course comprising a set canon of subjects and following a distinct curriculum and, as Sujatha points out, "distinct epistemic models of the body" (Sujatha 2011: 191).[21] Siddha medical training was restructured on the basis of a Western-style education and modelled along the lines of the biomedical curriculum, as is obvious from the length of the course, the distinction between under-graduate and postgraduate training, the subjects taught,[22] the setting of the teaching, and the way the students are examined.[23] This restructuring has had

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19 Previously, in 1822, a Native Medical Institution was opened in Calcutta, which aimed at a hybridized form of the Western and Indian medical systems. It was closed in 1835 (Fischer-Tiné 2013: 35).

20 Today there are seven Siddha medical colleges in Tamil Nadu and one college in Kerala offering a BSMS degree. Six of them are private and the other two government institutions.

21 The curriculum of the 5.5-year college program was designed by the CCIM (Central Council for Indian Medicine), cp. http://www.ccimindia.org/siddha-syllabus.php, July 10, 2016.

22 The BSMS includes subjects such as biochemistry, microbiology, anatomy and physiology; cf http://www.ccimindia.org/siddha-syllabus.php, July 10, 2016.

23 Jansen shares a similar observation with regard to naturopathy (2016: 15).

an effect not only on the form and content of Siddha medicine as a medical discipline, but also on the practice of the prospective practitioners.[24] I observed during my fieldwork that Siddha physicians who studied exclusively in the college setting often exhibit striking similarities to biomedical doctors: they wear white coats, are equipped with stethoscopes, and speak of metabolism, hypertension, and sugar levels in generic biomedical language; also, they are addressed by patients as "doctor" and hardly ever as *vaittiyar* or *maruttuvar*. Moreover, these practitioners often begin a consultation by checking the patient's blood pressure using a sphygmomanometer, but hardly ever assess the imbalance of the three humors (*mukkuṟṟam* or *tridoṣa)* of wind (*vātam*), bile (*pittam*), and phlegm (*kapam*) by sensing the patient's pulsation (*nāṭi paricōtaṉai* or *nāṭi pārttal*).[25] Also, they send their patients to take X-rays and blood tests in laboratories and prescribe drugs in the same manner as biomedical doctors. The drugs are colorful capsules and sealed tablets that look very much like biomedical drugs. Furthermore, the professionalization of Siddha medicine involved the establishment of scientific societies and associations that were founded as a means to create a platform for the exchange of medical knowledge and to institutionalize the scientific ideal of transparency.[26]

The Indian government played a decisive role in the creation of the new medical institution, which leads Sujatha and Abraham to speak of a "state-induced institutional development" (2009: 37). They write (2009: 40): "The establishment of various councils, national institutes and drug testing laboratories were direct outcomes of the recommendations made by various committees set up by the government." One of the major concerns of this "state-induced institutional development" was the testing and validation of drugs in accordance with biomedical standards. New regulations concerning the production of drugs were introduced. One of these regulations requires that drugs which are produced for sale on the pharmaceutical market have to be patented by the Office of Drugs Control and must receive a Good

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24 Referring to these changes, Sujatha speaks of a process of "pharmaceuticalization" (2011: 193).

25 On sensing the pulse, cp. Daniel 1984: 115; cp. Sieler 2014: 325–326.

26 The establishment of scientific societies is a strong example of what Habib and Raina call the "routinizing [of] a new set of institutional practices that were elements of the modern research systems" (2005: 74).

Manufacturing Practice (GMP) certificate (Sébastia 2012a: 178–179, 2015: 951). In order to obtain this certificate, the composition of the drug has to comply with the Drugs and Cosmetics Act (1940) and Rules (1945), which, as Sujatha and Abraham rightly state, subjects "the ISMs [Indian Systems of Medicine] to the political economy of the laboratory" (Sujatha/Abraham 2009: 40–41) and restricts the agency of the practitioner in the production of the medicine. The role of the government in the process of professionalization also becomes visible with regard to legal regulations concerning the requirements for the practitioners. One of these regulations is the Indian Medicine Central Council Act, introduced in 1970, under which only physicians with the required credentials have the authority to practice medicine (Payyappallimana/Hariramamurthi 2012: 284).[27] With the introduction of this act, holding an officially recognized certificate became mandatory to practice Siddha medicine legally, which delegitimizes other forms of knowledge transmission (Sébastia 2012b: 5).[28] Thus, professionalization introduced occupational closure on the basis of a requirement for formal qualification and created a group of professionals who are entitled to practice Siddha medicine legally and, *vice versa*, a group of practitioners who are excluded from the profession because they do not have the documents authorizing them to practice. These government regulations thus replaced other, informal mechanisms of occupational closure laid down by the *gurukula* institution, or, more broadly speaking, the government regulations did not reinforce the authority of the *gurukula* institution but undermined it. As will become clear in the following reconstruction of my interlocutors' self-understanding, it is this process of the formal professionalization of Siddha medicine that is constitutive of the emanation of the figure of the hereditary Siddha practitioner.

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27 This act was preceded by several other registration acts, such as the Medical Registration Acts introduced between 1912 and 1919 in all the provinces of India (Hardiman 2009: 275).

28 Since 1977, the required certificate has been the Bachelor's degree in Siddha Medicine and Surgery (BSMS).

4 THE FIGURE OF THE HEREDITARY SIDDHA PRACTITIONER

Using one of Bourdieu's phrases, the reconstruction of my interlocutors' narratives regarding their self-representation provided in the following section takes the form of "'an account of the accounts' produced by social subjects" (Bourdieu 1989: 15). It emphasizes especially how my interlocutors construct symbolic boundaries, that is, conceptual distinctions which social actors deploy to organize their social worlds (Lamont/Molnár 2002: 168). Investigating symbolic boundaries sheds light, as Lamont and Molnár remark, on "the dynamic dimensions of social relations, as groups compete in the production, diffusion, and institutionalization of alternative systems and principles of classifications" (ibid: 168). It is this dimension of social relations and the construction of classifications which is ultimately of interest here. The analysis of the construction of symbolic boundaries is divided into two sections. The first part focuses on the "*constitutive outside*" (Hall 2003: 17, emphasis in the original) in the accounts of my interlocutors. The argument formulated here is based on the common assumption that "all identity is differential identity" (Laclau 1995: 151) and that therefore the outside is constitutive of the identity concerned. The second part focuses on the appropriation of symbolic resources in the process of self-fashioning, such as conceptual distinctions or interpretive strategies. Special attention is given to the fusion of a religious and a scientific semantics in the self-fashioning of the hereditary Siddha practitioner and to the emphasis on tradition versus innovation.

4.1 The Constitutive Outside

My interlocutors distinguish the hereditary Siddha practitioner from three figures and their respective forms of medicine: the biomedical doctor, the Ayurveda practitioner, and the college-trained Siddha practitioner.

4.1.1 The Biomedical Doctor as the Constitutive Outside

All my interviewees, apart from Devanesan, refer to biomedical doctors and biomedicine.[29] Their descriptions of biomedicine revolve around a small repertoire of topics on the basis of which they demonstrate Siddha medicine's alleged superiority over biomedicine. A dominant theme which runs through their accounts is the juxtaposition of biomedicine as a man-made invention and Siddha medicine as a "divine medicine" (Prem Nath, 31.12.2014) with a "divine origin" (Surendran, 16.1.2015). Regarding this matter, Prem Nath (31.12.2014) says: "It [Siddha medicine] is not invented by anybody else. Not ['by'] me, nor ['by'] my ancestors nor by anybody else."[30] It has, he states, a "divine source." My interlocutors describe biomedicine, by contrast, as a science developed by human scientists who gradually come up with new technology and new medical formulations that only have a provisional validity and will eventually be overwritten by new inventions:

"Then the next thing, in allopathy they find out some combination. Then, after ten years, what they say is, 'this medicine is not good for this problem, so please avoid this medicine.' But in Siddha medicine what was written three thousand years back, still I am doing that same medicine. And three thousand years from now, my successor will still be doing this medicine. How miraculous it is!" (Anbarasi, 6.1.2015)[31]

Another issue which comes up with regard to biomedical drugs is the nature of the drugs themselves. My interlocutors share the view that biomedical drugs are made of chemicals. Anbarasi states, for example: "All are chemical. Not natural. It is a pity what is going on." (6.1.2015) Siddha medical drugs, on the other hand, are held to be composed of natural substances and

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29 While my interlocutors speak of "allopathy," "modern medicine" or "English medicine," I will use the term "biomedicine," which is a common term in academic literature.

30 Mr. Prem Nath practices Siddha medicine in his own clinic in Thiruvananthapuram. He hails from a hereditary Siddha family with a lineage dating back in history before the Common Era. He has a Diploma in Siddha medicine.

31 Mrs. Anbarasi practices Siddha medicine in her own clinic in Coimbatore and runs a business selling drugs to retailers. She has studied in a *gurukula* and has a Bachelor's degree in Siddha Medicine and Surgery.

thus to be in tune with nature. The trope of Siddha medicine's harmony with nature is prominent in all my interlocutors' accounts, and it is also visually present on their webpages, as well as in the leaflets and brochures they provide through icons such as fresh leaves, flowers, roots, and images of manual tools for the production of drugs. Biomedicine appears in all the accounts (except in Devanesan's) as a counter-example to the naturalness of Siddha medicine. The chemical substances of biomedical drugs are considered "poison" (Anbarasi, 6.1.2015) and are seen as the source of the side effects (pakkaviḷaivu) of these drugs.[32] The characterization of biomedicine as a medicine with side effects is present in all my interlocutors' accounts (again not in Devanesan's). Kapilan states: "[…] the problem is the side effects caused by this treatment. One disease will disappear with the medicine, and another will arise in another part of the body because of the medicine."[33] (12.1.2015) Siddha medical drugs, on the other hand, are described as drugs which do not have any adverse effects—provided they are made in the right way—because, as stated above, they are believed to be made from natural substances, or, as my interlocutors also say, they are made in accordance with the pañcapūtam theory. This theory comprises the view that the micro- and macro-cosmos are both constituted of the five elements—earth, water, fire, air, and space—and that accordingly everything that we take in should only comprise these pañcapūtas.

"So we are using the herbs to prepare the medicine. With the help of *pañcapūta*s only we are treating the patients. So the herbs have *pañcapūta*s, our bodies have *pañcapūta*s. […] But allopathy medicines are not made by *pañcapūta*s. Or were they made by *pañcapūta*s? No! Allopathy is made by a company. They mix up chemicals and make them into a medicine. That is all." (Anbarasi, 6.1.2015)

With regard to biomedical drugs, my interlocutors raise another aspect, namely the curing mechanisms. All my interlocutors (except Devanesan)

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32 This claim can be taken as a reversal of the accusations with which their "guild" is often confronted today: accusations of quackery and of causing harm to people.

33 Mr. Kapilan practices Siddha medicine in his own clinic in Pollachi. He has studied in a *gurukula* and has a certificate in Siddha medicine issued by a Siddha association.

express the view that biomedicine treats the symptoms while Siddha medicine treats the root cause of the disease.

"And in allopathy, I am not blaming it, but in allopathy they are only treating the symptoms. But we are not giving any treatment to the symptoms. We only focus on the root cause. So when the root cause will be gone, automatically the problem will subside." (Rubendran, 6.1.2015)[34]

4.1.2 The Ayurveda Practitioner as the Constitutive Outside

Ayurveda practitioners and Ayurveda medicine appear in all my interlocutors' narratives, yet only on the periphery. This is a surprising finding, since, during the Tamil revivalist movements of the twentieth century, Ayurveda figured as the quintessential "other" of Siddha medicine (cp. Weiss 2008, 2009). On the basis of this observation, and with Richard Weiss in mind, I am inclined to translate this finding as an expression of a shift in boundary-making.

It is noticeable that, when my interlocutors refer to Ayurveda, they do not emphasize the differences between Siddha medicine and Ayurveda in the first place but rather accentuate their similarities. My interlocutors stress that the two medical systems are both Indian, that they share diagnostic procedures (Rubendran), medical formulas (Rubendran, Anbarasi, Surendran) and concepts about the constitution of the body (Devanesan, Surendran), and that they mainly differ in terms of language (Tamil for Siddha medicine and Sanskrit for Ayurveda). However, and this should not be overlooked, at the same time they subordinate Ayurveda to Siddha medicine. Some of my interlocutors (Surendran, Avalok, Rubendran) do this by arguing that Siddha is the older and original medicine and that Ayurveda is just a translation of Siddha medicine into Sanskrit. Most often, however, Ayurveda is subordinated to Siddha on the basis of the substances used for the medical drugs. Four of my interlocutors describe the use of metals and minerals as one of the quintessential and unique characteristics of Siddha medicine, while they describe

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34 Mr. Rubendran practices Siddha medicine in his own clinic in Coimbatore. He hails from a hereditary Siddha family with a lineage going back fifteen generations. He has a Bachelor's degree in Ayurveda Medicine and Surgery.

Ayurveda as herbal-based medicine, which they consider less effective and not fit for treating chronic and severe diseases.

"And this is another important thing: Siddhars did not only prepare medicine with herbs, but also metals and minerals and salts, byproducts from the sea, shells, all kinds of shells […]. So our Materia Medica is not only herbs, but also metals-medicine, minerals-medicine. If we look at the books, it is alchemy work. In the whole world until now, nobody did that, nobody else can do it." (Anbarasi, 6.1.2015)

On the basis of the same argument, Prem Nath describes Ayurveda as "human medicine" (*maṉuṣavaittiyam)* and Siddha medicine as "divine medicine" (*tēvavaittiyam)*. He classifies Ayurveda as *maṉuṣavaittiyam* because it is herbal-based medicine that does not require higher knowledge for the production of drugs. Conversely, he argues that Siddha medical drugs can only be produced by applying the "divine method"[35] for the purification of metals and minerals, that is, the method that was discovered by the siddhars, which makes Siddha medicine *tēvavaittiyam*.

4.1.3 The College-Trained Siddha Practitioner as the Constitutive Outside

The figure of the hereditary Siddha practitioner is primarily framed against the figure of the college-trained Siddha practitioner. The latter is, so to speak, the main "constitutive outside" of the hereditary Siddha practitioner in my interlocutors' accounts. In my interlocutors' view, college-trained practitioners are Siddha practitioners who studied exclusively in a modern college setting. Prem Nath describes them as "university people" or "academic people" who follow the "university model." Alternatively, they are depicted as practicing the "modern" (Devanesan, 5.2.2015) or the "regular" (Anbarasi, 6.1.2015; Surendran, 16.1.2015) Siddha medicine. The college-trained Siddha practitioner is constructed as the negative other of the hereditary practitioner with reference to a number of issues, all of which can be interpreted as expressions of my interlocutors' perceived struggle to have their knowledge approved and of the question of what constitutes genuine Siddha

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35 http://www.siddhavaidyam.com/Principles_of_SiddhaMedicine.html, August 18, 2017.

medical knowledge. Furthermore, my interlocutors share the view that the establishment of the college institution has not contributed to the preservation of the medical tradition but, on the contrary, poses a danger to its continuation. Kapilan encapsulates this view by stating that the college-trained practitioners are "tweaking the original concept" of Siddha medicine and that "therefore there is a danger that people who are bookish are destroying the real practical tradition of Siddha" (12.1.2015). This leads him to speak of the "false institutionalization of Siddha medicine," which amounts to the "systematic destruction of Indian traditional culture."

My interlocutors share the view that one cannot learn the real Siddha medical knowledge in colleges because colleges are not in possession of it. Prem Nath says that colleges do not have access to the "key books," that is, to the knowledge revealed by the god Śiva, because this knowledge is kept within the families of hereditary Siddha practitioners. The "proper knowledge" can therefore not be acquired in college. On Prem Nath's webpage it says:

"Today there are recognized Siddha Medical Colleges [which] run under the government universities where Siddha medicine is taught. But they are running the course with average syllabus [compared] to the knowledge of Traditional Vaidyas. In Siddha Vaidyam […] many toxic drugs and heavy metals are [used] for manufacture [of] bhasmas and chindooras. [Lack] of proper purification will cause major draw-backs in health. Traditional Siddha Physicians are doing effective purification process. But they hide it as traditional secret and transfer [it] only to the next generation."[36]

As this quote shows, my interlocutors are mainly concerned about knowledge that pertains to the production of Siddha drugs that involves the purification of the substances, that is, the transformation of metals and minerals into medicine. In their view, this purification process is the unmistakable characteristic of Siddha medicine and an essential element of Siddha practice. Rubendran states that he learnt the production of medicine from his father, which is the only way to master that practice. And Surendran too states that in college you can only learn how to become a Siddha physician,

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36 http://www.siddhavaidyam.com/siddhavaidyam.html, August 18, 2017.

you cannot learn how to produce medicine, because, he states, "[f]or that we need a guru."[37]

My interlocutors do not just speak of the omission of certain elements of Siddha knowledge, but also of the remaking of Siddha knowledge through the merging of traditional Siddha knowledge with biomedical knowledge. With regard to this remaking, Prem Nath mentions the mixing of modern anatomy, physiology, and pathology books such as Chaurasia's *Anatomy* or Hutchinson's *Clinical Methods* with the classical Siddha literature. Two of my interlocutors (Devanesan, Avalok) also mention the introduction of bio-medical diagnostic techniques into Siddha practice, such as measuring blood pressure, taking blood tests, and doing X-rays, instead of assessing the imbalance of the three humors (*mukkuṟṟa* or *tridoṣa)* through the *nāṭi pārttal* (examination of the *nāṭi*).

"The *vaittiyar*s who lived here, they healed people in this way. They would not take a stethoscope and check, no […]. But now everybody has different techniques. […] I cannot criticize that. I am only telling you the way how I prefer it." (Devanesan, 5.2.2015)[38]

Furthermore, Devanesan points to the change in how the medicine is dispensed. He says that the "modern practitioner" prescribes manufactured medicines which come in capsules, tablets and syrups, and he adds:

"How can you trust that modern medicine? I cannot trust that modern medicine. They are putting preservatives. Preservatives are damaging the liver! So why would we do it like that? This Siddha medicine is meant to be taken naturally. This is how the divine gave it." (Devanesan, 5.2.2015)

With regard to changes to Siddha medical knowledge through the establishment of a college education, Prem Nath (31.12.2014) speaks of the

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37 In this respect, some of my interlocutors mention the omission of formulas for the production of key drugs in Siddha medicine such as *muppū* or *navapāṣāṇam*, which are thought to cure all diseases and even to bestow immortality.

38 Mr. Devanesan practices Siddha medicine in his own clinic in Pondicherry. He has studied in a *gurukula* and has a certificate in Siddha medicine issued by a Siddha association.

consolidation of a "fake route": "[…] unfortunately I want to say that the new government policies like AYUSH and medical universities and everything is going on a fake route." In his view, the siddhars transmitted to humanity a complete science which ought to be followed uncompromisingly. He says: "If you want to teach the exact way, you need to follow exactly whatever is written in manuscripts, [isn't] it?" And a little later he says: "Whatever is explained by lord Śiva to Pārvatī, by Pārvatī to Murukaṉ, by Murukaṉ to Akattiyar, that needs to be studied." He argues that in college they teach an altered version of the "divine science," which thus has "lost the sacredness that was conceived [by] the Siddhars."[39]

Another issue that the majority of my interlocutors bring up is the type of knowledge that can be acquired in college. They describe the college as a place that only provides theoretical knowledge and that does not acknowledge the centrality of practical and experiential knowledge to Siddha medicine. They share the view that *nāṭi pārttal* for diagnosing diseases and the methods of producing drugs cannot be learnt theoretically but only practically by gaining experience from experienced persons. Prem Nath speaks in this regard of "*aṉupavam citta vaittiyam cikiccai*," which he translates as "Siddha medicine as the treatment of the experience" (31.12.2014). The theoretical knowledge of the schoolbook is not sufficient to become a Siddha practitioner. Kapilan refers to college-trained practitioners as "bookish people" and states that "there is a danger that people who are bookish are destroying the real practical tradition of Siddha" (12.1.2015). They pose a danger to the Siddha system because they "cannot prepare Siddha medicine" (Kapilan, 12.1.2015), which, however, as mentioned above, is a defining characteristic of Siddha practice. In my interlocutors' view, the Siddha medical texts do not contain straightforward instructions for how to practice Siddha medicine but are written in an encoded manner that is generally known as *paripāṣai* (obscure language). Rubendran says: "The books are full of secrets, and the experience-people, they find out these secrets. Each and every *śāstra*, every poem, every note has some secrets." (6.1.2015) It is only through practice that the physician can discover the meaning of the texts and learn how to practice the medicine properly. This experiential knowledge is not, as Rubendran stresses, written down and can thus only be acquired by

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39 http://www.devavidya.com/vision.html, September 29, 2016.

learning from an experienced teacher. Apprenticeship and not studying is thus the appropriate mode of learning.

The last dominant theme in the framing of the college-trained practitioner that I want to mention revolves around the duration of the study period. Four of my interlocutors point out that the study of Siddha medicine is a long-term commitment, or, as Prem Nath puts it, a "lifetime enrolment" (31.12.2014). A Bachelor's degree in Siddha Medicine and Surgery, by contrast, is completed within only five and a half years, a timeframe within which, in my interlocutors' view, Siddha medicine cannot be mastered:

"Definitely it is not enough. It is not enough! How can you learn all those things in five and a half years? In that time we can just learn the basic things, that's it." (Rubendran, 6.1.2015)

"Let's take a *śiṣyan* [student; NR]. You know *śiṣyan*? He must learn at least twelve years under the supervision of a guru. Then only he is eligible for practice." (Surendran, 16.1.2015)[40]

4.2 The Self-Fashioning of the Hereditary Siddha Practitioner

All my interlocutors present themselves as protecting and disseminating Siddha medicine, which is congruent with their view that Siddha medicine is on the verge of disappearing and that, in order to preserve it, the medicine needs to be spread, both locally and globally. Though my interlocutors agree on the Tamil character of the medicine—according to the common narrative, Śiva gave the medical knowledge to the siddhars in the Tamil language—they also agree that Siddha medicine is not supposed to remain within the Tamil community but is destined to be a global commodity. My interlocutors' efforts to preserve Siddha medicine, or, as Kapilan says, "to rekindle the Siddha practice and Siddha way of life" (12.1.2015), is sometimes directed against biomedicine, but mainly against Siddha medicine as taught and learnt in Siddha medical colleges. This becomes evident, as I show below, in how they

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40 Mr. Surendran practices Siddha medicine in his own clinic in Coimbatore and runs a business selling drugs to retailers. He has studied in a *gurukula* and has a Bachelor's degree in Siddha Medicine and Surgery.

fashion themselves as hereditary practitioners in opposition to the college-trained practitioners and in the specific way they frame the traditional Siddha medicine. Among my interlocutors, Prem Nath challenges the college version of Siddha medicine in the most explicit way, as becomes visible in the figure of the rebel that he enacts:[41]

"Sometimes university people have a lot of trouble with me. They are thinking I am a rebel. No, I am not a rebel, but yes I am, this is my blood, this is my tradition, I cannot disobey my ancestors' comments […]." (Prem Nath, 31.12.2014)

The other interlocutors also fashion themselves as hereditary practitioners in opposition to college-educated Siddha practitioners, a position that finds expression in the criticism they articulate against them, yet they apply a less insurgent rhetoric than Prem Nath. My interlocutors employ four main themes in their fashioning of the figure of the hereditary Siddha practitioner and their framing of traditional Siddha medicine. On the basis of those four themes, they differentiate more or less explicitly the hereditary Siddha practitioner from the college-trained practitioner who serves them as a primary source of legitimacy. These four themes share a distinct religious semantics and a strong emphasis on tradition. They are: type of knowledge (man-made versus divine), access to knowledge (college versus *gurukula*), the purpose of the medicine (physical versus religious), and the motivation for the practice (money versus karma).

4.2.1 Type of Knowledge

My interlocutors differentiate between divine knowledge and man-made knowledge, portraying traditional Siddha medical knowledge as belonging to the former and the college version of Siddha medicine as well as biomedicine to the latter. As mentioned above, my interlocutors classify Siddha medicine as divine medicine, *tēvavaittiyam*, because of the medicine's provenance: Siddha medicine is not seen as an invention but as a divine discovery,

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41 Prem Nath enacts the role of the rebel not only in the interview he gave me, but also in interviews on local TV channels. See, for instance, his interview on *Surya TV* (Devavidya, 2015).

that is, as a discovery of the siddhars, the "godly people" (Anbarasi). On Prem Nath's webpage we read:

"Palm Leaf Manuscripts says [*sic*] that the Siddha System of medicine was first taught by Lord Shiva to his wife Goddess Parvathy. Goddess Parvathy in turn passed on all these knowledge to her son Lord Muruga. Lord Muruga then taught Siddha Medicine to his favorite disciple Sage Agasthya. It was from Agasthya and his disciples, the 18 Siddhars, the great wisdom of Siddha spread to what it is today."[42]

The divine nature of Siddha medical knowledge is expressed in different ways, the most dominant being its characterization as absolute knowledge. Avalok, for example, speaks of Siddha medicine as a complete body of knowledge that the siddhars have obtained and transmitted, and Anbarasi says in a similar vein:

"Everything is there. You cannot go anywhere from here. Everything is written. Everything is finished. Everything is over. There is no need to find new things. Everything is written. You just have to take and do and give. It will be effective." (Anbarasi, 6.1.2015)

Prem Nath also speaks of the completeness of Siddha medicine, his point being that it is flawless and unerring knowledge. In this connection, he complains that, if a treatment is unsuccessful, college-trained practitioners blame the medicine for the failure. However, as he also says: "There is no mistake happening in the science, only in the scientist." (31.12.2014)

The absolute character of the medicine is also expressed on the basis of its timelessness. As I have already mentioned, Siddha medicine is contrasted with biomedicine on the basis that Siddha medicine will never correct itself. Surendran states:

"The medicines present today will disappear in five years. But our medicines, no one will ever change them. Even one million years after. It was their [the Siddhars'] intuition, by meditation ['they obtained it']." (Surendran, 16.1.2015)

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42 http://www.devavidya.com/siddhavaidyam.html, June 29, 2016.

Furthermore, as I mentioned before, Prem Nath argues that humans are not supposed to change anything in the Siddha knowledge, since any alteration of divine knowledge is a corruption of the absolute knowledge, an argument he uses to challenge the college version of Siddha medicine: "If I invent something, it is a fake statement." (31.12.2014) He says that he has "no right" to customize the knowledge because he is not the creator of the knowledge, but only a medium who transfers this knowledge on to others: "I am an agent. The masters are above me, beyond my control."[43] Prem Nath thus demands proper respect for it: "[…] when a god gives you a chance to know these things, don't neglect, don't challenge the god; you have to obey the orders of divine source." Anbarasi and Surendran too stress that it is crucial that they exactly follow "whatever is written in the literature" (Anbarasi, 6.1.2015) in order to produce good medicine.

4.2.2 Access to Knowledge

My interlocutors claim to have access to the complete Siddha knowledge because they have studied in a *gurukula* with hereditary Siddha physicians, who are believed to hold the real knowledge, unlike the colleges. The "key books," as Prem Nath notes, are in the hands of hereditary practitioners, and the knowledge they contain is only transmitted through hereditary lineages: "blood is thicker than water," he says proverbially to indicate that Siddha knowledge is not shared with outsiders but remains within the family (31.12.2014). The importance of the sense of belonging to a lineage of hereditary Siddha practitioners is also reflected in Prem Nath's self-presentation on his webpage:

"Prem Nath hails from a traditional Siddha family dating back to pre-british [*sic*] era in India. His family migrated to Kerala from Pandi Kingdom of Tamil Nadu on the

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43 Prem Nath is reflexive about innovative elements in his own practices, such as running a website, providing consultancy through skype, appearing on TV, or offering an online Siddha training program. He applies the analogy of "old wine in a new bottle" to point out that the form of knowledge transmission can be altered if this is beneficial for the quest to preserve divine knowledge, though the knowledge itself ought not to be changed.

request of the king Cheraman Perumal to provide Varmam training[44] to his military as well as to serve as Siddha physicians in the court. […] The most revered vaidyam of his lineage is the Velitheriyil Kesavan Vaidyan about whom even poets have sung."[45]

His webpage also states that his family possesses texts composed by the siddhars: "He hails from a traditionally reputed family of Siddha Physicians. They have [a] huge collection of old secret manuscripts about Siddha Science."[46] Avalok too claims to belong to a hereditary Siddha family in the fifth generation, and he states that he learnt Siddha medicine with his grandfather and that the Siddha manuscripts which he showed me belong to his family. Surendran also states that he stayed with different hereditary practitioners in order to learn the art of medical production, which is kept secret from outsiders. And Rubendran points out decisively that he belongs to a lineage of hereditary practitioners. He opens his account by saying that he belongs to the fifteenth generation of practitioners in his family. The element of lineage is also strongly present on his webpage. The "About Us" section on the webpage starts with the following sentences:

"The founder of Agasthiyar Siddha Ayurveda Hospital was the Great Legend Late Dr. Sri Brahmananda Swamigal. He was born […] as the 4th son of Sivadha Achary, a well-known traditional siddha physician and Ammaluammal. He got interested in medicine at the age of 8 yrs. So he started his Gurukulam period under his respectful master Sri Velayuthampillai from Thiruvettar in Kanyakumari District."[47]

The webpage also informs the reader that Dr. Sri Brahmananda Swamigal, who is Rubendran's father, also "gathered much knowledge of traditional Siddha medicine from his father" and that he had two other gurus. Rubendran stresses that he has studied Siddha medicine since childhood under the guidance of his father and thus learnt how to produce drugs, which is impossible in the college setting:

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44 "Varma training" refers to *varmakkalai*, the art of the vital spots, a technique which constitutes a sub-branch of Siddha medicine; cp. Sieler 2015, 2012.

45 http://www.devavidya.com/management.html, September 29, 2016.

46 http://www.devavidya.com/about.html, September 29, 2016.

47 http://agasthiyarsiddhaayurveda.com/aboutus.html, June 2, 2017.

"Nobody in any university or any college can teach these medicine preparation or purification, because they don't know. They don't know. The teachers, they don't know how to prepare. That is what I told you. Many of the poems, they have a secret. Those secrets are never taught in the colleges, never taught in the universities, that is, only hereditary people, they only know." (Rubendran, 6.1.2015)

This quote shows that from my interlocutor's point of view access to knowledge depends not only on physical access to the manuscripts, but also on access to their meaning, which requires someone with the expertise to decode the encrypted information contained in the Siddha poems.

4.2.3 Purpose of the Medicine

A further recurring theme is the purpose of the medicine. Four of my interlocutors express the view that Siddha medicine's ultimate objective is not to cure a physical sickness, but to serve as a means to unify with god, that is, to attain liberation, a view which is not "their own," but which is present in the classical Siddha literature.[48] They share the view that the siddhars have passed on a medical system which guarantees longevity.[49] Kapilan even speaks of "deathlessness" (12.1.2015). Longevity in turn allows for more time to complete the process of spiritual perfection, which will ultimately lead, as Devanesan says, to "a connection between the soul and the divine" (5.2.2015), by which he means liberation (*jīvaṇmukti*). The theme of liberation is most distinctly discussed by Anbarasi, who makes the strong point that wellbeing is a precondition for liberation. Siddha medicine, according to Anbarasi, is a means to purify the body and the mind, which is needed for doing good things in society and is, in turn, a step towards one's merging with god. In her view what might appear to be a preventive and rejuvenating medicine serves a religious purpose. She says:

"So those who are strong in physical, they will reach god, they will do service to the people with their healthy body, so they will reach god. This is the main aim of our Siddhars." (Anbarasi, 6.1.2015)

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48 Cp., for instance, Zvelebil 1973: 29.

49 They are referring to *kāyakaḻpa*, a major subfield of Siddha medicine which teaches techniques for the prolongation of life.

And elsewhere she states:

"If our body is healthy only, we can do, with the help of this body only we can do service to the society […]. We will become part of god in future. That is the main thing of the Siddhars." (Anbarasi, 6.1.2015)

4.2.4 Motivation for the Practice

The fourth dominant theme in the fashioning of traditional Siddha medicine that I wish to highlight revolves around the question of the motivation for carrying out this medical practice. All my interlocutors express the view that a main characteristic of the hereditary Siddha practitioner is that he or she is not driven by entrepreneurial motives but rather practices Siddha medicine out of a sense of duty. They all present themselves as working for the preservation of Siddha medicine, which they describe as their duty towards humanity and their tradition. Devanesan, for example, speaks of it being his duty to protect Siddha medicine from disappearing, and Avalok states that he makes great efforts to share his knowledge with other traditional physicians in order to preserve it. Prem Nath too describes his Siddha medical activities as a duty, an idea he connects with the supposedly divine nature of the medicine. He states that Siddha medicine was "developed for human beings" and that he therefore wants to turn the secretly kept knowledge into "a public property" and make it accessible to the people (31.12.2014). He states that this is a duty which was given to him by god:

"Without the grace of god and master, we cannot do it [practice the medicine]; if god opens a gateway to the system, we have to enter it, realize it, not for you, but for your people." (Prem Nath, 31.12.2014)

Anbarasi equates duty with karma: "Definitely, it is a duty, it is karma" (6.1.2015), and she goes on to say that she does her Siddha medical work out of a sense of karma, without any financial motivation. Four of my interlocutors express the view that executing a (divine) duty should not be a means of making money. Prem Nath, for example, states that there "cannot be a business motivation; money is wrong motivation," and elsewhere he says that "healing is not […] for money. It has a divine, a divine source, a divine vision" ((31.12.2014). And finally, my interlocutors contrast their non-

entrepreneurial motivations with the motivations of the college-trained Siddha practitioners, which they unanimously describe as being financial in nature. Devanesan says, for example: "The modern way is, it is a commercial way, you know, [it is] business" (5.2.2015). In my interlocutors' view, the quintessential materialization of the commercialization of Siddha medicine is the pharmaceutical companies that are competing for money. Anbarasi states:

"Another big company is INCOPS, a government company in Chennai. But the INCOPS medicine, they are making them for commercial purpose. They are supplying all primary health centers all over Tamil Nadu. […] But they are going commercial. Myself, we are not commercial; our medicine should act well […], so we are concentrating on the quality of the medicine." (Anbarasi, 6.1.2015)

While my interlocutors describe the college-trained practitioner and pharmaceutical companies as prioritizing economic profit over quality, they fashion themselves as giving the utmost importance to quality and as having no interest in financial profit.

5 SEMANTIC POSITIONING IN A STRATEGIC ACTION FIELD

5.1 Positioned Semantics

The finding of the similarities and overlaps in my interlocutors' accounts could be interpreted in different ways, such as mere coincidence, the result of the particular interview situation, or the reproduction of a dominant discursive strand. The finding could also be viewed as an expression of the shared structural constraints within which the accounts are constructed, which indeed is the interpretation I suggest applying. I will argue for this interpretation on the basis of Bourdieu's proposition that

"[…] social space is so constructed that agents who occupy similar or neighboring positions are placed in similar conditions and subjected to similar conditionings, and therefore have every chance of having similar dispositions and interests, and thus of producing practices that are themselves similar." (Bourdieu 1989: 17)

Accordingly, I adopt the position that my interlocutors internalize their structural conditions and enact them in their practices, thus producing similar semantic patterns which become apparent in their accounts. This Bourdieuesque stance that the individual is socially constituted does not imply that the individual does not "possess the necessary properties" to structure the field him- or herself (Bourdieu/Wacquant 1992: 107). According to Bourdieu, the individual is both socially structured by the field and also actively structures the field.[50] I go with this proposition in so far as I do not consider my interlocutors as mere "epiphenomena of structures" (Honneth et al. 1986: 41), nor regard their semantic construction of the figure of the hereditary Siddha practitioner as an act of tacit reproduction of what the objective structures allow to be articulated. Rather, I suggest that my interlocutors recognize and reproduce symbols of authority in their self-fashioning while also consciously reconfiguring them, at least partially, that is, within the structuring framework of their social position. I understand their self-fashioning in this sense as "regulated improvisations" (Bourdieu 1990: 59), a term which interweaves the embodiment of objective structures with human agency.

What are these symbols of authority, and how are they reconfigured in my interlocutors' accounts? The most dominant symbol of authority is science and biomedicine. As I have already mentioned, the professionalization of Siddha medicine meant the adaptation of the Siddha medical tradition to the biomedical paradigm and the introduction of the secular, scientific rationale as the yardstick of its validity. Clearly, my interlocutors recognize the biomedical paradigm. The majority of them frame Siddha medicine as a science; they speak of the efficacy of their drugs, provide catalogues with treatments and medication to their patients, and use a biomedical vocabulary to describe diseases. However, they also interweave a religious semantics with the scientific semantics and in doing so reconfigure the notion of science. In their accounts Siddha medicine is not just a science, it is a divine science, a science, moreover, with absolute validity and completeness, a science that has not been invented by mortal scientists but was discovered by the siddhars.

And what are the structural conditions to which the fashioning of the figure of the hereditary Siddha practitioner is subjected? As has hopefully

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50 Kaldewey (2015: 104) uses the term "co-construction" to describe the relationship between the subject's habitus and the social field.

become clear in the preceding sections, I argue that the semantic figure of the hereditary Siddha practitioner emerged as a reaction to the professionalization of Siddha medicine. The specific fashioning of this figure can be read as an expression of their perceived struggle to preserve and disseminate their knowledge and practice with the authority of which it has been deprived in the process of the professionalization of Siddha medicine. As I stated above, the professionalization of Siddha medicine induced, at least normatively, a standardization of the medical system. This led to the creation of a more homogenized version of Siddha medicine and to the delegitimization of certain forms of knowledge and practice. I argue that it is my interlocutors' experience of the marginalization of their knowledge which leads them to formulate narratives that confront the dominant version of Siddha medicine. Thus, their accounts can be read as alternative narratives that on the one hand recognize the scientific paradigm, yet on the other hand interweave a religious semantics with the scientific semantics, producing counterhegemonic accounts as a result.

So why, one might ask, do religious semantics and tradition figure so prominently in these counterhegemonic accounts? Generally speaking, interpretative social scientists are wary of asking for explanations because they carry an air of positivism and determinism at worst and provide a reductionist analysis at best (Charmaz 2006: 126). Nevertheless, I will point to one possible explanation for the distinct delineation of the hereditary Siddha practitioner in my interlocutors' accounts. I suggest that the rhetoric of religion and tradition is particularly effective as a symbolic resource because the college version of Siddha medicine prioritizes a scientific over a religious logic and uses a secular, scientific rationale as the yardstick for its validity, or to put it more generally, because the professionalization of Siddha medicine entailed a secularization of the Siddha system. The government's recognition of Siddha medicine as an Indian medicine and its integration into the AYUSH ministry alongside other medical systems—and not, for example, into the Ministry of Culture—happened alongside its "scientification." By emphasizing religious elements in the depiction of the "real" Siddha medicine, my interlocutors accentuate exactly those elements that are absent from their constitutive outside. Furthermore, the college version of Siddha medicine is not guarded by a religious authority but by a secularized medical profession. The representatives of the college version of Siddha medicine do not appear as religious experts, but rather as medical experts who are close to the

biomedical profession and not to any religious group or community. Hence, the representatives of the college version of Siddha medicine are not interested in participating in a religious discourse and therefore do not pose a challenge to my interlocutors' religious strategy: the medical authority will not question my interlocutors' religious semantics or confront it with an alternative religious interpretation, which makes it a powerful strategy. Finally, reference to religion, whether by emphasizing its divine provenance, stressing the sacredness of the knowledge or introducing concepts such as *jīvaṉmukti*, grants my interlocutors a degree of stability and independence which they would not acquire if they were trying to authorize their knowledge by obtaining the backing of other medical entities such as the WHO or medical research institutes. Reference to religion is unproblematic and is favored because religion appears as an independent entity. This is particularly true of the Hindu religion, which is the source of my interlocutors' claims to legitimacy: there is no higher or centralized religious authority in the Hindu religion which could challenge my interlocutors' narratives, and the religious figures they draw on are the gurus, the siddhars and Śiva, who, however, are both absent and invisible.[51]

5.2 Competition for Power

Shmuel Eisenstadt states concisely that processes of institutionalization entail "the creation and definition of norms to regulate the major units of social behavior and organization," as well as the "criteria according to which the flow of resources is regulated between such units, and sanctions to ensure that such norms are upheld" (1964: 235f). It is hardly surprising that the creation, definition, and sanctioning of norms involves struggles over power because these practices set standards which marginalize and exclude certain actors. The present section deals with these power struggles.

What is meant by power and power struggles? A social field in the Bourdieusque relational view is a "*field of struggle*" (Bourdieu/Wacquant 1992: 101, emphasis in the original) in which the actors strive to maintain or improve their relative positions. The relationship between different positions is structured on the basis of the distribution of the power that is valid within a particular social field (ibid: 97). Possessing power encompasses the authority

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51 For a discussion of the role of the guru in Hinduism, cp. Mlecko 1982.

to grant or refuse access to resources and to decide about the inclusion of people in and their exclusion from "the game". Bourdieu speaks here of "symbolic power" (1989: 22), that is, the "power of 'world-making'" (ibid: 22). It is this struggle for symbolic power that is at stake in the accounts of my interlocutors, the struggle over the power to formulate criteria of legitimacy, competence, and validity. Bourdieu equates power metaphorically with capital, a concept that he extends from material to intangible resources. He argues that the unequal distribution of capital structures the arrangement in the field and that the possession of power coincides with the possession of capital (Bourdieu/Wacquant 1992: 97). Bourdieu identifies four key types of capital, the four "fundamental powers" (1989: 17) of economic, cultural, social, and symbolic capital, which are relationally linked to the concepts of field and habitus in his theoretical framework. Capital is field-specific, meaning that the different types of capital become effective in different fields. "Fields designate arenas," as Swartz paraphrases Bourdieu's stance, "where specific forms of capital are produced, invested, exchanged, and accumulated" (1996: 78). I want to argue that it is the production, investment, exchange, and accumulation of cultural capital that is at stake in the present case of the Siddha medical field.[52] In his numerous writings, Bourdieu uses the concept of cultural capital in different ways, giving it a polysemic character. Yet, broadly speaking, it can be described as a concept that pinpoints cultural resources as the basis for social inclusion and a means to improve one's social position. Swartz (1996: 75–76) states: "His point is to suggest that culture in the broadest sense of the term) can become a power resource." According to Bourdieu, cultural capital appears in three different types. It exists in an incorporated form, that is, in the form of embodied knowledge, of cultivated dispositions, or the habitus which a person has acquired (Bourdieu 1992: 55). Secondly, it exists in an objectified form, that is, in the form of material goods which make cultural capital materially transmittable (Bourdieu 1992: 59). Finally, it exists in an institutionalized form, that is, in

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52 In the eyes of Bourdieu, application of the term "cultural capital" might appear inappropriate here because he uses the term to denote signals which stem from the dominant culture. However, I am using the term to denote not that their cultural capital reflects the "*répertoire* of high status cultural signals" (Lamont and Lareau 1988:161, emphasis in the original), but that they have competence in the repertoire of "marginal high status signals" (ibid: 157).

educational credentials which sanction the incorporated capital (Bourdieu 1992: 61). Thus, cultural capital, unlike economic capital, does not follow an economic rationale and does not generate an economic profit in the first instance, but a symbolic value. The symbolic value is typically expressed in official nominations such as titles, recognized qualifications, and certifications which generate prestige, honor, or recognition (Bourdieu 1989: 21).

If we analyze the accounts of my interlocutors under these conditions, we see that Siddha medicine appears as cultural capital in their accounts, yet that they create an alternative version of cultural capital to the dominant form. In my interlocutors' discursive reality, the embodiment of knowledge generates prestige, honor, or recognition, yet it is not the accumulation of college knowledge but the accumulation of hereditary, traditional Siddha knowledge. The latter knowledge finds expression in an objectified form, in material objects which are not college books but old manuscripts. And the hereditary Siddha medicine appears as institutionalized cultural capital, not in the form of college diplomas attesting to college training, but in the form of membership of a *gurukula* which sanctions their claim to possess the "real" Siddha knowledge. The elements which act in my interlocutors' accounts as cultural capital correspond to those elements which are excluded from the college version of Siddha medicine. My interlocutors' alternative cultural capital is knowledge which is not tied to a modern educational institution, but to traditionally authoritative persons and lineages. My interlocutors refuse to acknowledge the capital of the college institution and construct instead the hereditary knowledge that is not certified by a BSMS as an alternative capital. This alternative capital serves them as a resource for the power with which they strive to improve their position in the field.

5.3 Strategic Semantics

I suggest conceptualizing the semantic construction of the figure of the hereditary Siddha practitioner as the expression of a strategy in a social field. Bourdieu's term "strategy" is far from being a voluntaristic and subjective pursuit of unrestricted freedom in a deliberate improvisation. Swartz (1996: 76) states concisely: "Bourdieu's actors pursue strategies but not as conscious maximizers of limited means to achieve desired ends." A strategy is

tied to the game in which it is played out and connotes "a feel for the game" (Lamaison/Bourdieu 1986: 111).[53]

Examining my interlocutors' accounts, I suggest that they pursue a strategy of heresy and that they speak from the semantic position of the challenger. Moreover, I suggest that they position themselves in opposition to the college-educated practitioner, who figures as the incumbent in the social field. The analytical distinction between the challenger and the incumbent has been introduced by Fligstein and McAdam (2012) in their analysis of the workings of strategic action fields, which is their own conceptual development of Bourdieu's concept of field.[54] They argue that strategic action fields are sites of constant rearrangements: "In short, we expect strategic action fields to always be in some sort of flux, as the process of contention is ongoing and the threats to an order always present to some degree." (Fligstein/McAdam 2012: 13) Responsible for this flux are the two figures of the challenger and incumbent, which (together with the governance units) compose a strategic action field.[55] Incumbents are the actors "who wield disproportionate influence within a field and whose interests and views tend to be heavily reflected in the dominant organization of the strategic action field" (ibid: 13). It is the incumbents' interests which structure the field. Challengers, on the other hand, occupy a less influential position within the field. According to Fligstein and McAdam, challengers "recognize the nature of the

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53 With this stance, Bourdieu distinguishes his own concepts from rational action theory and stresses that actors' choices are tacit and dispositional and are determined by their socialization and the opportunities and constraints provided by the field in which they act.

54 Fligstein and McAdam define a strategic action field as a "constructed mesolevel social order in which actors (who can be individual or collective) are attuned to and interact with one another on the basis of shared (which is not to say consensual) understandings about the purposes of the field, relationships to others in the field (including who has power and why), and the rules governing legitimate action in the field" (2012: 9).

55 The analytical distinction between incumbent and challenger can be traced back to Bourdieu's differentiation between conservation strategy and strategy of heresy (1993: 73). According to Bourdieu, conservation strategies are followed by the orthodox, those who aim at the consolidation of the social order, whereas strategies of heresy are pursued by the heterodox, those whose aim is its subversion.

field and the dominant logic of incumbent actors," but formulate an alternative version of the social field and their position within it (ibid: 13).

I argue that the circumstances generated by the professionalization of Siddha medicine lead my interlocutors to articulate an alternative version of the social order to secure for themselves a position in the social field. In this alternative version, they disparage the knowledge of the college-trained practitioner as corrupted, whereas they assess their own knowledge as being of divine provenance and hence flawless. They claim that they learnt the "real" Siddha medicine from practitioners who stand in a lineage of hereditary Siddha physicians who trace their origin ultimately back to the siddhars. Clearly, my interlocutors' semantic strategy does not aim at consolidating the social order. On the contrary, they try to reframe the social order in a way that is profitable to them. In this sense, I argue that their self-fashioning as hereditary Siddha practitioners and their devaluation of the latter's knowledge is to be interpreted as attempts to attain a different status in the social field. Their claim to belong to a lineage of hereditary Siddha physicians and the distinct stylization of traditional Siddha knowledge serve them as weapons with which to counter the dominant position in the field and the dominant narrative. My interlocutors need a "weapon" in order to maintain and bring into the present their understanding of Siddha medicine, in which lineage is an integral part. Only if the element of lineage is accepted as a relevant feature of the medical tradition can my interlocutors survive and thrive.

6 CONCLUSION

From my interlocutors' point of view, the recognition of the Siddha medical system by the Indian government and its integration into the public health sector does not favor the medicine's preservation, nor does it have an empowering effect on Siddha practitioners. On the contrary, they argue that it has corrupted the divine medicine. Furthermore, they argue that recent developments have undermined their authority and restricted them in their agency, subjecting them to a multitude of regulations. This is a common assessment made by my interlocutors, who fashion themselves as hereditary Siddha practitioners. However, from an analytical perspective it can be argued that it was precisely the formal professionalization of Siddha medicine that created the conditions under which the semantic figure of the hereditary

Siddha practitioner could emerge. The conditions created by the profession-alization of Siddha medicine allow Siddha practitioners like my interlocutors to position themselves in relation to college-trained practitioners and to fashion their self-image in opposition to them. The figure of the hereditary practitioner thus appears as a counterpoint to the college-trained practitioner. Though the hereditary practitioner opposes the college-educated practitioner, they stand in a symbiotic relationship. It is only in this opposition that the religious semantics becomes effective and the figure of the hereditary Siddha practitioner becomes meaningful. Though the heterodox strategy of the challenger and the orthodox strategy of the incumbent are two distinct strategies, they need to be seen as mutually constitutive: "Orthodoxies," as Swartz puts it (1996: 80), "call into existence their heterodox reversals by the logic of distinction that operates in cultural fields." Obviously, this argument does not aim to make the dread expressed by my interlocutors less real or less valid. However, it does deconstruct their accounts as discursive strategies and reminds us of their historical contingency. The argument stresses that the semantic construction of the hereditary Siddha practitioner aims at reconsti-tuting the epistemic hierarchies. Accordingly, I propose that the hereditary Siddha practitioner be conceptualized as following a strategy of heresy or the strategy of a challenger, both of which aim to improve the challenger's social position in the field. Moreover, I suggest their narratives, which give space to religion and emphasize tradition, should be read as a mode of cultural pro-duction through which they attempt to attain a different status in the social field. The adoption of a religious semantics and the emphasis on tradition become effective in this strategy because my interlocutors position them-selves in opposition to an "other" who lacks those very qualities.

BIBLIOGRAPHY

Arnold, David (2000): The New Cambridge History of India: Science, Tech-nology and Medicine in Colonial India, Cambridge: Cambridge University Press.

Bala, Poonam (2007): Medicine and Medical Policies in India: Social and Historical Perspectives, Lanham: Lexington Books.

Bernard, Russell H (2011): Research Methods in Anthropology: Qualitative and Quantitative Approaches. 5th edn., Lanham: AltaMira Press.

Bourdieu, Pierre (1989): "Social Space and Symbolic Power", in: Sociological Theory (7/1), pp. 14–25. doi:10.2307/202060.

Bourdieu, Pierre (1990): The Logic of Practice, Stanford: Stanford University Press.

Bourdieu, Pierre (1992): Die verborgenen Mechanismen der Macht (=Schriften zu Politik & Kultur, Volume 1), Hamburg: VSA-Verlag.

Bourdieu, Pierre (1993): Sozialer Sinn: Kritik der theoretischen Vernunft, Frankfurt am Main: Suhrkamp.

Bourdieu, Pierre/Wacquant, Loïc J.D. (1992): An Invitation to Reflexive Sociology, 1st edn., Chicago: The University of Chicago Press.

Brass, Paul (1972): "The Politics of Ayurvedic Education: A Case Study of Revivalism and Modernization in India", in: Susanne Hoeber Rudolph/Lloyd I. Rudolph (eds.), Education and Politics in India: Studies in Organization, Society and Policy, Cambridge MA: Harvard University Press, pp. 342–371.

Broman, Thomas (1995): "Rethinking Professionalization: Theory, Practice, and Professional Ideology in Eighteenth-Century German Medicine", in: The Journal of Modern History (67/4), pp. 835–872.

Broom, Alex/Assa Doron/Philip Tovey (2009): "The Inequalities of Medical Pluralism: Hierarchies of Health, the Politics of Tradition and the Economies of Care in Indian Oncology", in: Social Science & Medicine (69/5), pp. 698–706.

Charmaz, Kathy (2006): Constructing Grounded Theory: A Practical Guide through Qualitative Analysis, London: Sage.

Daniel, Valentine (1984): "The Pulse as an Icon in Siddha Medicine", in: Contribution to Asian Studies (18), pp.15–26.

Dumit, Joseph (2010): "A Digital Image of the Category of the Person", in: Byron J. Good/Michael M.J. Fischer/Sarah S. Willen/Mary-Jo DelVecchio Good (eds.), A Reader in Medical Anthropology: Theoretical Trajectories, Emergent Realities, Oxford: Wiley-Blackwell, pp. 367–376.

Eisenstadt, Shmuel N. (1964): "Institutionalization and Change", in: American Sociological Review (29/2), pp. 235–247. doi:10.2307/2092126.

Engler, Steven (2003). "'Science' vs. 'Religion' in Classical Ayurveda", in: Numen (50/4), pp. 416–463.

Fischer-Tiné, Harald (2013): Pidgin-Knowledge: Wissen und Kolonialismus, Zurich: Diaphanes.

Fligstein, Neil/Doug McAdam (2012): A Theory of Fields, New York: Oxford University Press.

Gamson, William A. (1985): "Goffman's Legacy to Political Sociology", in: Theory and Society (14/5), pp. 605–622.

Glaser, Barney G. (1978): Theoretical Sensitivity: Advances in the Methodology of Grounded Theory, Mill Valley: Sociology Press.

Goffman, Erving (1974): Frame Analysis: An Essay on the Organization of Experience, Cambridge: Harvard University Press.

Habib, S. Irfan/Dhruv Raina (2005): "Reinventing Traditional Medicine: Method, Institutional Change, and the Manufacture of Drugs and Medication in Late Colonial India", in: Joseph Alter (ed.), Asian Medicine and Globalization (Encounters with Asia), Philadelphia: University of Pennsylvania Press, pp. 67–77.

Hall, Stuart (2003): "Introduction: Who Needs 'Identity'?", in: Stuart Hall/Paul Du Gay (eds.), Questions of Cultural Identity, London: Sage, pp. 1–17.

Hardiman, David (2009): "Indian Medical Indigeneity: From Nationalist Assertion to the Global Market", in: *Social History* (34/3), pp. 263–283.

Hausman, Gary (1996): Siddhars, Alchemy and the Abyss of Tradition: 'Traditional' Tamil Medical Knowledge in 'Modern' Practice. PhD dissertation, University of Michigan.

Honneth, Axel/Kocyba, Hermann/Schwibs, Bernd (1986): "The Struggle for Symbolic Order: An Interview with Pierre Bourdieu", in: Theory, Culture & Society (3/3), pp. 35–51. doi:10.1177/026327686003003005.

Jansen, Eva (2016): Naturopathy in South India: Clinics between Professionalization and Empowerment. (=Sir Henry Wellcome Asian Series), Leiden: Brill.

Kaldewey, David (2015): "Tacit Knowledge in a Differentiated Society", in: Frank Adloff (ed.), Revealing Tacit Knowledge: Embodiment and Explication, Bielefeld: transcript, pp. 87–112.

Krishnamurthy, K. H./Mouli, Chandra (1984): "Siddha System of Medicine: A Historical Appraisal", in: Indian Journal of History of Science (19/1), pp. 43–53.

Kuckartz, Udo (1991): "Ideal Types or Empirical Types: The Case of Max Weber's Empirical Research", in: Bulletin of Sociological Methodology/Bulletin de Méthodologie Sociologique (32/1), pp. 44–53.

Laclau, Ernesto (1995): "Subject of Politics, Politics of the Subject", in: Differences: A Journal of Feminist Cultural Studies (7/1), pp. 146–164.

Lamaison, Pierre/Bourdieu, Pierre (1986): "From Rules to Strategies: An Interview with Pierre Bourdieu", in: Cultural Anthropology (1/1), pp. 110–120.

Lamont, Michèle/Lareau, Annette (1988): "Cultural Capital: Allusions, Gaps and Glissandos in Recent Theoretical Developments", in: Sociological Theory (6/2), pp. 153–168. doi:10.2307/202113.

Lamont, Michèle/Lareau, Annette/Molnár, Virág (2002): "The Study of Boundaries in the Social Sciences", in: Annual Review of Sociology (28/1), pp. 167–195. doi:10.1146/annurev.soc.28.110601.141107.

Langford, Jean M (2002): Fluent Bodies: Ayurvedic Remedies for Postcolonial Imbalance, Durham: Duke University Press.

Last, Murray (1996): "The Professionalization of Indigenous Healers", in: Carolyn Fishel Sargent and Thomas M. Johnson (eds.), Handbook of Medical Anthropology: Contemporary Theory and Method, revised edn., Westport: Greenwood Press, pp. 374–395.

Leslie, Charles (ed.) (1976): Asian Medical Systems: A Comparative Study, Berkeley: University of California Press.

Mlecko, Joel D (1982): "The Guru in Hindu Tradition", in: Numen (29/1), pp. 33–61. doi:10.1163/156852782X00132.

Naraindas, Harish/Quack, Johannes/Sax, William S. (eds.) (2014). Asymmetrical Conversations: Contestations, Circumventions, and the Blurring of Therapeutic Boundaries, 1st edn., New York: Berghahn Books.

Payyappallimana, Unnikrishnan/Hariramamurthi, Govindaswamy (2012): "Local Health Practitioners in India: Resilience, Revitalisation and Reintegration", in: V. Sujatha/Leena Abraham (eds.), Medical Pluralism in Contemporary India, New Delhi: Orient Blackswan, pp. 279–304.

Priya, Ritu (2012): "AYUSH and Public Health: Democratic Pluralism and the Quality of Health Services", in: V. Sujatha/Leena Abraham (eds.), Medical Pluralism in Contemporary India, New Delhi: Orient Blackswan, pp. 103–129.

Ranganathan, Aruna (2013): "Professionalization and Market Closure: The Case of Plumbing in India", in: ILR Review (66/4), pp. 902–932.

Schlehe, Judith (2003): "Qualitative ethnographische Interviewformen", in: Bettina Beer (ed.), Methoden und Techniken der Feldforschung, Berlin: Reimer, pp. 71–93.

Sébastia, Brigitte (2012a): "Competing for Medical Space: Traditional Practitioners in the Transmission and Promotion of Siddha Medicine", in: V. Sujatha/Leena Abraham (eds.), Medical Pluralism in Contemporary India, New Delhi: Orient Blackswan, pp. 165–185.

Sébastia, Brigitte (2012b): Governmental Institutions vs. Associations: The Multifaceted Expression of Siddha Medicine in Tamil Nadu. Article qui sera publié dans un ouvrage collectif, pp. 1–17. <halshs-00408677>

Sieler, Roman (2014): "Patient Agency Revisited: 'Healing the Hidden' in South India", in: Medical Anthropology Quarterly (28/3), pp. 323–341. doi: 10.1111/maq.12067.

Sieler, Roman (2015): Lethal Spots, Vital Secrets: Medicine and Martial Arts in South India, New York: Oxford University Press.

Sujatha, V. (2011). "Innovation Within and Between Traditions: Dilemma of Traditional Medicine in Contemporary India", in: Science, Technology & Society (16/2), pp.191–213. doi:10.1177/097172181001600204.

Sujatha, V./Abraham, Leena (2009): "Medicine, State and Society", in: Economic and Political Weekly (44/16), pp. 35–43.

Swartz, David (1996): "Bridging the Study of Culture and Religion: Pierre Bourdieu's Political Economy of Symbolic Power", in: Sociology of Religion (57/1), pp. 71–85.

Venkatraman, Ramaswamy (1990): A History of the Tamil Siddha Cult, Madurai: Ennes Publications.

Weiss, Richard (2005): "The Autonomy of Tradition: Creating Space for Indian Medicine", in: Steven Engler/Gregory Price Grieve (eds.), Historicizing 'Tradition' in the Study of Religion (Religion and Society), Berlin: Walter de Gruyter, pp. 175–194.

Weiss, Richard (2008): "Divorcing Ayurveda: Siddha Medicine and the Quest for Uniqueness", in: Dagmar Wujastyk/Frederick Smith (eds.), Modern and Global Ayurveda: Pluralism and Paradigms, New York: State University of New York Press, pp. 77–99.

Weiss, Richard (2009): Recipes for Immortality: Medicine, Religion, and Community in South India, Oxford: Oxford University Press.

White, David Gordon (1996): The Alchemical Body: Siddha Traditions in Medieval India, Chicago: The University of Chicago Press.

Wujastyk, Dagmar/Smith, Frederick M. (eds.) (2008): Modern and Global Ayurveda: Pluralism and Paradigms, Albany: State University of New York Press.

Zvelebil, Kamil (1973): The Poets of the Powers, London: Rider.
Zvelebil, Kamil (1974): Tamil Literature, Wiesbaden : Otto Harrassowitz.
Zvelebil, Kamil (1996): Siddha Quest for Immortality, Oxford: Red Wheel Weiser.

LINKS

http://agasthiyarsiddhaayurveda.com/aboutus.html, June 2, 2017.
http://www.ccimindia.org/siddha-syllabus.php, July 10, 2016.
http://www.devavidya.com/siddhavaidyam.html, June 29, 2016.
http://www.devavidya.com/siddhatraining.html, September 29, 2016.
http://www.devavidya.com/management.html, September 29, 2016.
http://www.devavidya.com/about.html, September 29, 2016.
http://www.devavidya.com/vision.html, September 29, 2016.
http://www.siddhavaidyam.com/Origin_of_SiddhaMedicine.html, August 18, 2017.
http://www.siddhavaidyam.com/Principles_of_SiddhaMedicine.html, August 18, 2017.
http://www.siddhavaidyam.com/siddhavaidyam.html, August 18, 2017.

Ayurveda and Discursive Formations between Religion, Medicine and Embodiment

A Case Study from Germany

Antony George Pattathu

ABSTRACT

This article examines the discursive formations of Ayurveda as a healing practice that is entangled between religion and medicine, along with its potential for religious embodiment. Looking at the historical development of Ayurveda in Germany and its treatment by different academic disciplines, the article addresses the positions of Ayurveda practitioners in relation to religion and medicine, showing how this affects them and the potential for religious embodiment in the interactions and relationship between practitioner and patient. In this regard, the doctrine of the Doshas in Ayurveda plays a crucial role in its representation as the epitome of holistic healing. It will be shown that the notion of religious embodiment and the positions of the practitioners are constantly involved in processes of negotiation correlated with flexibility of positioning within the discursive field constituted by Ayurveda, religion, and medicine.[1]

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1 INTRODUCTION

In Germany, Ayurveda is one of the fastest growing healing practices in the field of complementary and alternative medicine or CAM.[2] Based on the Indian cultural context and its historical development, Ayurveda is often linked to spirituality or religion in the study of religious approaches and debates (cp. Koch 2005a; Knoblauch 2009; Lüddeckens 2018). In particular, Ayurveda's connection with New-Age influences and questions regarding the authenticity of its practice have been discussed (cp. Otten 1996; Reddy 2000; Zimmermann 1992; Zysk 2001). Accordingly, studies have been published in the disciplines of religious studies, anthropology, sociology and medicine addressing the discursive field constituted by Ayurveda, religion, and medicine (cp. Chopra 2008; Engler 2003; Langford 2002; Warrier 2008, 2011).

The increase in alternative healing practices[3] has to be understood as a reaction to transformations and reforms in health-care systems (Frank 2004: 32; Lüddeckens 2012: 288). The historical dissemination of the doctrine of the separation of mind and body (Cartesian dualism) within biomedicine[4] has created a need for alternatives on the market. CAM therapies, with their holistic conceptions, fill this gap and are becoming increasingly attractive (Kaiser 2001: 16). With this development as a backdrop, we can observe the

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2   The World Health Organization (WHO) defines CAM as follows: "The terms 'complementary medicine' or 'alternative medicine' are used interchangeably with traditional medicine in some countries. They refer to a broad set of health care practices that are not part of that country's own tradition and are not integrated into the dominant health care system." This is consistent with Cant and Sharma, for whom CAM can also be understood as "forms of healing that depend on knowledge bases distinct from that of biomedicine and which, as such, do not share the special legitimation that the state has conferred upon biomedicine" (1999: 5). The term itself is one of the problems that CAMs face.

3   Cp. Lüddeckens in this volume.

4   Here the word "biomedicine" refers to the dominant form of medicine that is dispersed globally and that in Germany is designated as *Schulmedizin*. This term is used in medical anthropology to refer to biological and pathophysiological perspectives on the human body and to emphasize the normative and technological implications that are inscribed into biomedicine's history and development. For an overview of this discussion, cp. Lock and Nguyen 2010.

boundaries between religion and medicine shift. Territories that formerly fell mainly within the scope of medicine have increasingly been addressed by religion and vice versa (cp. Lüddeckens 2012). These shifting boundaries are influenced by the historical development of both categories in the context of "scientific authority, capitalist commodification of medicine, and colonialism and postcolonialism" (Klassen 2017: 403). This also affects the self-understanding of practitioners in both fields, and there is an increasing boom in religious therapeutics (Fields 2001: 2; Kaiser 2001; Koch 2005a: 24).

Ayurveda is entangled exactly within this field of shifting boundaries between religion and medicine, as it caters to the need for an alternative to the biomedical system that goes beyond the separation of mind and body. This entanglement is inscribed into the holistic healing approach of Ayurveda that is rooted in the doctrine of the Doshas.[5] This doctrine has the potential for religious embodiment within Ayurveda and locates it in the discursive field constituted by Ayurveda, religion, and medicine.[6]

Here religious embodiment is understood as a process that is negotiated between the practitioner, the patient, and their surroundings. In this process the body becomes the medium between the inner and outer worlds and oscillates between processes of subjective perception and objectification (cp.

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5   Discussion of the meaning of the Doshas forms a discourse in its own right within Ayurveda, with different positions and philological interpretations (Heckmann 2003: 35; Mittwede 1998: 89–91). In relation to the ethnographic research described in section 2 below, I will provide an explanation of the Doshas based on a German Ayurveda textbook that is linked to practitioners in this field. According to this textbook the Doshas can be understood as forms of energy that constitute and guide the body's physical and psychological processes. In their materiality the different Doshas of Vata, Pitta and Kapha are based on the elements of earth, water, fire, air and ether. They can be found in different parts of the body in different concentrations and are characterized by different qualities (e.g. Vata has the quality of movement). Depending on whether the Doshas are in balance or not, they can cause different illnesses or can cure. They can be affected by medicines, nutrition and behavior (Heckmann 2003: 35–40).

6   This discursive field, which is addressed in this study with regard to the possibilities for religious embodiment in the healing practices of Ayurveda, is conceptually based on an approach to discourse influenced by Michael Bergunder (2008: 491, 2011: 19), Stuart Hall (2011), and Judith Butler (1997, 1999).

Csordas 1990; Schüler 2015; Klinkhammer/Tolksdorf 2015). The experiences of patients and practitioners, the aesthetic setting, their preconceived imaginations, and their knowledge of Ayurveda are the prerequisites for this process.[7]

Genealogically the article will trace positionalities in the field in the light of historical developments. This will be done to decipher the ways in which Ayurveda is constructed, articulated, and performed by the actors in the field, rather than looking at the origins of Ayurveda to determine whether it is religion or medicine. According to Butler (1999: xxix), "genealogy investigates the political stakes in designating as an origin and cause those identity categories that are in fact the effects of institutions, practices, discourses with multiple and diffuse points of origin. The task of this inquiry is to center on—and decenter—such defining institutions." Which attributes and characteristics are ascribed to Ayurveda by different authorities in the field? What does this mean for practitioners who position themselves in relation to religion and medicine, and how does this enable or prevent religious embodiment within Ayurveda?

With regard to different authorities or actors in the field, connections between academic statements on Ayurveda and the emic perspective must be examined because they determine the positions of the practitioners. The question of religious embodiment in Ayurveda is connected to the self-understandings of its practitioners,[8] who convey their own understandings of Ayurveda to their patients and enable or restrict practices that can be perceived as a form of religious embodiment. Given the specific historical context of Ayurveda in Germany, certain academic positions on whether Ayurveda is religion or medicine, taken together with the perspectives of its practitioners, will reveal interferences between Ayurveda and religious

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7 The conceptual framework of this article and the material available only allow a few examples to be provided of a form of religious embodiment in Ayurveda rooted in different conceptions of Ayurveda by different practitioners, the emic perspective of its patients and the actors in this discursive field.

8 The terminology practitioner is specifically chosen to grasp the wide spectrum and diversity of Ayurveda practitioners. Compared to terminologies like therapist or healer the whole range of practitioners from medical doctors to nutritionists can be integrated and the terminology also integrates the possibility of multiple qualifications, as the following paragraphs will show.

embodiment. This will help us map a first layer of the relevant discursive networks and structures in both the academic and the emic perspective in relation to Ayurveda and religion in Germany.

The different conceptualizations of Ayurveda by practitioners, academics, journalists, and other authorities in the field, who constitute a discourse community, can be understood as a discursive network held together through communication, language, practices, and the institutionalization of Ayurveda, religion, and medicine in Germany. These articulations and conceptualizations of Ayurveda as a form of "identity marker" in the sense of Michael Bergunder and Stuart Hall[9] take place in different discursive fields (media, science, law, politics, etc.). The different fields constantly overlap, and different authorities can be active within different fields. As part of these networks and its field of discourse, Ayurveda can be also understood either as spiritual or religious, or as a form of spirituality negotiated by agents in the field.[10] In this context, the discursive elements that condition the potential for religious embodiment within Ayurveda will be addressed.

On the basis of fieldwork conducted in 2009, the aim of this article is to map the discursive field constituted by Ayurveda, religion, and medicine, and to illustrate the circumstances that make religious embodiment possible for the patient. The practitioners' point of view will be helpful in understanding how positionings between religion and medicine take place in the German health-care market and how these positionings are influenced by academic discourses. In the following especially, the initial consultation and the interaction and relationship between practitioner and patient will provide access points for the discussion.

2 ETHNOGRAPHIC RESEARCH

The point of departure for this article is ethnographic research consisting of three months of fieldwork carried out between December 2008 and February 2009 and based on the anthropological method of participant observation and

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9 Identity in this sense is always contested and negotiated (Bergunder 2008: 492)

10 As will be shown, the focus on this discursive field is very much influenced by existing academic studies and media representations (Bergunder 2011: 44–45).

semi-narrative interviews with Ayurveda practitioners inspired by grounded theory.[11] The study was also based on an analysis of media representations of these practitioners and their institutions in the form of advertising brochures, webpages, newspaper articles, and both academic and non-academic publications by the interviewees. As part of the study, different Ayurvedic facilities in southern Germany have been visited, among them private clinics and hospitals, health centers, and the practices of *Heilpraktiker* (alternative practitioners). The study explicitly tried to capture the broad range of Ayurveda practitioners, which other studies often reduce to a specific status group, such as medical doctors (MDs).[12]

The duration of the participant observation varied from three to four days to half a day. The interviews were conducted in this period, as well as a number of informal conversations and interviews with staff and patients. Nine practitioners in particular form the core of the study, among them two *Heilpraktiker*, two Bachelors of Ayurvedic Medicines and Surgery (BAMS),[13] and five medical doctors. Two of the MDs were female and three male, all the other practitioners being male. The aim of the ethnographic research was to describe the different forms of Ayurveda practices and to identify the positioning of Ayurveda practitioners within the German healthcare system. Questions regarding career development, therapeutic measures, and motivation formed part of the interviews. Already here the question of the

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11 The ethnography is the result of cooperation with Prof. Harish Naraindas from JNU in Delhi and would not have been possible without his support. I would also like to thank Prof. Gabriele Alex, who made this cooperation possible. The interviews conducted for this research were held in English, many of which contain linguistic errors that have been retained in the quoted passages to provide an authentic impression of the interview situation. The names of the interview partners have been changed to protect their identities.

12 For example, Robert Frank only takes medical doctors into account in his work: see his "Globalisierung alternativer Medizin: Homöopathie und Ayurveda in Indien und Deutschland" (Frank 2004: 200).

13 The title "BAMS" is given to students within the Ayurveda college system in India, being based on a study program lasting five to six years which is increasingly integrated with and adapted to the biomedical curriculum (Langford 2002: 130; Welch 2008: 129).

relationship of their particular Ayurveda practices to religious influences and medicine formed part of the interview schedule.

It should be mentioned that the focus on religious embodiment in this article requires a long-term and thorough study of practitioner-patient inter-actions and consultations. Lacking this, the article can only provide initial insights into the potential for religious embodiment based on an analysis of the discursive field and the perspectives and practices of some Ayurveda practitioners.

3 THE HISTORICAL DEVELOPMENT OF AYURVEDA IN GERMANY

The historical development of Ayurveda in Germany already gives the first indications of the relationship of Ayurveda to religion. As in Suzanne New-combe's description of the development of Ayurveda in England, only media representations and initial processes of institutionalization can be found in the evidence for the historical development of Ayurveda in Germany (2008: 257). The following descriptions of this development must be understood as a sketch that can only give a rough idea of its course. At the beginning stands the founding of the Deutsche Gesellschaft für Ayurveda in Osnabrück in 1983 as the first association of Ayurveda practitioners in Germany. The first Maharishi Ayurveda health center was also founded in Osnabruck (Frank 2004: 198).[14]

Already in 1980 Maharishi Mahesh Yogi[15] was invited to a conference in Delhi, where he announced the worldwide dissemination of Ayurveda and

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14 Examples of other associations that have been founded since then and acquired an influence over the development of an Ayurveda practitioner's network in Ger-many are the European Professional Association of Ayurveda-Practitioners and Therapists (VEAT) and the German Doctors Association for Ayurveda Medicine (Deutsche Ärztegesellschaft für Ayurveda-Medizin, DÄGAM).

15 Maharishi Mahesh Yogi (1911–2008) was an Indian physics graduate who stud-ied at the Sankaracarya Jyotir Math with Brahmananda Saraswati (1869–1953) and was introduced to the teachings of the Advaita Vedanta. He was the founder of the technique of transcendental meditation and came to fame as the guru of certain celebrities such as the Beatles and Mia Farrow (Knott 2006: 634).

the revitalization of the Vedic sciences (Jeannotat 2008: 300). The founding of the Deutsche Gesellschaft für Ayurveda, which is connected to the German Academy of Ayurveda, has to be understood in context of the Maharishi movement, even though this connection has become weaker, especially since the Maharishi's death.

The Association is registered as such and claims to be an independent and autonomous association of experts in which Ayurvedic medicine is not bound to any particular school.[16] The explicit reference to Maharishi Ayurveda as a seal of quality supported by the All India Ayurvedic Congress can be found in a special section on its webpage, where the Association also cautions against facilities that lack standardized forms of quality management.[17] Here we can observe how the exclusion of non-standardized Ayurveda practitioners is used as a marketing strategy in media representations that at the same time lend credence to the Maharishi Ayurveda label. Not only is Maharishi Ayurveda a registered trademark (™) that offers a whole range of products, the Maharishi Ayurveda system is itself a franchise that represents one of its first tangible processes of institutionalization in Germany (Humes 2008: 309–310). Maharishi Ayurveda has played a similar role in the institutional development of Ayurveda in England (Newcombe 2008: 257) and North America (Reddy 2000: 5).

In the 1980s and 1990s Maharishi Ayurveda represented the most complex networks within the German Ayurveda landscape. With own products, its private clinics and health centers played an important part in the popularization of Ayurveda (Jeannotat 2008: 303). The movement also caused a lot of criticism because it combined Ayurveda with transcendental meditation (TM),[18] as the following excerpt from the German news magazine *Der Spiegel* shows:

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16 Cp. http://www.ayurveda.de/index.php/gesellschaft-die-nr-1-in-europa/historie, July 10, 2018.

17 Cp. http://www.ayurveda.de/index.php/gesellschaft-die-nr-1-in-europa/maharishi-ayurveda, July 10, 2018.

18 Kim Knott defines TM as follows: "[T]ranscendental meditation is a technique for mental and physical well-being and rejuvenation which, for some committed meditators, leads on to programmes for higher spiritual development (e.g. sidhi yoga), alternative medicine (ayurveda), and Vedic astrology" (2006: 634–635).

"Ayurveda, the ancient Indian medical system, is a mega trend in the wellness sector. The German market is dominated by disciples of his holiness the Indian guru Maharishi Mahesh Yogi. With costly treatments, his holiness markets his transcendental meditation and abstruse world salvation theories." (Schwertfeger 2004, author's translation)

This short media representation points to the fact that this aspect of the development of Ayurveda in Germany through the Maharishi Movement attracted criticism.

The ethnographic research for this article also revealed other strands in the historical development of Ayurveda in Germany that ran in parallel to the institutionalized development of the Maharishi Movement. Individual practitioners who began their training in India in the 1980s and 1990s or earlier and who migrated from there to Germany to practice Ayurveda characterize these trends. This was the case for the two BAMS practitioners who feature in the ethnographic research. The public visibility of Ayurveda practitioners and institutions that are not part of the Maharishi Network has increased over the last years. One example of this is the European Academy of Ayurveda, which was founded by Kerstin and Mark Rosenberg in Birstein in 1993 and is led by both (Rosenberg 2012: 63). They offer a broad variety of training programs and have been able to initiate a program for Ayurveda consultants (*Ayurveda Fachberater*) that is certified by the Saarland Chamber of Commerce and Industry (IHK). In addition, they offer a master's degree for medical doctors and medically qualified employees in cooperation with Middlesex University in the UK.[19]

This article can merely point out some of the highlights of the historical development of Ayurveda in Germany. This development must be thoroughly researched to obtain a deeper understanding of the current situation, but a comprehensive history of Ayurveda in Germany providing a genealogy that reveals the breaks and continuities in the historically dominant narratives remains a research aim. Hopefully, however, this brief genealogical sketch will give an idea of the dominant forces and processes of institutionalization in the field and of the insights into public perceptions of this development.

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19 Cp. https://www.ayurveda-akademie.org/das-kompetenzzentrum-fuer-ayurveda-und-yoga/studieren-an-der-akademie/internationales-netzwerk/, July 10, 2018.

The tendencies that are visible in the development of Ayurveda in Germany have nevertheless been framed conceptually by Anne Koch in order to provide a deeper understanding of the current situation. With reference to Michael Stausberg, Koch takes into account the reaction of science[20] to the historical development, media representations, and different meanings of Ayurveda (2005a: 26). Taking this as a premise, she distinguishes three phases in the development of Ayurveda, which she describes as (a) homogenization, (b) popularization and (c) diversification.

(a) The fact that Ayurveda is perceived as a homogeneous object in her descriptions is the result of the translations and receptions of different academic works and concepts of Ayurveda by different scholars. Through their own academic work, these scholars have played their own part in the canonization and standardization of Ayurveda, and it is this that Koch describes as homogenization. In this context the reform and modernization of the Indian Ayurveda landscape has played a role in its existence in Germany, but German discussions of the relationship of Ayurveda to religion and medicine cannot be deduced from the Indian context (Koch 2005a: 27).

(b) The popularization of Ayurveda is characterized by a number of different factors. Here important roles have been played by institutionalization processes and new writings, as well as by individual practitioners who act as multipliers for the propagation of Ayurveda. Special attention in this phase is given to the history of the New Age Movement,[21] which Koch mentions with reference to the scholar of religious studies, Christoph Bochinger, especially pointing out the mixture of secular and religious elements within the movement in relation to ecology and holism. This development and the mixture of New Age and Ayurveda will be given special attention in the next section. The popularization of Ayurveda can be related to the growth in medical pluralism within the German health-care market, which can be understood as a reaction to changes in the health-care system and the "religious

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20 In this contribution, the word "science" refers to branches of science and the scholars who have dealt intensively with the practice and theory of Ayurveda, primarily indologists, anthropologists, sociologists, medical practitioners, and public health and religious studies scholars.

21 For the discussion about New Age and the different approaches of conceptualization within the Study of Religion, cp. Bergunder 2008, Bochinger 1994, Hanegraaff 1996 and Heelas 1996, 2008.

field."[22] The rise in CAM therapies can be also attributed to these developments, as this emerging medical pluralism serves as a kind of catalyst for the popularization of Ayurveda in Germany. This also has the effect that some of the practitioners who feature in the ethnographic research have offered not only Ayurveda but a broad variety of CAM therapies (Koch 2005a: 28–30).

(c) This kind of combination of Ayurvedic practices with other therapies and the introduction of Ayurvedic principles into other areas for commercial purposes can be understood as part of what Koch describes as Ayurveda's diversification, which at the same time is closely linked to its popularization. Diversification is the third phase in the development of Ayurveda in Germany for Koch, which she dates to the 1990s. A special characteristic of this period is Ayurveda's intensified institutionalization and the sort of marketing strategies that can be observed with the Maharishi Movement. Representations of Ayurveda on the web and marketing strategies selling Ayurveda as wellness or cosmetics are also characteristic of this stage. At this point it is the legal aspects of practicing Ayurveda and legitimizing it that come to the fore (Koch 2005a: 30).

Koch's conceptual frame, taken together with the examples from the ethnographic study, provides a first access point for a better understanding of the historical development of Ayurveda in Germany, even though an adequate study is still missing. In this sense the three phases form a heuristic tool with which to describe processes that have taken place diachronically but that also exist in parallel to the current situation of Ayurveda in Germany.

In the following section, the discursive field constituted by Ayurveda, religion, and medicine will be mapped by the statements of scholars from sociology, Indology, religious studies and medicine. The reaction of science in the field that Koch describes will be deciphered in detail to show how Ayurveda has become an "identity marker" that is negotiated around religion and medicine. It will be also shown how these positionings enable the potential for religious embodiment as an aspect of therapy.

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22 Koch uses the terminology of the "religious field" with reference to Pierre Bourdieu (2006, 60–61)

4 THE DISCURSIVE FIELD CONSTITUTED BY AYURVEDA, RELIGION, AND MEDICINE IN GERMANY

To map the discursive field constituted by Ayurveda, religion, and medicine in Germany, different positionings must be taken into account. In the previous section, Ayurveda's historical development in Germany was described in order to form a background for some of the positions in this discourse. Examining different academic positions within this field of discourse will demonstrate the normative impact, both implicit and direct, that these evaluations and conceptualizations have on the self-positionings of Ayurveda practitioners within the field. In some cases, practitioners' voices cannot be sufficiently taken into account unless they are actually spoken to. For example, Anne Koch and Dorothea Lüddeckens analyze media representations of Ayurveda (cp. Koch 2005a; Lüddeckens 2018), while Zysk provides a general diagnostic of the situation of Ayurveda (cp. 2001).

In this section I would like to contrast their observations with the results of my own ethnographic research, which addressed the level of the practitioners and practitioner-patient interactions in order to discuss the relationship of Ayurveda to religion, medicine, and the potential for religious embodiment.[23] Academic positions, media, practitioners, and patients are important factors in mapping the field within which Ayurveda is characterized as medicine, as spiritual or religious, or as religion. In order to consider these positionings critically, I will examine a few arguments in the academic field to show how Ayurveda is often construed as the "other" of religion.[24]

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23 This article is very much part of the discourse that is discussed here and it has a normative effect in itself. Contrary to other articles in the field the trajectory here is to integrate the opposing positions to capture the plurality of Ayurveda and discuss the possibilities of a religious embodiment instead of locating Ayurveda on the side of religion or medicine.

24 This can be illustrated by the following quote: "Hence, Ayurveda is able to cover important life spheres in a spiritual or world-view like manner, which are not covered in Christianity" (Koch 2005b: 253, author's translation). By contrasting Ayurveda directly with Christianity in this way without taking the multiplicity of non-religious positions on Ayurveda into consideration, Ayurveda automatically becomes the "other" of religion.

One of the schools of Ayurveda that is clearly characterized by strong religious connotations is Maharishi Ayurveda, already mentioned in the previous section. First and foremost, this characterization is due the connection with transcendental meditation that formed part of the world view of Maharishi Mahesh Yogi and that is still propagated by his followers. In his teachings, Ayurveda is only one of the Vedic sciences that are being revitalized. Another is Gandharva Veda, a specific form of Vedic music that is used to accompany some of the treatments of Maharishi practitioners, as was observed in the ethnographic research. Listening to this music is said to enable a direct connection to transcendental consciousness.[25] In this strand of Ayurveda, these techniques form part of an even broader spectrum of the religious techniques of the Maharishi movement.[26]

The movement is one of the examples used by the Indologist Kenneth Gregory Zysk to describe Ayurveda in the West[27] as "New Age Ayurveda". Zysk uses this terminology to describe the current phase in the history of Indian medicine, which for him is characterized by the importation of Indian medicine into the West. Criticism of biomedicine and Cartesian dualism from within the New Age Movement was correlated with the development of the "Holistic Health Movement,"[28] the link that enables Zysk to talk about

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25 "Gandharva music is the eternal melody of Nature which is ever-lively in Transcendental Consciousness. From there it reverberates and constructs different levels of creation. Gandharva Veda is the basis of all order and harmony in Nature, therefore is [sic!] has that most harmonizing, most integrating influence" (cp. http://gandharva-veda.com/page4.htm, July 10, 2018.)

26 For a discussion and an overview of the techniques in the Maharishi movement, cp. Jeannotat 2008: 285–307.

27 The terminology "west" here is set in quotation marks to emphasize the pejorative history of the terminology and undifferentiated dichotomy that is implied in its use. My own understanding of "west" is in accordance with Talal Asad's: "There is in my view the west, but I think it is best regarded neither as a geographical place nor as a self-contained civilization, but as a hegemonic project, global in scope." (2006: lecture).

28 Hanegraff (1996) sees the concepts of holism, mildness and the harmonization and integration of body and mind as central aspects of "holistic medicine" arising out of the Holistic Health Movement. Like the latter, holistic medicine has the goal of healing the person as a whole. In this constellation, every individual is

New Age Ayurveda (2001: 13). He frames this concept as follows: "The most recent manifestation of Ayurveda is found in the Western world. It combines the spiritual and ideological elements of the New Age Movement with an ancient Indian medical tradition to produce New Age Ayurveda" (ibid.: 26). In this way Zysk implicitly gives Ayurveda a religious characterization and creates an antagonism between what he perceives as authentic Ayurveda in India and his concept of New Age Ayurveda in the West (ibid.).[29] Using his description of what authentic Ayurveda is, Zysk replicates the opposing forces of the field, thus supporting the emic authenticity discourse of its practitioners in Germany and India, instead of describing the discourse and multiplicity of Ayurvedic practices and trying to understand why and how this authenticity is claimed to work.[30] The phrase "New Age Ayurveda" also has a stereotyping effect and excludes the highly politicized discussion over religion and spirituality among the community of practitioners (Warrier 2011: 87). The aim of this article is to understand how specific truth claims within Ayurveda in relation to religion and medicine are construed within the field and how they stand in relation to the potential for religious embodiment (Langford 2002: 2). The critical reception of this categorization of New Age Ayurveda by practitioners is illustrated by the following quote:

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considered to be an interdependence of body, mind and emotions. The healing process involves all these aspects and goes even deeper, as the interdependence that constitutes the individual is itself constituted by the universe, and the healing process addresses precisely this inner connection and power. The power of the mind over the body is a crucial feature of this healing process and has the potential to heal, but at the same time it is a source of illness. The individual must understand the deeper meanings of the disease and hence become the center of treatment (Hanegraaff 1996: 53–55).

29 Wujastyk and Smith (2008) also apply the concept of "New Age Ayurveda" by referring to Zysk and describe it as one of three forms of "global Ayurveda" that have evolved outside the Indian context in different regions. In their conceptualization, "New Age Ayurveda" stands in opposition to the secularized Ayurveda that is practiced in India (2008: 2).

30 For a similar argument concerning the authenticity of Ayurveda in the West, cp. Otten 1996 and Zimmerman 1992. Both come to the conclusion that Ayurveda in the West is merely sold as a form of rehabilitation and wellness therapy, not as codified medical system.

"This Ayurvedic department is not a 'wellness center'; patients usually come here to treat or prevent diseases. It also must be stressed that Ayurveda, as it is understood here, is not a spiritual discipline, nor is it 'New Age Ayurveda.' […] Rather, it is a medical discipline in continuation of a centuries old tradition." (Chopra 2008: 244)

This positioning of the practitioner's field is that described by Ananda Samir Chopra,[31] a medical doctor and chief physician at the Habichtswald Klinik in Kassel. He explicitly positions himself, his facility, and his practice in opposition to Zysk's categorization. The economic situation and the marketing strategies of Ayurveda as a form of wellness are another source of opposition. In particular, the academic ascriptions that categorize Ayurveda as religious or spiritual reveal another facet of the discursive field that addresses the practice of Ayurveda in Germany. The efforts to legitimize Ayurveda as a medical system in Germany are fully evident in Chopra's statement.

The fact that in Germany, Ayurveda is inclined towards spirituality and religion is not only evident in respect of its historical development, is also validated in a recent study from the medical field by Kessler et al. (2013). The positioning of both practitioners and patients in relation to religion, spirituality, and medicine was assessed using a primarily quantitative approach. In total 140 people formed part of the evaluation cluster and were questioned by means of a questionnaire. Of those, 70 were practitioners and 70 were patients. It should be pointed out that 73% of all respondents viewed Ayurveda as a form of spirituality and only 11% as a religion, while 100% understood Ayurveda as a health science and 95% as a medical system (Kessler et al. 2013: 5). For the respondents Ayurveda therefore embodies aspects of spirituality, religion and science. However, it is the medical dimension of Ayurveda that comes first for them, and they do not exclude the possibility of combining it with biomedicine (ibid.: 6).

The arguments of Kessler et al. (2013) and Chopra (2008) make it clear that the connection with spirituality and religion requires further consideration in respect of practitioner-patient relations and the question of how religion and spirituality are dealt with in practice (cp. section 6).

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31 Chopra is an indologist and works on different projects at the intersection of medical anthropology and indology. His person also exemplifies the plurality of the discursive field, because he is active in different fields and has multiple qualifications.

In addition, the medical understanding of Ayurveda and its practice, as well as the self-positioning and understanding of Ayurveda practitioners, should be analyzed against the background of a health-care system that is dominated by biomedical agents and institutions, showing how this influences the field and its practitioners (cp. section 5).

These examples make it clear that academic ascriptions of Ayurveda in relation to religion and spirituality form part of the tensions arising in the positionings between religion and medicine and that they also influence the potential for religious embodiment. What is interesting in Zysk's contribution (2001) and Chopra's reaction (2008), as well as in the historical development of Ayurveda in Germany, is the connection of Ayurveda to the New Age Movement. Koch has already drawn attention to this, and Zysk also emphasizes it in connection with the Holistic Health Movement in support of his own conceptualization of Ayurveda. The medical sociologist Sita Reddy (2000) also shows this for North America, emphasizing that Ayurveda is increasingly framed as a form of holistic health care and arguing that this is an adaptation to the American context reflecting the influence of New Age movements. For her, this connection between Ayurveda and spirituality becomes a form of symbolic capital in the health-care market while at the same time being the pivotal point in the critiques of biomedicine made by Ayurvedic practitioners (2000: 5).

The aspect of "holism" and holistic healing is a crucial part of the Ayurveda "identity marker" as construed by academic discourse. This is also the case for Anne Koch's "web-ethnography" (2005a).[32] In her investigations of web representations of ten Ayurveda providers from 2004 she systematically analyzes the credibility, representation, language, and aesthetics of the Ayurveda offering. In doing so, she develops an aesthetic content cluster that

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32 Koch's publications elaborately cover different aspects of Ayurveda in Germany. She has worked on the representation of Ayurveda in cookbooks and religious codification in Ayurvedic nutrition (cp. Koch 2005b), the attractiveness of Ayurveda as an alternative healing system (cp. 2006), the ethical plausibility patterns of Ayurveda in the West, and the "formation of German Ayurvedas" examined on the basis of their presence on the web (cp. 2005a). In this contribution, the results of the web ethnography are referred to especially since they imply direct connections to the practitioners in the ethnographical research and the quoted words of A.S. Chopra.

exposes the semantic stereotypes of the web representation. Here the first six of eleven points are of importance regarding the discursive field constituted by Ayurveda, religion, and medicine in Germany:

"1. Authentication/standardization of the offer; 2. Origin and dating of Ayurveda, definition (e.g. health science, [natural] healing system, alternative medicine), possibly mentioning the earliest written sources; 3. Labeling of Ayurveda, mostly as gentle, individual, complementary, holistic; 4. Theory of the elements and tri-dosha teaching with balance; 5. Types of constitution; 6. Pathology: dosha, equilibrium theory." (Koch 2005a: 35–36, author's translation)[33]

These semantic stereotypes resonate with the findings of my own ethnographic research and are often mentioned in the positionings of the practitioners. The statement by Chopra quoted above is a further example that emphasizes this resonance through the definition, dating, and authentication of Ayurveda, which are important criteria for the positionings of those Ayurveda practitioners who want to frame Ayurveda as a medical discipline. The features of "mildness", "individual," and "holistic" reoccur in debates on authenticity and are used to condemn Ayurveda as practiced in the West as inauthentic (cp. footnote 26). After a qualitative description of the web pages and a compilation of the semantic stereotypes, Koch introduces her results with the following words: "We could observe the establishment of a federal German 'holistic religion.' Healing, categorization, meditation, and civilization-critical stress management all play roles within it" (Koch 2005a: 40, author's translation).[34] Characteristics drawn from the results of the analysis

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33 The other aspects of the semantic stereotypes are: "7. Highlighting the prevention and benefits of chronic diseases, lists of indication; 8. explanation of the treatment methods, especially Panchakarma; information on other included holistic procedures: yoga, meditation, color therapy, psychotherapy, conventional medicine etc.; 9. Nutrition; 10. Service: accommodation, costs, directions, price lists; 11. Disclaimer." (Koch 2005a: 36).

34 A localization of Ayurveda in the religious field is also carried out by Hubert Knoblauch: "An impressive example of the spiritual form of medicine is certainly Ayurveda, which has spread throughout Germany since the 1990s." (2009: 168). Knoblauch largely draws on the contributions by Anne Koch to locate Ayurveda in the field of popular religion.

are thus used to define Ayurveda as a specific form of religion based on "holism."

The different positions in the academic field in Germany have shown that the discourse marker "holism/holistic" repeatedly became the decisive criterion in locating Ayurveda in the religious field. The idea of holism as an aspect of the historical development of Ayurveda can be related to the arguments of authors like Zysk (2001), Reddy (2000), Koch (2005a, 2005b) and Lüddeckens (2018) that Ayurveda belongs to the New Age, as in the case of Maharishi Ayurveda. These arguments locating Ayurveda in the religious field can be verified through the understanding of practitioners and patients that Ayurveda is spiritual or a religion (cp. Kessler et al. 2013). However, these arguments and statements oppose the statements of Chopra and other practitioners while also hiding the aspect of the self-image of Ayurveda practitioners that locates them primarily in the realm of medicine.

The discursive field constituted by Ayurveda, religion, and medicine in Germany is characterized by diverse positions within the field. Media representations, academic positions, and practitioners' views support and/or contest each other, each presenting a conception of what the Ayurveda "identity marker" means by using different discourse markers. These positions—that is, Ayurveda as a religion based on semantic stereotypes (cp. Koch 2005a, 2005b), Ayurveda as a medical discipline based on tradition (cp. Chopra 2008; Kessler et al. 2013), and Ayurveda as spiritual through its connection to New Age movements and notions of holistic health (cp. Reddy 2000; Zysk 2001)—take part in constant processes of exchange. In particular, the efforts of practitioners to establish Ayurveda as a medical discipline in a biomedically dominated health-care system illustrate a basic hierarchical difference, as well as saying something about power relations between the different defining agents and institutions. This influences the positions of practitioners and their self-image, as well as their understandings of Ayurveda and how they represent and define it in the face of agents in the discursive field.

5 DISCURSIVE EXCHANGE PROCESSES

Based on the interview statements of the practitioners involved in my ethnographic research, this section will discuss their positions in relation to Ayurveda, biomedicine, and religion, as well as showing how these positions are characterized by different discursive processes of exchange. To understand the relationship between Ayurveda and religion in terms of the practitioners' self-conceptions and practices, one must first understand the relationship of Ayurveda to biomedicine. None of the practitioners referred to the relationship of Ayurveda to religion or spirituality as a primary discursive marker. Instead they saw Ayurveda as a CAM or a medical system, also stressing the explanation of Ayurveda as holistic, without necessarily pointing to any religious or spiritual dimension it might have.

Within a biomedically dominated health-care system, Ayurvedic practice is constantly being transformed and subjected to biomedical processes of adaptation, which can be observed in the translation of Ayurvedic principles into the biomedical system. These adaptations and translations are necessary in order to be able to practice Ayurveda within a biomedical health system.

On the official level, Ayurveda in Germany cannot be practiced as an officially recognized medical system like biomedicine in Germany or Ayurveda in India.[35]

For economic reasons, *Heilpraktiker*, physicians, and BAMS practitioners often have no other option than to balance between the dominant media representations and images of Ayurveda as wellness and its representation as an alternative healing method and then to imply their own understanding of Ayurveda, whether as purely medical or as connected with a spiritual practice, in their practice and in respect of practitioner-patient interactions. In recent years there has been an increase in statements in academic publishing by German practitioners positioning Ayurveda in the medical field and breaking up the tension in the field described above. The conception of Ayurveda as a "Whole Medical System" by Kessler and Michalsen (2012) provides an example of this.[36]

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35 For an outline of the historical process of the state recognition of Ayurveda in India, cp. Wujastyk and Smith 2008: 8–9.

36 "Whole medical systems are eo ipso complete and coherent systems of medical theory that have evolved, and continue evolving, in different regions, cultures and

If experts were to practice Ayurveda as a recognized medical system, a completely different corpus of laws would apply, and the administration of many Ayurvedic medicines would no longer be possible unless they fulfilled the requirements of the laws on medicines. BAMS Shulaji, one of my interviewees who is a senior Ayurvedic doctor at a center with thirty beds, emphasized that he is forced to register his facility as a business and that he has to label Ayurveda "wellness," even though he does not perceive his practice in any way as wellness. The status of Ayurveda in Germany leaves him in a legally gray area. When I asked him about the administration of Ayurvedic medicines in his institution, he replied:

"We give herbal teas. *Kashayam* [an Ayurvedic concoction] is actually a herbal medicine, but we are giving it as a tea. You know, here, everywhere there are loopholes. If you say *kashayam* is a medicine you are not allowed to use it. But if you declare it is a tea, you are allowed." (Shulaji, BAMS, 10.12.2008)

The clinical trials required to legitimize Ayurvedic medicines in accordance with German law are very costly, and often the financial resources are not available to perform pharmacological and clinical studies. These studies are slowly increasing in number, but they are still faced with the fundamental problem that the principles of Ayurveda have to be translated into a biomedical context.[37]

This shows that institutional influences (e.g. from the Federal Institute for Drugs and Medical Devices) on the discourse constituted by Ayurveda, religion, and medicine creates multiple processes of exchange, practices, and descriptions that provide the "identity marker" (e.g. Ayurveda as wellness, Ayurveda as religion, Ayurveda as a medical system). These descriptions and

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time periods around the globe, independently from modern western medicine […]. Here, the most well-known traditional Indian system of medicine, Ayurveda, can spearhead as pars pro toto for all others for a particular reason: on top of its inbound coherence it possesses an inherent outbound quality of openness to its surrounding realities." (Kessler/Michalsen 2012: 65) This definition and the related article clarify the efforts to legitimize Ayurveda and give it a firm and recognized place in the German health-care system.

37 For a similar situation integrating *kanpo* medicine as a form of "traditional medicine" into biomedicine in Japan, see Schrimpf, this volume.

attributions to Ayurveda are related to each other in a complex discursive network and influence each other. The relationship of Ayurveda to biomedicine is hegemonic and forces Ayurveda practitioners to define Ayurveda in a variety of ways. Therefore, none of the practitioners interviewed denied the reference to or the involvement of biomedicine, an expression of the discursive premise that biomedicine has to be integrated.

The positions of the practitioners and their representations of Ayurveda must in this sense be understood as multiple. Different dimensions of the practice reflect the situation and hierarchies within medical pluralism and the vexed relationship with religion. In this connection, the following statement by medical anthropologists Sarah Cant and Ursula Sharma on the situation of CAM therapies applies to the positioning of Ayurveda in the German health-care system:

"In as much as these forms have not been totally incorporated into biomedical practices and knowledge they do not share biomedicine's privileged relation to the state, though the precise nature and degree of their delegitimation varies from case to case and from country to country." (Cant and Sharma 1999: 6)

This also becomes evident at the practitioner level, as is clearly seen in the statement of Dr Tumar, an Ayurvedic practitioner and medical doctor: "Doctors of modern medicine tell me that I do not have a clue and because I do not have a clue, this is why I am using alternative medicine" (Dr Tumar, physician, 10.12.2008). Delegitimization is not only perpetrated by one's peers, as in the case of Dr Tumar, it also appears through the association with religion, that is, in practice. When asked about the role that religion plays in his practice, BAMS Shulaji answered as follows:

"No, we are not doing that, especially because we are Indians. We have our religion and our culture, but I don't want to implement that in this center with Indian meditation and everything. […] I say you can believe in whatever you believe God is. There is one energy, and I am born in a Hindu family. We have employees from the Muslim and Christian religion here, but we do only Ayurvedic treatment, nothing more. If you start and make some meditation and everything, the local publics will start and say: 'That is a sect'. […] We have to be careful […]." (Shulaji, BAMS 10.12.2008)

This statement by Shulaji expresses his concern about implementing religion in his practice without denying his own religious background. The associations he makes with meditation and his fear of being identified as a "sect" resonate with the historical development of Ayurveda in Germany and the practice of Maharishi Ayurveda, as depicted in *Der Spiegel*.[38] This is an example of one of the arguments in which the relationship of Ayurveda to religious embodiment is rejected, since religion is viewed as a de-legitimizing factor and a danger to the practice. The same applies to Chopra, quoted earlier, who does not situate his Ayurvedic institution and practice in the field of wellness or spirituality, but sees it as a medical discipline. Chopra's opposition reveals a clear strategy to legitimize Ayurveda as a medical discipline. To be publicly perceived as a secular medical discipline, the aspects of wellness and spirituality must be excluded.

With regard to the school of Maharishi Ayurveda, it is particularly interesting that the three participants in the ethnographic research who called themselves Maharishi Ayurveda practitioners have moved away from administering and combining transcendental meditation with their Ayurveda practice. One reason for this was the cost of the meditation courses. One of the doctors emphasized that, although she still indeed regularly advises on TM and recommends its effects to every patient, that is not a condition for therapeutic treatment, a position held by all three Maharishi practitioners.

However, one example of religious embodiment in Ayurveda is transcendental meditation. This is connected to a broader belief system in which the individual practice of the patient has an effect on the whole of humanity, affects the cosmos, and influences the Doshas (Newcombe 2008: 263). The positions of the practitioners presented so far show a clear aversion to directly combining Ayurveda and religion. Kessler et al.'s and Koch's studies, on the other hand, clearly stress the religious or spiritual aspects of Ayurveda. This was also the case for the practitioners in my ethnographic research when it comes to therapeutic measures and consultation.

However, it becomes clear that the answer to the question of whether Ayurveda has a religious aspect has to start with the practitioners' own positions and their economic and legal strategies. Here a political dimension is recognizable, as shown by the statements of BAMS Shulaji and the Maharishi practitioners in my ethnographic research, as well as by Chopra. Dr

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38 See the above quote from Schwertfeger 2004: 7.

Tumar mentioned that, in cases of doubt involving a particular colleague, she would conceal the religious connotations that Ayurveda has for her, seeing this aspect as crucial not for the scientific evaluation of Ayurveda, but for the relationship between practitioner and patient (Dr Tumar, physician, 10.12.2008).

The relationships between Ayurveda, religion, and medicine are more complex than the frequent situating of Ayurveda in the religious field suggests. Therefore, a thorough analysis of the practice, practitioner-patient relations, and the respective prevailing conditions should reveal how they influence the potential for religious embodiment.

Fundamentally, it should be remembered that the relationship between practitioner and patient has a foundation of trust in which the practitioners introduce their respective understandings of Ayurveda. The initial consultation and the teaching of the Doshas play a central role in both the individual treatment and the patients' understandings of Ayurveda, as well as in respect of religious embodiment into the therapy.

6 THE POTENTIAL OF RELIGIOUS EMBODIMENT IN AYURVEDA THERAPY

Consultations as a means of therapeutic practice in Ayurveda are particularly relevant to the question of how far certain elements of Ayurveda are considered religious in the context of treatment, as well as in understanding how they find their way into therapy. Neither the study by Kessler et al. (2013) nor the studies by Koch (2005a, 2005b), Lüddeckens (2018) or Zysk (2001) investigate how the relationship to religion and spirituality is dealt with on the level of practitioner-patient relations. This article can only provide an initial insight into the potential for religious embodiment based on the analysis of the discursive field and the perspectives and practices of certain practitioners of Ayurveda. The focus on religious embodiment would ideally require a long-term and thorough study of practitioner-patient interactions and the respective consultations.

Fundamental to the treatment, as all practitioners in my ethnographic research have stressed, is the initial consultation. It is on this occasion that the basics of Ayurvedic practice are explained in relation to the needs of the patient and that the patient's initial resistance to or sympathy for a "religious"

therapy becomes apparent. In many consultations and treatments, religion or spirituality are not directly addressed in relation to Ayurveda unless this is desired by the patient. This requires some flexibility on the part of the practitioner in dealing with the patients. Apparently, a religious interpretation of Ayurveda has to be understood as a process that can be established in the treatment depending on the preferences of both the patient and the practitioner. In addition, these initial consultations with practitioners are supported by lectures in their clinical institutions. In the case of private clinics these are public lectures, while in the context of smaller facilities they are tailored to the patients' interests.

The results presented in this article are based on interviews with practitioners. However, they highlight key elements of the consultations that enable religious embodiment.

Heilpraktiker Lutz, who runs a small private practice in which he also offers outpatient therapies, begins his consultation with questions relating to a patient's birth (e.g. the circumstances of the birth process) and his or her social and family relations. The antagonism to common biomedical consultations can be seen when the patients express their surprise at the fact that the practitioners want to hear their individual stories in more detail. This is a common experience shared by most practitioners, as BAMS Shulaji and other practitioners reported (Pattathu 2009: 62–77). Based on the initial consultation and the description of the Doshas, it is possible to show how religious embodiment may take place. It is a crucial factor that the depiction of the Doshas gives the patient the opportunity to become familiar and identify with the Ayurvedic categories. The following interview excerpt conveys how *Heilpraktiker* Lutz introduces the concept of Doshas in his consultations:

"The Doshas vata, pitta and kapha […] I describe for example vata as vayu (wind), its akasha (ether) and vayu. Wind and ether, I tell them, for example, vata is a very thin person, tall or small, and because of what? The wind is cooling, makes the people cold, wind is drying. If there is water it dries the water, it dries the skin, the eyes, the hair, some organs, the stool, and this main center of vata is the colon […] for example kapha is water and earth. If wind blows into the earth like in the desert, the sand is flying away, so you need some water to make a sandcastle. I tell them, if you do some castles at the seaside, sand alone is nothing, but you need the water and, well, also pitta. These elements, 20% water and mostly fire, it holds the temperature, it makes the metabolism." (Lutz, healing practitioner, 18.12.2008)

All practitioners refer to the Doshas as the main concept that constitutes the relationship between illness and health. The Doshas are described as part of the biological process and the physical nature of the body, but always in relation to the mental characteristics and traits of the person. They are based on a selection of the five elements of fire, water, earth, air / wind and space / ether, which are part of the nature of all substances and form an integral part of the Ayurvedic cosmology, as Lutz explained in the course of the interview. At the same time, he showed the applicability of the teaching of the Doshas to the environment. For example, wind as part of vata, having the property of drying, dries the skin and clarifies the relation of the Doshas to the body. This basic tenet of Ayurveda explains the role of the body as connecting the outside world of the patient with his or her inner world. Through the Doshas, which are based on the elements, the outside world affects the human body.

The Doshas are the central principles in Ayurvedic teachings and are what enables the identification of Ayurveda as "holistic." They are representative of the overcoming of the mind-body opposition, since every Dosha is understood both physically and mentally. For Zysk and Koch this aspect is a clear reference to the New Age or Holistic Health Movements, which place Ayurveda in the religious domain. The role of the elements with regard to notions of harmonization, balance, and relation to the cosmos is one reason why Koch categorizes Ayurveda as a form of religion.

These aspects are in fact the focal point of the potential for religious embodiment. Yet in order to see how religious embodiment takes place as a process of negotiation, the perspectives of the practitioners and patients must be taken into account. According to one of the Maharishi practitioners, the process of religious embodiment begins just through the setting of his clinic and the Vedic Gandharva music, which brings both his Doshas and those of his patients into balance. In this way practitioners and patients can feel, think, and identify with the elements and the Doshas, which, according to the religious views of the Maharishi, bring them into harmony with the cosmic order.

The patients can actively participate in the embodiment of Ayurveda, since they are guided by the practitioner's explanations and can re-consolidate their identity within the doctrine of the Doshas. The problem of the legitimacy of Ayurveda is rooted in a clash of two discursive premises, namely the biomedical and Ayurvedic perspectives, but this can be transformed into

a dialogue that is further developed in the practitioner-patient relationship. Some informal discussions with patients during the ethnographic research described just such a dialogue. According to them, their illnesses and personalities were recreated through the dialogue with the practitioners and their explanations.

In light of Judith Butler's conceptualization of speech, the illness of the patient, her identification with the disease, and her identity are all re-signified performatively through the terms of the Doshas. This resignification partly takes place in the communication between the practitioner and the patient, as well as in her own reflections and conversations about this process. Similarly, as the word "queer" is re-signified from a hurtful slur into a positive identity, the Doshas enable a positive identification for the patients (Butler 2006: 28).[39] Whereas from a biomedical perspective the body and in a sense the identity of the patient are conceptualized as "sick", that is, as pathological, this identity is re-evaluated in the communication between the Ayurveda practitioner and the patient. By means of the Dosha concept body and identity are re-consolidated, not as ill but as "out of balance". This process affects everyday life, since the Dosha teachings are linked to the patients' daily activities, for example, through dietetics.

The results of Christine Kupfer's thesis, "Caring for the Whole Self: How German Patients Use Ayurvedic Concepts" (2006), also describe everyday use of the Doshas by patients. Over a period of three weeks, she observed the therapy process of Ayurveda patients in an Ayurvedic clinic and interviewed twenty patients. She came to the conclusion that for many patients the Doshas represent one of the central building blocks in their conceptualization of Ayurveda. For the patients, the Doshas are a vehicle of self-empowerment[40]

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39 "More generally, then, this suggests that the changeable power of such terms marks a kind of discursive performativity that is not a discrete series of speech acts, but a ritual chain of resignifications whose origin and end remain unfixed and unfixable. In this sense, an "act" is not a momentary happening, but a certain nexus of temporal horizons, the condensation of an iterability that exceeds the moment it occasions. The possibility for a speech act to resignify a prior context depends, in part, upon the gap between the originating context or intention by which an utterance is animated and the effects it produces." (Butler 1997: 14).

40 With regard to self-empowerment in the context of alternative therapies, see Zeugin, Lüddeckens, Schrimpf and Lüddeckens in this volume.

that they can use to maintain their own individuality, autonomy, and decisions regarding their own self-care, as well as their healing process (Kupfer 2006: 110–114). Kupfer does not neglect the role of the practitioners' instructions in this regard. She explains how they support the patients and contribute to a better understanding of the concepts. She also stresses that through the Doshas patients become able to access Ayurveda on the basis of their previous knowledge and to confirm this knowledge with a new vocabulary associated with the Doshas (ibid: 72).

Especially at this level of individual trust and communication in the interaction between practitioner and patient, both the social circumstances of the patients and their possible reservations have to be taken into account. In this regard, the sensitive character of the practitioner-patient relationship requires great flexibility on the part of the former. Dr Tumar emphasized this point when it comes to linking Ayurveda to religion during consultations and therapy:

"So you can use it, and that is a very nice thing about Ayurveda, that, according to the level of your patient, you can stay on a functional level. But the more you realize the patient opens up to more, the more you can also kind of introduce terms like prana. You can introduce terms like chakra; you can show what the different chakras' energies are for. Whatever their 'thing' is. […] You have incredible options in Ayurveda. You can start with simple oils and herbs, […] the physical therapy, and you can go to the extremely subtle and extremely fine therapies, depending on what level the patient is ready to come with you." (Dr Tumar, physician, 10.12.2008)

This statement by Dr Tumar is central to the understanding of religious embodiment in Ayurvedic treatment, showing that the field of tension between religion and medicine requires a flexible and individual approach to religion in practice. The possibilities of Ayurveda being practiced on a functional level and of introducing religious or philosophical concepts prove the negotiable character of religious embodiment in Ayurveda.[41]

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41 This kind of flexibility is interpreted by Lüddeckens as a characteristic of CAM, seen as a "loosely coupled field." See Lüddeckens, this volume.

7 CONCLUSION

The positionings and voices of practitioners in a field that is characterized by a religious understanding of Ayurveda, and the interest in establishing Ayurveda as a recognized medical system, are central but also conflictual elements in the field of discourse that constitutes Ayurveda, religion, and medicine in Germany. Practitioners, patients, media presentations, and recipients' perspectives—in short, the entire discourse community involved in the articulation of Ayurveda—should be included in observations of this field. The construction of Ayurveda as a counterpart to religion in the sense of "New Age Ayurveda" (Zysk 2001) or as a "Federal German holistic religion" (Koch 2005a) represents a categorization that omits key aspects of the practice and conceptions of Ayurveda in the emic, popular, and scientific understandings of Ayurvedic practitioners and scholars.

Ayurveda has many spiritual and religious connotations, as is evident from the historical development of Ayurveda in Germany, in which the Maharishi movement has been a central player, as well as in the emic perspectives described in the study by Kessler et al. (2013).

The discursive approach using the perspectives of medical anthropology and religious studies showed on the one hand how practitioners position themselves within a biomedical field that is determined by a hegemonic relationship with biomedicine. On the other hand, it revealed how the different authorities in the field influence practitioners' positions through the distinctions they make between religion and medicine. I argue that Ayurveda is constituted and defined in multiple ways, which also determine the possibilities of religious embodiment.

Using the teachings about the Doshas as an example, it was possible in this article to show how they serve as a means to enable the patient to identify with a particular concept of Ayurveda and hence enable religious embodiment. The Doshas provide a way to re-define one's identity. If and how Ayurveda provides a religious connotation as an aspect of this identity depends on the respective patient and practitioner. Hence a flexible treatment of Ayurveda, whether on the medical level and/or on the religious level, is based in the procedural relationship between practitioner and patient.

The aim of this article has been to show how Ayurveda as a medical system is entangled with religion and biomedicine and to analyze how it offers the potential for religious embodiment, especially in the initial consultation

and the practitioner-patient relationship. The conditions for this religious embodiment are already determined by the ways in which practitioners position themselves in the German health-care market, and they require flexibility in their approach to Ayurveda, religion, and medicine.

The various positions in the discursive field constituted by Ayurveda, religion, and medicine, and the processes of negotiation that became obvious through the interviews and the ethnographic fieldwork, both revealed the potential for religious embodiment in theory and practice. The positionalities and power relations in the field require additional ethnographic research on practitioner-patient interactions and consultations. This will enable us to open up new perspectives that leave room for exploring the voices of those concerned in order to capture the complexities of Ayurveda in Germany.

BIBLIOGRAPHY

Asad, Talal (2006): Thinking about Blasphemy and Secular Criticism, Stanford University, lecture, 9 October 2006.

Bergunder, Michael (2008): "Was ist Esoterik? Religionswissenschaftliche Überlegungen zum Gegenstand der Esoterikforschung", in: Monika Neugebauer-Wölk (ed.), Aufklärung und Esoterik: Rezeption – Integration – Konfrontation, Tübingen: Niemeyer, pp. 477–507.

Bergunder, Michael (2011): "Was ist Religion? Kulturwissenschaftliche Überlegungen zum Gegenstand der Religionswissenschaft", in: Zeitschrift für Religionswissenschaft 19, pp. 3–55. doi:10.1515/zfr-2011-0001.

Bochinger, Christoph (1994): "New Age" und moderne Religion: Religionswissenschaftliche Analysen, Gütersloh: Kaiser.

Butler, Judith (1997) Excitable Speech: A Politics of the Performative, New York [etc.]: Routledge.

Butler, Judith (1999): Gender Trouble: Feminism and the Subversion of Identity, New York [etc.]: Routledge.

Butler, Judith (2006): Haß spricht: Zur Politik des Performativen, Frankfurt am Main: Suhrkamp.

Cant, Sarah/Sharma, Ursula (1999): A New Medical Pluralism? Alternative Medicine, Doctors, Patients and the State, London: UCL.

Chopra, Ananda Samir (2008): "Practicing Ayurveda in the Western World: A Case Study from Germany", in: Dagmar Wujastyk/Frederick M. Smith (eds.), Modern and Global Ayurveda: Pluralism and Paradigms, Albany: State University of New York Press, pp. 243–255.

Csordas, T. J. (1990): "Embodiment as a Paradigm for Anthropology", in: Ethos, 18(1), pp. 5–47.

Engler, Steven (2003): "'Science' vs. 'Religion' in Classical Ayurveda", in: Numen 50(4): 416–463.

Fields, Gregory (2001): Religious Therapeutics: Body and Health in Yoga, Ayurveda, and Tantra, Albany, NY: State University of New York Press.

Frank, Robert (2004): Globalisierung alternativer Medizin: Homöopathie und Ayurveda in Indien und Deutschland, Bielefeld: Transcript.

Hanegraaff, Wouter J. (1996): New Age Religion and Western Culture: Esotericism in the Mirror of Secular Thought, in: Studies in the History of Religions 72. Leiden [etc.]: Brill.

Heckmann, Jürgen (2003): "Die drei Körperbestandteile", in: Subhash Ranade/Christian Hosius/Jürgen Heckmann Ayurveda (eds.), Basislehrbuch, Munich [etc.]: Urban & Fischer, pp. 34–40.   '

Heelas, Paul (1996): The New Age Movement: The Celebration of the Self and the Sacralization of Modernity, Oxford [etc.]: Blackwell.

Heelas, Paul (2008), Spiritualities of Life: New Age Romanticism and Consumptive Capitalism. Oxford [etc.]: Blackwell.

Humes, Cynthia Ann (2008): "Maharishi Ayur-Veda: Perfect Health through Enlightened Marketing in America", in: Dagmar Wujastyk/Frederick M. Smith (eds.), Modern and Global Ayurveda: Pluralism and Paradigms, Albany: State University of New York Press, pp. 309–332.

Jeannotat, Françoise (2008): "Maharishi Ayur-Ved: A Controversial Model of Global Ayurveda", in: Dagmar Wujastyk/Frederick M. Smith (eds.), Modern and Global Ayurveda: Pluralism and Paradigms, Albany: State University of New York Press, pp. 285–308.

Kaiser, Peter (2001): Arzt und Guru: Die Suche nach dem richtigen Therapeuten in der Postmoderne, Marburg: Diagonal.

Kessler, Christian and Andreas Michalsen (2012): "The Role of Whole Medical Systems in Global Medicine", in: Forschende Komplementärmedizin 19(2), pp. 65–66. doi:10.1159/000338294.

Kessler, Christian et al. (2013): "Ayurveda: Between Religion, Spirituality, and Medicine", in: Evidence-Based Complementary and Alternative Medicine, pp. 1–11. doi:10.1155/2013/952432.

Klinkhammer, Gritt/Tolksdorf, Eva (eds.) (2015): Somatisierung des Religiösen: Empirische Studien zum rezenten religiösen Heilungs- und Therapiemarkt, Bremen: Universität Bremen.

Knoblauch, Hubert (2009): Populäre Religion: Auf dem Weg in eine spirituelle Gesellschaft, Frankfurt am Main: Campus.

Knott, Kim (2006): "Transcendental Meditation", in: Peter B. Clarke (ed.), Encyclopedia of New Religious Movements, London: Routledge, pp. 634–635.

Koch, Anne (2005a): "Spiritualisierung eines Heilwissens im lokalen religiösen Feld? Zur Formierung deutscher Ayurveden", in: Zeitschrift für Religionswissenschaft 13(1), pp. 21–44. doi:10.1515/zfr.2005.13.1.21.

Koch, Anne (2005b): "Zur religiösen Codierung moderner Ernährung: Ayurvedische Koch- und Ernährungsbücher als Lebensratgeber", in: Zeitschrift für Religions- und Geistesgeschichte 58(3), pp. 243–264. doi:10 . 1163 /1570073054396000.

Koch, Anne (2006): "Ayurveda: Zur Attraktivität eines alternativen Heilsystems", in: Verena Wetzstein (eds.), Was macht uns gesund? Heilung zwischen Medizin und Spiritualität, Freiburg: Herder, pp. 57–75.

Kupfer, Christine (2006): "Caring for the Whole Self: How German Patients Use Ayurvedic Concepts", Magisterarb. Heidelberg: Universität Heidelberg (not published).

Langford, Jean M. (2002), Fluent Bodies: Ayurvedic Remedies for Postcolonial Imbalance. Durham, NC and London: Duke University Press.

Lock, Margaret M./Nguyen, Vinh-Kim (2010): An Anthropology of Biomedicine, Oxford: Wiley-Blackwell.

Lüddeckens, Dorothea (2018): "'Imagined Origin': Ayurveda, Reiki und Traditionelle Chinesische Medizin", in: Martin Tulaszewski/Klaus Hock/Thomas Klie (eds.), Was heilt – Krankheitsdeutung zwischen Religion, Medizin und Heilkunde, Bielefeld: Transcript (forthcoming).

Mittwede, Martin (1998), Der Ayurveda: Von den Wurzeln zur Medizin heute, Haug.

Newcombe, Suzanne (2008): "Ayurvedic Medicine in Britain and the Epistemology of Practicing Medicine in 'Good Faith'", in: Dagmar Wujastyk/Frederick M. Smith (eds.), Modern and Global Ayurveda: Pluralism

and Paradigms, Albany: State University of New York Press, pp. 257–284.

Otten, Tina (1996): "Die sanfte Veränderung ayurvedischer Heilverfahren am Beispiel der Pancha Karma Kur", in: Angelika Wolf/Michael Stürzer (eds.), Die gesellschaftliche Konstruktion von Befindlichkeit: Ein Sammelband zur Medizinethnologie, Berlin: VWB, pp. 75–88.

Pattathu, Antony George (2009): "The Glocal German Ayurvedascape: A Case Study from South Germany", Magisterarbeit, Universität Heidelberg (not published).

Reddy, Sita (2000): "Reinventing Medical Traditions: The Professionalization of Ayurveda in Contemporary America", PhD thesis, Philadelphia, PA: University of Pennsylvania.

Rosenberg, Mark (2012): "The European Academy of Ayurveda: 20 Years of Ayurvedic Education in Germany", in: Ancient Science of Life 32(1), pp. 63–65. doi:10.4103/0257-7941.113797.

Schüler, Sebastian (2015): „Religion zwischen Kognition, Körper und kollektiver Dynamik: Versuch einer religionswissenschaftlichen Dialektik", in: Martin Radermacher/Judith Stande/Annette Wilke (eds.), 103 Jahre Religionswissenschaft in Münster. Verortungen in Raum und Zeit, Münster: Veröffentlichungen des Centrums für religionsbezogene Studien, pp. 227–247.

Schwertfeger, Bärbel (2004): Maharishi-Ayurveda: Die Wellness-Jünger Seiner Heiligkeit. Spiegel Online, http://www.spiegel.de/wissenschaft/ mensch / maharishi - ayurveda - die - wellness - juenger - seiner - heiligkeit-a-289737.html, accessed August 23, 2014.

Warrier, Maya (2008): "Seekership, Spirituality and Self-Discovery: Ayurveda Trainees in Britain", in: Asian Medicine 4(2), pp. 423–51.

Warrier, Maya (2011): "Modern Ayurveda in Transnational Context", in: Religion Compass 5(3), pp. 80–93. doi:10.1111/j.1749-8171.2011. 00264.x.

Welch, Claudia (2008): "An Overview of the Education and Practice of Global Ayurveda". in: Dagmar Wujastyk/Frederick M. Smith (eds.), Modern and Global Ayurveda: Pluralism and Paradigms, Albany: State University of New York Press, pp. 129–138.

Wujastyk, Dagmar/Smith, Frederick M. (2008): "Introduction". in: Dagmar Wujastyk/Frederick M. Smith (eds.), Modern and Global Ayurveda:

Pluralism and Paradigms, Albany: State University of New York Press, pp. 1–29.

Zimmermann, Francis (1992): "Gentle Purge: The Flower Power of Ayurveda", in: Charles Leslie/Allan Young (eds.), Paths to Asian Medical Knowledge, Berkeley, CA: University of California Press, pp. 209–223. doi:10.1525/california/9780520073173.003.0010.

Zysk, Kenneth Gregory (2001): "New Age Ayurveda or What Happens to Indian Medicine When it Comes to America", in: Traditional South Asian Medicine 6, pp. 10–26.

LINKS

http://www.ayurveda.de/index.php/gesellschaft-die-nr-1-in-europa/historie, July 10, 2018.

http://www.ayurveda.de/index.php/gesellschaft-die-nr-1-in-europa/maharishi-ayurveda, July 10, 2018.

https://www.ayurveda-akademie.org/das-kompetenzzentrum-fuer-ayurveda-und-yoga/studieren-an-der-akademie/internationales-netzwerk/, July 10, 2018.

Complementary and Alternative Medicine (CAM) as a Toolkit for Secular Health-Care

The De-differentiation of Religion and Medicine

Dorothea Lüddeckens

ABSTRACT

Complementary and Alternative Medicine (CAM) plays a crucial role in many contemporary societies. While biomedicine observes the social differentiation between medicine and religion, holistic healing systems integrate the two. After clarifying important terms, this article begins with a brief sketch of research on these topics. Referring to Ann Swidler's concept of the "tool kit," it suggests an explanation for the attractiveness of CAM to both patients and practitioners. Drawing on relevant studies and data from the author's qualitative study of palliative care, it argues that the attraction of CAM lies in its function as a tool kit that is not differentiated into medicine and religion but is characterized internally by being a loosely coupled field that offers a resource for self-empowerment.

1 INTRODUCTION

The use of complementary and alternative medicine (CAM) by the general population in many countries, such as the United States, the United Kingdom, Japan, and Switzerland, is substantial.[1] Indeed, CAM therapies are

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1   Surveys suggest that the use of CAM increased in the United States (Eisenberg et al. 1998) until around 2000 and that it has been more or less steady in several

practiced within the conventional health-care systems of modern western countries, as well as outside them. Referring to the United States, Kaptchuk and Eisenberg state that

"[...] substantial portions of the medical system have begun to seek reconciliation with alternative medicine. Managed care, insurance carriers, hospital providers, major academic medical centers, and individual MDs are increasingly receptive to developing new 'integrative' models of health care [...]" (2001: 193).

Similarly, Frisk (2013: 388) notes the "increasingly blurred borders between the medical mainstream and complementary and alternative therapies" in Sweden, while Wahlberg points out how "various CAM therapies come to be mainstreamed into national health delivery..." (2007: 2310) in the UK. The situation is similar in Switzerland, where a growing incorporation of CAM into both the academic educational system and public health care can be seen.[2] This "reconciliation" seems astonishing, given the in many respects successful struggle of biomedicine against what it sees as "heterodox" healing systems and actors. The evolution of modern biomedicine or so-called

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countries since then (Hunt et al. 2010: 1501). For further information, cp. Harris and Rees 2000, Yamashita et al. 2002, Wolf et al. 2006, Harris et al. 2012, Becker et al. 2010. One has to bear in mind that there is no uniform way to define CAM and operationalize its use. While some studies include, for example, prayer or dietary supplements, others do not (Hunt et al. 2010: 1501). Therefore, it is difficult to give accurate quantitative data about the popularity of CAM.

2   In 2009, 67 percent of Swiss voters supported a constitutional article on CAM (Federal constitution Art. 118a BV (new): "The Federal government and cantons shall ensure that, within the scope of their jurisdiction, complementary medicine is taken into consideration." Since at least 2012 CAM has slowly been integrated into the Swiss public health sector (https://www.bag.admin.ch/bag/de/home/themen/strategien-politik/nationale-gesundheitspolitik/stand-umsetzung-des-neuen-verfassungsartikels-zur-komplementaermedizin.html?_organization=317, 13 June 2017). Cp. also Martin and Debons 2015. On CAM's institutional integration into the Swiss academic educational system, cp., for instance, www.ikom.unibe.ch, May 18, 2017; www.iki.usz.ch, May 18, 2017; https://www.hes-so.ch/de/bachelor-osteopathie-3381.html, May 18, 2018; for Germany, cp., for example, Spielberg 2007.

conventional medicine during the nineteenth century, which was closely entangled with the development of public health-care systems, is linked not only to the struggle of "orthodoxy" against "heterodoxy,"[3] but also to the social process described as "differentiation" (cp. Luhmann 1984, 1995; Parsons 2001), including that between medicine as physical healing and religion as focusing on the metaphysical and transcendent aspects. As many healing practices and concepts belonging to CAM include such aspects, it is astonishing to see CAM becoming more and more established in institutionalized secular medical contexts. As I will argue below, I interpret this development as an indication of de-differentiation.

My aim in this article is to suggest an explanation for why, among other possible reasons, CAM is attractive in certain medical contexts by looking at the situation in Switzerland. In asking this question, I use Ann Swidler's concept of the "tool kit" (1986), outlining three specific traits that are consistent with many CAM therapies.[4] Before doing so, I will clarify the relevant terms and give a very brief introduction to the historical background of modern medicine and the process of social differentiation in Europe.

The theses presented in this article are backed up by empirical data derived from a Swiss research project on "Alternative Religion at the End of Life," as well as by related studies by other authors. We conducted this project with Rafael Walthert, Mirjam Mezger[5] and Barbara Zeugin in six health-care institutions in the German-speaking part of Switzerland from 2013 to 2016.[6] We carried out qualitative research in different kinds of hospital, a hospice and a nursing home for the elderly. Two of these institutions had a specific ideological background based in anthroposophy, but the others had none apart from the fact that they practiced biomedicine. In all six case studies, we carried out participant observation and conducted guided interviews with nurses (28), doctors (11), therapists (17), chaplains (11), and in most

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3 Cp., for example, Wahlberg 2007.

4 As this suggestion stems from a social-scientific position and reflects the non-normative perspective of the Study of Religion, the potential medical effects of CAM will not be discussed in this article.

5 Cp. Mezger 2018.

6 This project was conducted with the financial support of the Swiss National Foundation. Further information on this project and further results can be found at http://p3.snf.ch/project-139280.

cases with the patients (18) and other staff and volunteers as well. We analyzed the data based on the analytical background of grounded theory. The coding procedure was supported by Atlas ti.

2 A MINEFIELD OF TERMS

Kaptchuk and Eisenberg (2001: 189) called the taxonomy of contemporary unconventional healing practices a "linguistic minefield". Further minefields are the taxonomies of "conventional healing practices," "religion," and "spirituality." The use of these taxonomies is influenced by power struggles over legitimation and is profoundly linked to value judgements.

According to Ernst, the umbrella term "complementary and alternative medicine" (CAM) "refers to a diverse array of treatment modalities and diagnostic techniques that are not presently considered part of conventional/mainstream medicine and emphasize a holistic approach towards health care" (2008: 2). Kelner and Wellman[7] explain that the "concept of CAM" covers

"[…] a diverse set of healing practices, which do not normally fit under the scientific medical umbrella. Instead, these practices emphasize the uniqueness of each individual, integration of body, mind and spirit, the flow of energy as a source of healing, and disease as having dimensions beyond the purely biological. The life force is very commonly seen as a crucial element of the healing process and strong emphasis is placed on the environment, the subjective experience of patients, the healing power of nature, and health as a positive state of being." (2000: 5)

CAM therefore unites very different healing practices and hence inevitably leads to unjustifiable generalizations.[8] However, in this context, the term

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7   Kelner and Wellman are referring here to the perspectives of Howard S. Berliner and J. Warren Salmon, as well as Michael Goldstein.

8   On the terminology here, cp. Koch 2015; Ernst 2008:2–3. Similarly used terms are "heterodox medicine" and "holistic medicine."

"biomedicine" refers to the more or less consistent medical system that is restricted to the principles and academic knowledge of the natural sciences.[9]

I use the term "religion" as an etic term, including concepts and practices that practitioners may not refer to as "religion" but as "spirituality." This usage is similar to that of Wouter J. Hanegraaff (2000), who also uses religion as an umbrella term, but differentiates between "a religion" (institutionalized) and "a spirituality" (individual), both of them being "religion". Adapting Geertz, Hanegraaff defines "religion" as

"[…] any symbolic system which influences human action by providing possibilities for ritually maintaining contact between the everyday world and a more general meta-empirical framework of meaning" (2000: 295).

This perspective is compatible with Luhmann's notion of religion, who states that "communication is always […] religious when it observes immanence from the point of view of transcendence […]" (2002: 77).[10] In this sense, semantics can be called "religious" if something that is perceived as "immanent" is framed by something that is perceived as "transcendent" (Luhmann 1989: 313–316).

For various reasons I do not follow the emic distinction between "religion" and "spirituality," which is often used in a highly normative way: religion is seen as something institutionalized, which may be superficial, dogmatic, exclusive, and intolerant, or even dangerous and aggressive, while spirituality is seen as experience-based, private, "universal," and "wholesome".[11] These normative associations are often the reason why the respective terms are used or rejected by particular agents.[12] I wish to avoid the normativity of these distinctions by using "religion" as an umbrella term. This

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9   Other authors prefer terms such as "conventional," "allopathic," "orthodox," "Western," or "modern" medicine in this context.

10   English translation in Laermans/Verschraegen 2001: 15.

11   Cp. Sinclair et al. 2006: 475.

12   The right of religious freedom makes the label "religion" attractive to specific actors, while the aim of becoming integrated into secular systems, as for instance into secular schools or secular hospitals, can cause its rejection and replacement with the label "spirituality."

also allows me to take the continuity between phenomena labeled "religious" or "spiritual" into account.

Assuming a modern, Western, and Christian environment, in this paper, "alternative religion" is understood as a relative concept referring to a pool of practices and concepts that are not commonly seen as forming part of the traditional canon of Christianity in its institutionalized forms. Although they may even be more popular than traditional practices and concepts,[13] in the West they are seen as "alternative". This pool has no strict boundaries, and the respective practices and concepts—such as, for example, belief in reincarnation or meditation practices—can also be found in conventional religious communities, for instance in churches. There is a huge overlap with tendencies often called "Esotericism" (Frisk 2013: 373) or "New Age," which may themselves be influential. Referring to Hanegraaff, Steven J. Sutcliffe (2014) has referred to this field of religion as "New Age sensu lato", that is, as a field that "remain[s] analytically elusive despite [its] increased visibility in many societies" and that tends to "blur the boundaries between expressions of 'religion' and 'culture'" (2014: 42).

In the case of health care, this blurring refers to the boundaries between expressions of religion, medicine, and therapy. Since the first publication of *New Age Religion and Western Culture*, this "wider New Age movement" has diffused into the wider cultural and social environment of modern "secular" societies and therefore yielded a "fluid New Age".[14]

It is important to realize that there is no unified "movement" or entity that contains unifying concepts. Nevertheless, what could be called a "fluid New Age" and be seen as part of this "alternative religion" may be delineated by the field's emphasis on emotions and subjective experiences, combined with an "individualistic orientation and a weak tendency to organization and holistic function" (Knoblauch 2008: 142).[15] Typical markers of "alternative religion" are the self-identity of being an alternative to something else (Sutcliffe 2004: 467, 479), hence the conceptualization of the self as being different from the kind of religion that is seen as traditional and conservative. This is frequently combined with a sense of belonging to the future, with a

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13 Cp. Partridge 2005.

14 Cp. Lüddeckens/Walthert 2010: 9–17.

15 Even if there is organization in this field, the self-perception is often in non-conformity therewith.

sense of having outgrown the old "narrow-minded" religions and of belonging to some kind of growing movement that is different from the predominant materialism. The narrative of the autonomy of the individual is crucial. The individual him- or herself is the guiding principle for the acceptance of authority and for decisions about orthodoxy and orthopraxy. One's own authentic experiences are the normative reference,[16] and communicating choices as individual ones is important. Paul Heelas (2002: 362) in particular called attention to the focus on life in the sense of one's own "true inner life". Quite often it is the life and the focus on the body of the individual in the here and now and the aim of the progress of the individual—her or his transformation into a higher spiritual and mental level (Frisk 2013: 373)—that counts more than the prospect of an afterlife. As we shall see later, these aspects of alternative religion play a crucial role in the context of CAM.

3 THE EVOLUTION OF MODERN ACADEMIC MEDICINE AND SOCIAL DIFFERENTIATION

Three linked developments are important to consider with regard to the evolution of biomedicine as a differentiated social subsystem in the Global North.[17] These developments were responsible for the medical and social success of biomedicine while at the same time giving rise to ongoing criticism.

First, the "clinical gaze" (Foucault 1973), decisive for the evolution of biomedicine, went along with a social differentiation between physician and patient. Within the modern institution of the hospital, patients were no longer

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16　Heelas and Woodhead choose to use the term "spirituality" and describe the same phenomenon by calling it a "subjective turn" (2005: 2–5). The emphasis on the individual is in accordance with Callum Brown's observation (2006) of the narrative of individual self-fulfillment and personal freedom that has arisen since the 1960s.

17　The developments described in what follows reflect the medical history of European and subsequently North American societies. However, similar (at least to a certain extent) developments in the direction of the establishment of biomedicine took place in other parts of the world, as exemplified in this volume by case studies in Tanzania (W. Bruchhausen), India (N. Rageth), and Japan (M. Schrimpf).

in a feudal patron-client relationship but had become "objects" for the physician to work on. Moreover, the "transition from Bedside Medicine through Hospital Medicine to Laboratory Medicine was accompanied by a shift in cosmological form away from a person orientated towards an object orientated cosmology" (Jewson 1976: 225).[18] Medicine was no longer "person-oriented," with the physician perceiving the patient as a "holistic" person, but disease-oriented: patients were seen as separate from their social positions, relationships, and social traits, and were only viewed from the aspect of a disease (cp. Vogd 2007; Schoene 1980).

"The modification in professional self-understanding from a healer whose duty is to preserve the patient as a creature of God in a more or less artistic way to a scientist whose duty is to understand illness in a rational way, also changed the attitude towards patients which, in the age of science, seems almost indifferent, at least from today's standpoint." (Atzeni/von Groddeck 2015: 31)

(Bio)medicine became confined to the empirical level, often being perceived as fragmentary and mechanistic. Patients became bodies, and bodies were seen as matter. Atzeni and von Groddeck (2015: 30) analyzed doctors' autobiographies and summarized them with reference to the generation "who started their careers around the middle of the nineteenth century," as well as emphasizing the "scientific aspect of medicine" in their professional self-understanding:

"Doctors save bodies, not souls. This self-understanding is connected with the belief that the human body is the sum of a person (biological reductionism). Through methodical examination, which Foucault describes as the 'medical gaze' on the body (Foucault, [1976] 1994), the doctor deduces symptoms, illnesses, and causes by applying scientific methods." (Atzeni/von Groddeck 2015: 30)

Hence, patients might experience themselves as being reduced to a diagnosis—a person as a patient seems to be nothing more than his or her illness.[19]

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18 On the development from patient-centered to physician-centered medicine, cp. Lachmund/Stollberg 1995.

19 "From the late 1960s onwards, the image of the heroic, paternalistic doctor disintegrates" (Atzeni/von Groddeck 2015: 33). Concepts and norms of the

Secondly, as the developing biomedicine based itself on scientific methods, it distanced itself from religion and even excluded it. A corresponding development can be observed in modern academic psychology, where "transcendence was structurally excluded and the physical determinism of the 1880s was adopted as an academic theory" (Koch 2015: 436).

The approach to the body as matter and thus the exclusion of any metaphysical, non-empirical aspects led to knowledge that claimed to be scientific because it was based on and restricted to the body as an empirical entity.[20]

Medicalization[21] linked to rationalization (cp. Turner 2008; Ballard/Elston 2005) is compatible with secularization (cp. Bull 1990), of which it forms a part: for example, many "conditions have become transformed from sin to crime to sickness" (Conrad 1992: 213). Deviant social behavior, such as homosexual practices or epileptic seizures, and bodily dysfunctions like infertility, formerly understood in a religious framework, became medicalized and were redefined as medical:

"Disapproved behavior is more and more coming to be given the meaning of illness requiring treatment rather than of crime requiring punishment, victimization requiring compensation, or sin requiring patience and grace." (Freidson 1988: 248)

"autonomous patient" and the "informed patient" became relevant and led to a change in the general attitude towards patients.

20 It was common in the struggle for medical legitimization to declare one's own kind of medicine to be "scientific" instead of "religious". Therefore, one argument put forward by a medical editor in 1876, an advocate for medicine relying on clinical empiricism as opposed to medicine relying on laboratory experimentation, was, for example: "The practitioner, at the bedside of his patient does not care to indulge in medical metaphysics. [...] In his attempts to solve mysteries, known only to the Infinite, the modern speculator makes bold assertions, not guaranteed by a single fact, and with an audacity unparalleled, will no doubt shortly give the medicinal effects of religion on the human soul, describing the essence of the vital spark, its chemical constituents, and a number of newly discovered elements contained therein." (cited in Cunningham/Williams 2002: 132).

21 Medicalization is a "sociological concept, that essentially refers to the process by which social life comes to be seen through a medical framework" (Howarth 2007: 119).

Thirdly, the evolution of "medicine" as a distinct social and academic system was accompanied by increasingly successful attempts at the subordination and exclusion of practitioners who did not belong to the same academic system and did not share the same "scientific" rationale.[22] While there has always been medical pluralism in the form of different kinds of healers, during the nineteenth century many new healing systems emerged, leading even more strongly to the formation of an "orthodox professional identity" and a "rigid ideology of orthodoxy" (Warner 1998: 5), as well as vice versa (Starr 1982: 95).[23] This antagonism divided biomedicine from medical concepts and treatments that did not restrict themselves to the academic knowledge of the natural sciences and did not necessarily exclude religion. With the "profession of medicine" (Freidson 1988), the profession of medical doctors defined by a certain academic education, and the evolution of specialized professional institutions, (bio)medicine became an "official social order" (Freidson 1988: 303). According to Freidson, "[...] it cannot fail that their [practicing professions'] conceptions will be different from that of the man on the street […]" (1988: 303). This alienation of professional conceptions from the conceptions of patients is strongly interrelated with the "clinical gaze" described above.

The result of these three linked developments was the differentiation between medicine as biomedicine, inseparably linked to the natural sciences[24] and focused on immanent physical illness, on the one hand, and religion,

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22 However, this was not a straightforward development without any setbacks. In the pre-war period in the USA, for example, "the power and prestige of the regular profession were declining" (Warner 1998: 6). Nevertheless, in this period many boundary structures evolved: the American Medical Association (AMA, founded 1847), for example, had as one of its goals to "draw the line of demarcation between those who are of the profession and those who are not" (cited in Warner 1998: 9).

23 The opposition was to medically exclusive "systems" that were "rationalist" instead of "empiricist" in orientation, as especially homeopathy was said to be (Warner 2003: 347).

24 This link does not hint at the de-differentiation between medicine and science, but, in the language of systems theory, to its "subsidiarity" (Schützeichel 2011: 86). Medical praxis, the practice of dealing with patients, should first of all be aimed at their health, not at the acquisition of new scientific knowledge.

concerned with transcendent matters, on the other.[25] Sociological differentiation theory (cp. Parsons 2001; Luhmann 1984, 1995) assumes that there are functionally differentiated systems in modern societies. These systems have different functions for society and operate with different codes. As Schützeichel (2011) observes, in modernity we move within the framework of different *Sinnwelten*, such as art, science, religion, or medicine. According to Schützeichel, we usually know in what kind of framework or Sinnwelt we are and "which rules apply, where the boundaries of these rules are, and therefore where the boundaries of these areas are" (2011: 73, my translation). Medicine in the shape of biomedicine is just one such "area" in the sense of a functionally differentiated subsystem of society (Luhmann 1983, 1990: 183–187; Pelikan 2007, 2009: 42–43), and religion is another (cp. Luhmann 2002).[26]

While "(bio)medicine" operates with the code "sane/insane", "religion" operates with the code "transcendent/immanent," its function being to reduce contingency or eliminate it, at least temporarily. Luhmann assumed that religion will not be part of other functionally differentiated systems in modern societies. Correspondingly, we observe the "separating out of welfare [including medical care] as a distinct area of activity […] central to the process of secularization in European societies […]" (Davie 2013: 225). This separation went along with professionalized agents and the creation of an autonomous sphere with institutions organized by scientific instead of religious logics, norms, and structures. According to Casanova, "differentiation and emancipation of the secular spheres from religious institutions and norms

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25 Starr mentions the different moral and religious as well as naturalistic American responses to the cholera epidemics of the nineteenth century: "During a second epidemic in 1849, clerical attacks on science were common, but religious authority no longer figured prominently in response to a third cholera epidemic in 1866. By then, public health methods and organizations were assuming more effective authority." (1982: 36)

26 As Peter Beyer pointed out, under modern circumstances religion, as a functionally systemic form, acquired "essential symptoms of such systematization": "convergent centres of religious authority, expressly religious organizations (many with global extent or at least more than local range), articulated religious programmes elaborating clear religious binary codes, and the effective (self-)observation of these institutions explicitly as religion" (1997: 222).

remains a modern structural trend" (1994: 212). Religion is still present in medical institutions, especially in the field of dying and death, but medical and religious care have been separated: medical staff are responsible for the body, while chaplains are responsible for the soul. According to the World Health Organization, "spirituality" (not "religion"!)[27] should be an integral part of palliative care, and many manuals of various palliative care units demand that medical staff provide spiritual as well as medical support. But these agents are not expected to do both at the same time within the same interaction. All this fits into the framework of social "differentiation," where different social subsystems are responsible for physical health on the one hand and religious well-being on the other. The process of medicalization and the exclusive focus on physical health in biomedical contexts are more sophisticated with regard to psychiatry and psychosomatic medicine. Psychiatrists might feel responsible for the religious well-being of their patients in so far as they may discuss feelings of religious guilt or the fear of hell, but conventional psychiatrists will discuss these matters within a psychiatric framework: their focus is on the health status of their patients, not their transcendent salvation.

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27 "Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual." (http://www.who.int/cancer/palliative-/definition/en/, June 14, 2018).

4 THE CAM TOOL KIT

In the following, I will suggest explanations for why, in a modern differenti-
ated society, processes take place that may be understood as part of a de-
differentiation of medicine and religion. In particular, I will focus on the
question of why CAM is attractive in certain medical contexts. This question
was inspired by the observation in our case studies that many nurses, thera-
pists, and patients in biomedical institutions used practices that belong to the
field of CAM, such as aromatherapy, aura-healing, polarity, breath therapy
etc.

I will argue that CAM is attractive because it does not differentiate be-
tween medicine and religion, because internally it is a "loosely coupled field"
in the sense of Weick (1976), and because it offers a resource for self-em-
powerment. The first trait, I argue further, is especially important and rele-
vant for the other traits. Therefore, I will concentrate on it more broadly.
These arguments have been developed on the basis of various case studies of
alternative medicine in Europe and the US, in combination with theoretical
reflections on contemporary religiosity and religion. They are substantiated
by observations and interview data from our own research project.

4.1 CAM as an Undifferentiated Tool Kit

Grace Davie and Terhi Utriainen have already used the term "de-differenti-
ation" with regard to processes in the field of health care in Britain and Fin-
land respectively. Davie (2013: 233) called European developments, espe-
cially in Britain, "de-differentiation," where religious agents—the churches
among others—are meant to provide a system of welfare, while the state re-
treats at least partly. Utriainen observed "de-differentiation" with regard to
"spiritual care," which she distinguished from Christian pastoral care. She
refers to the entering of "spiritual care" in secular institutions and the lan-
guage of care "becoming increasingly indeterminate and boundless"
(Utriainen 2010: 446). She further suggests that "spiritual care is becoming
part of the language and, perhaps increasingly, part of the practice of care,
[which] will be understandable when it is seen in its historical context and
conceptualized as de-differentation" (Utriainen 2010: 447). While Davie and
Utriainen discussed the de-differentiation of medicine and religion without
referring to CAM, Buss and Schöps see the recognition of naturopathy as an

example of de-differentiation phenomena. However, they do not explicitly discuss this topic with regard to religion (Buss and Schöps 1979: 327). Schlieter suggests to see Kabat-Zinn's MBSR in clinical settings as an example of "dedifferentiation in biomedicine" and argues that "we may describe 'dedifferentiation' more precisely as a process in which two independent systems interact in a shared interface [...]" (2017: 457). It is one argument of this article that the CAM tool kit is used because it is undifferentiated with regard to medicine and religion.

I suggest using the concept of de-differentiation not only where we find the same actors practicing medicine and religion, but also where practices are intended to have religious as well as medical effects and aims at the same time. In other words, I suggest using the concept of de-differentiation where communication deals simultaneously with the differentiation between sane/insane and transcendent/immanent (Luhmann 1989: 313–316). In the cases described in this paper, therefore, (immanent) medical situations and practices are observed under the perspective of transcendence.

Thus, the CAM tool kit does not reproduce the social differentiation between medicine and religion that took place with regard to biomedicine. As I will show below, its strength lies in opposing the developments sketched out above.

The advocates of the unorthodox healing systems of the nineteenth century distanced themselves from what they called "allopathy" or later "Schulmedizin" (Jütte 1996: 23–35). While the German pathologist Rudolph Virchow, for example, used the label "medical science" for the kind of medicine that was mainly taught in the universities and stressed the orientation toward the natural sciences, opponents put "nature" in opposition to the "natural sciences." Accordingly, they blamed allopathy for not being oriented towards nature and even for working against nature and against patients' bodies by means of its barbaric practices. To contrast the measures associated with "heroic medicine," they claimed that their own therapies and remedies were smooth, "natural," and in harmony with nature. Catherine Albanese quotes part of the motto of two Thomsonian editors:

"No poisoning, bleeding, blistering, or physicing—no secret nostrums—the unity of disease, it being an obstruction to the free operation of the laws of vitality—the use of those remedies only, that act in harmony with nature's laws." (1986: 492–493)

These healing systems, later summarized under the term "CAM," did not accept the "clinical gaze" and did not want to reduce the patient as a person to an object with a very specific illness related to specific aspects of her or his body.[28] Many CAM practices and concepts claim to be "holistic" and to deal with the person as a unity of "body, mind and soul/spirit".

While biomedicine differentiated itself from religion, CAM, at least in its holistic branches, integrated medicine with religion simultaneously.

4.1.1 CAM and Alternative Religion

The integration of religion took place through the reception of alternative religion that did not follow the process of becoming a functionally differentiated subsystem of society.[29] In modern societies we witness religion expressing itself not only in a functional system and in social movements, as Beyer outlines, but in "non-systemic forms" as well (Beyer 1997: 223). These "non-systemic forms" are an "alternative for religion and its carriers […] to avoid functionally specific systemization, to avoid extensive organization, orthodoxifications, and self-presentation as religion" (Beyer 1997: 223).

New healing systems of the nineteenth century, such as homeopathy, Thomsonianism, osteopathy, and hydropathy, were influenced by the

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28 Sered and Agigian call this a "holistic illness narrative" and explain that, while the "discursive expansion of illness intrinsic to the *holism* of holistic healing may be no less valid than conventional understandings of breast cancer," there are "hidden costs to the holistic illness narrative, just as there are hidden costs to the conventional medical narrative" (2008: 617).

29 Apparently, there is a striking parallel and link between "alternative/unorthodox" and "conventional/orthodox" systems in the medical and religious fields. For example, William H. Holcombe (1804–1870), a North American adherent of Swedenborgianism and a prominent homoeopathic physician, saw a strong coherence between his religious and medical convictions and his opposition to "allopathy" and orthodox theology: "Today when speaking rather bitterly of Roman Catholic mummeries, my mind following a familiar undercurrent of thought, I misnamed it Allopathic mummeries. The Old and New Medicine. Indeed, I am a Homeopath simply in primary view because I was previously a new Churchman" (Holcombe as cited in Warner 1998: 8).

alternative religions of their time: Swedenborgianism, mesmerism, spiritism, transcendentalism, and magnetism. Accordingly, mind and body, material matter and spirit, nature and divine energy, were seen as intermingled and in correspondence with each other (Albanese 1986). Albanese described these conceptions, which "deified nature and made it into religion" and where "nature became a symbolic and salvific center, encircled by a cluster of related therapeutic beliefs, behaviors, and values," by using the term "nature religion" and linking it to the experiences of industrialization and urbanization (1986: 489).

Beyer mentions as examples of contemporary "non-systemic forms" New Age movements, Western neo-paganism and Pentecostalism. All three of them are examples of religious expressions that show medical and therapeutic aspects as well. Alternative religion, with its "holistic" self-understanding, is deliberately capable of combining religious and medical practices and "avails itself of a range of bodily techniques, particularly healing techniques, meditation, yoga, Ayurveda [...]" (Knoblauch 2008: 144). Beyer explains that in the case of New Age, its eschewing "convergent systematization" means risking "the 'invisibility' of religion" (Beyer 1997: 223).[30] Correspondingly, writing of the 1970s, John Gordon Melton observed that "the New Age Movement and the holistic health movement merged to the extent that it is difficult, if not impossible, for an observer to draw the line between them" (1990: xix–xx).

The common semantics and conceptions of CAM and alternative religion still involve, for example, "energy," "the 'correspondence' of the physical realm with higher metaphysical realms, enabling lawful patterns of interaction among them" (Fuller 1989: 8), an "inner transcendent self" or subtle bodies (cp. Johnston 2010).[31] Some authors therefore see CAM as a gateway to alternative religion (e.g. Knoblauch 2008: 144; Andritzky 1997). According to Koch, "[...] 'spiritualization' in the sense of the adoption in society of elements linked to religion can [...] be observed in the sector of alternative medicine" (2015: 437). She observes further that, for example, "[...] an

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30 "All three of these [various religious manifestations like Western neo-paganism, New Age movements, and ironically enough, Pentecostalism] eschew convergent systematization in principle, if not actually in practice. This direction, however, risks precisely the 'invisibility' of religion [...]" (Beyer 1997: 223).

31 For a primary source, cp. Dale 2014.

increasing number of 'Ayurvedas' have appeared since the 1990s, which often expressly describe themselves as spiritual or use religious concepts (cosmological and anthropological concepts of happiness)" (Koch 2015: 437).

All this indicates that alternative religion and CAM go hand in hand in many cases. Aromatherapy, for example, is often perceived as a complementary therapy, with its "etheric qualities" as therapeutics for the body, mind, and spirit that improve well-being physically, mentally, and emotionally, as well as "spiritually." These effects are sometimes attributed to their influence on the limbic system. If a therapist wants to support a patient to connect with his or her "higher self" through an application of bergamot oil or to attract spiritual beings through the application of basil oil, there are obviously religious aspects involved. In our case studies, neroli, lavender, and rose (damascena and bulgarian) oil have been prominent. Beyond their physical and psychological effects, like "relaxing" and "calming," they are seen as "harmonizing," "protecting," "enveloping," "purifying," and supporting transitions, all of them being effects that belong to a wider spiritual concept. Rose oil especially is seen as supporting transitions. One nurse explained her usage of aromatherapy after being asked about any "spiritual practices":

"[...] because it [aromatherapy] is something that supports and comforts you. [...] For instance, especially slightly heavier scents like rose oil or lavender, um, (2) they help (.) people *say*, I don't know if and how this is scientifically proven (.) But people say that it, that it helps for restlessness, stress, anxiety, (.) that it also helps, specifically rose for, um, like letting go, or for, for, for transitions (.) um, like from life to death or vice versa (.). Into life, like at births, one uses that too." (Regina, nurse, 9.12. 2013)[32]

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32 Original wording: "will's halt au öppis isch, wo (5) wo eim irgendwo Halt und Trost git. [...] Zum Bispiel ähm (2) Aso gad so chli schwäri Düft wie, wie Rosäöl oder oder Lavendel, ähm (2) die würked (.) me SAIT's, ich weiss halt nöd, wie das würklich wüsseschaftlich irgendwie belait isch (.) Aber me sait, dass es, dass es aim, s hilft, gäge inneri Unrueh, gege Aspannig, gege Angst (.), dass au hilft, gad insbesondere jetzt halt Rosä äh zum wie chönne loslah, oder so für für für Übergäng quasi (.) ähm aso ebe vom Läbe in Tod, oder au umgekehrt (.) I's Läbe, aso bi Geburte brucht me das au". This interview was conducted by Mirjam Mezger.

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These practices (including communicated concepts) quite often go beyond the regulated practices suggested by the institutional manuals of secular health-care institutions.

Given the undifferentiated character of CAM, the question about the ways in which the use of CAM is made attractive is raised. What are the goals of using CAM in biomedical contexts?

In our case studies, nurses, therapists etc. often rely on CAM when they encounter limits with regard to the tools they are officially trained in. This is the case when nurses experience situations where they "cannot do anything more for the dying patient," and a medical system restricted to biomedicine can no longer work with its own references and logic of healing the physical body. This experience is irritating, as medical staff see themselves as professionals "helping" patients and having an empathic relationship with them. Therefore, they resort to CAM to develop strategies in order to keep in tune with their habitus, to be of help to their dying patients, and to maintain or enforce interaction with them:

"We, the nurses, would like to have complementary medicine tools sometimes, so that you are able to do something. Healing isn't possible anymore [at the palliative care unit], but at least to be able to do something—one has to be careful, whether one is doing it for the patient or for oneself.[33]" (Andrea, nurse, 17.6.2015)

The CAM tool kit involves "symbols, stories, rituals and world-views" (Swidler 1986: 273), practices and concepts that go beyond the framework of the natural sciences. When nothing else can be done for the healing of the body, support for emotional, metaphysical, and transcendent needs is an attractive strategy of action. CAM allows medical staff to rationalize their actions and the ends they are pursuing with them beyond the boundaries of biomedicine, framing them further as "supportive."[34] At the same time, this tool kit allows them to remain within the framework of "healing" and

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33 Field note, Dorothea Lüddeckens.

34 CAM also enables actors in the religious field, such as chaplains, to deal with precarious situations by targeting non-empirical as well as bodily levels. Thus, we found carers who rationalized their practices with alternative religious concepts and used CAM, as well as ecclesiastical ministers who completed complementary medical training.

"caring." The use of Aromtherapy by Regina mentioned above is an example of this: the aroma of rose oil is used to support the transition from life to death, the capacity of the patients to "let go", an aim for which no biomedical tools are available.

4.1.2 Religion as a Coping Strategy

CAM also offers a tool kit for agents who are generally interested in creating scopes of action that exceed the limits of their professions as defined and delimited by the differentiated subsystem we call "medicine". They attract actors in the medical field who do not want to restrict themselves to medical practices that focus only on the physical body but want to use religion, or rather "spirituality," as part of coping strategies. This again seems to be especially the case with palliative care, which today is strongly influenced by Cecily Saunders, a British Anglican social worker, nurse, and later physician, and Elisabeth Kübler-Ross, a Swiss-American psychiatrist. One reason for their continuing, international influence is that they combine conventional health care with so-called "spiritual care". As long as there is hope for healing, the physical body is at the center of attention in secular hospitals. Social relationships, psychological aspects, and above all religion are only seen as supporting factors in the physical healing process. However, in institutions and hospital units specialized in palliative care, just the opposite can be observed. The treatment of the body, in the sense of getting "symptoms under control," is seen as the condition for a process in which much more importance is attached to the idea of "a good death," which involves mental and "spiritual" engagement with dying and death, including "acceptance," "peacefulness," and "the decision to 'let go'".[35]

"There seems to be a corresponding interest on the part of the patients, as several studies hint at a 'value shift towards self-transcendent values in palliative care patients, possibly reflecting coping processes which take place in the face of a terminal illness'" (Fegg et al. 2005: 158).

CAM, in connection with "fluid New Age", often meets patients' need to understand their illnesses in broader contexts. It also allows them to discuss

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35 Cp. Demjén et al. 2016; Semino et al. 2014.

themselves and their bodies. Patients can understand their sick bodies and their own "spirituality" as an integral part of their own selves. According to our case studies, the tool of breath therapy, for example, may enable patients to connect with suppressed, difficult emotions with the goal of "letting them go". This in turn may be seen as a path to their "higher inner self". In the words of one patient,

"[...] last but not least my illness alerted me, to tell me, hey, do something, in your second life" (Elsbeth, patient, 8.6.2015).[36]

According to one therapist, falling ill is often seen as a task or a "'chance' to have to learn something that maybe I haven't learned in my last lives" (Mara, eurythmy therapist, 11.5.2015).[37] In a similar way, illness is perceived as a "path" or task for personal "development": "There is some reason for getting that [illness], however. And whether to develop myself, to, perhaps, become aware, this is who I am" (Manuela, nurse, 22.5.2015).[38]

Physical experiences in the context of treatments can be connected to the goal of spiritual development. This allows patients, especially when faced with their imminent death, to act, to do something for themselves, even without any opportunities to do anything actively to improve their bodily conditions. In this context, one therapist explained:

"Often it happens during the therapy that people [experience] a mini-enlightenment. [...] and from that something evolves." (Mara, eurythmy therapist, 11.5.2015)[39]

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36 Original wording: "Und nöd z letscht (.) hät mich d Chrankhet wieder emal druf ufegstosse, [Ja] mir z säge, hey, mach doch öppis [Ja] (-) mit dinere zweite Biographie." This interview quote and the following ones stem from interviews conducted by Barbara Zeugin.

37 Original wording: "Ich glaube [...] eine gewisse Krankheit (-) kann [...] sagen, dass ich jetzt was LERnen muss, was ich die letzten Leben vielleicht noch nicht gelernt habe."

38 Original wording: "Es hät ir (.) glich irgend en Grund, dass mer das überchunt. [...] Und segs (.) zum en Entwickligsschritt mache, zum (.) villich bewusst werde, das bin ICH."

39 Original wording: "Oftmals passierts in der Therapie, (1) dass die Leute (-) ne Mini kleine Erleuchtung. [...] Und daraus entwickelt sich dann was."

Many CAM treatments simultaneously have medical and religious aims or offer at least the opportunity for the treatments to be used for both purposes at the same time. Therefore, against the backdrop of the process of differentiation outlined above, the increasing incidence of CAM treatments and CAM practitioners in secular medical institutions may be seen as signs of a process of de-differentiation (Tiryakian 1985, 1992; Buss/Schöps 1979: 324). De-differentiation might be seen as "processes in which previously separate roles or organizations are fused to deal with a broader set of problems." (Rueschemeyer 1977: 8). However, a "'de-differentiated role' does not return to the structurally prior level of development characterized by lack of specialization" (Lipman-Blumen as cited in Tiryakian 1985: 121). The role of the nurse or therapist may become de-differentiated in serving medical and religious aims at the same time without a loss of medical specialization.

These phenomena appear mainly at the margins of the biomedical healthcare system in cases of palliative care, maternity wards, psychosomatic medicine, psychiatry, and preventive medicine. Yet it is often at the margins that new developments occur and this trend has already reached cancer treatment units in particular. Beyond institutional implementation, in our studies, nurses and therapists, as well as in some cases medical doctors, use CAM and explain their dealings with patients by referring to alternative religious concepts, such as extra-sensory perception. This presence of CAM in secular medical institutions, going along with religious semantics, concepts, and norms, hints at processes of de-differentiation.

4.2 An Internally Loosely Coupled Field

The field of alternative medicines and therapies and of alternative religion is decentralized and has so far been institutionalized only weakly. In being characterized by weak and non-committal internal connections between different agents, it can be called a loosely coupled field in the sense of Weick (1976). In contrast, in strongly institutionalized fields such as academic medicine or academic theology, the connections between agents, institutions etc. are much closer and more determined. This means first that training programs are comparatively open, with low-threshold access: one does not need a special level of educational attainment to be admitted to Reiki training, for example.

Secondly, being a loosely coupled field allows a semantic vagueness and a high level of sensitivity to the environment. Semantic vagueness[40] is highly compatible with the diverse professional self-perceptions and world views of the medical staff. The diversity and flexibility of the available concepts and practices enable selective reception with high degrees of accuracy and flexibility to form varying configurations to fit the respective actors and their situational needs, as there are no authorities who can regulate access or the application of concepts and practices.

Thirdly, this adaptability also applies to the relationship of alternative religiosity to medicine and established religion: selectively, theological and especially medical and scientific schemes are integrated into alternative religiosities and their therapeutic practices. Accordingly, we observe a "reflexive curing" culture (Koch 2015: 437) that corresponds to the popularization of the discourse in ritual studies (cp. Lüddeckens 2004) and "reflexive ritualization" (cp. Stausberg 2004). In the case of the latter, elements of anthropological theories of ritual are integrated into popular discourses about ritual (re)inventions. In the case of CAM, for instance, biomedical research, concepts, semantics, and symbols are partly integrated, or else references are made to science like quantum theory. CAM concepts involve, for example, nerve tracts, references to the chemical ingredients of remedies, biomedical diagnostics etc.[41] These flexible and selective connections allow actors to frame CAM as "compatible" with and "complementary" to their own biomedical professionalization.

4.3 A Resource for Self-Empowerment

In 1988, in his afterword to his study of 1970, in which he writes about the changed position of the patient since then, Freidson noted that "well-educated middle-class women of childbearing age have become more inclined to challenge medical authority and to insist on playing a more active role in their own treatment" (1988: 388). In fact, surveys show that the idea of having more autonomy is one of the crucial motives for patients turning to

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40 Typical examples of this semantic vagueness are terms like "energy", "nature," and "holistic".

41 One example in the Japanese context is *kanpō* medicine, Harasawa S., Miyoshi A., and Miwa (1998).

CAM.[42] Ahlin, who discusses several studies from Europe, Canada, and the USA, concludes that

"[…] most important among these [the appealing positive qualities of alternative therapists] is the sense of responsibility that alternative therapy offers its clients. In contrast to conventional medicine, the client is not a passive receiver of healthcare but a self-governing actor with responsibility regarding his/her health, both today and in the future." (2015: 406)

CAM practices do not necessarily involve patients more actively, and the autonomy of patients in their relationships with their therapists is in fact not necessarily greater than in a biomedical context. However, patients associate the use of CAM with their own control over their own health matters, and this image of CAM is decisive. Bishop, Yardley, and Lewith, in their article *A systematic review of beliefs involved in the use of complementary and alternative medicine*, concluded:

"The evidence suggests that CAM users want to participate in treatment decisions, are likely to have active coping styles and might believe that they can control their health.

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42 One has to take into account the fact that the different studies rely on users of different kinds of CAM and that some of them found different results for different practitioners (e.g. Reiki practitioners may differ from homeopathy users). Moreover, it makes a decisive difference whether one studies people who rely exclusively on CAM or people who combine CAM with biomedical treatments. Astin was able to show that the "desire for control over health matters" (1998: 1551) was one of the independent variables among the significant predictors for relying primarily on alternative forms of health care. Bishop, Yardley, and Lewith suggest that "people who use CAM might be more likely to prefer an active or collaborative role in treatment decisions than non-users" (2007: 852). Similarly, Pawluch outlined that "[...] complementary therapies represented a way to make a statement about the unresponsiveness and oppression of Western medicine. It represented a way to take control of one's health [...]" (2000: 261). In contrast to a study published in 2003 by Lönroth and Ekholm, as reported by Ahlin (2015), the gender aspect is rarely considered. The latter found that 25% of patients, most of them women, had a "wish to take an active part in the healing process," an important factor in the use of CAM (Ahlin 2015: 407).

They value non-toxic, holistic approaches to health and hold 'postmodern belief systems' with viewing themselves as unconventional and spiritual." (2007: 862)

My argument here is that CAM is associated with more autonomy than conventional biomedicine because it is perceibed, at least partly, as separate from the hegemonic health system dominated by biomedicine (which is experienced as depriving patients of their autonomy) and as something the "cultural authorities" do not accept and that is therefore to some extent "subversive." There is a congruence between these heirs of a "medical counter-culture" (cp. Saks 2003) and contemporary spiritualities along the lines of a New Age spirituality (cp. Hanegraaff 2000), the heirs to a "religious counter-culture". The impression that CAM is being increasingly accepted by the mainstream population, and even by the medical authorities, health insurance companies and so on, is even more a confirmation that the "truth" will prevail.

   Not only patients, but medical staff too may use CAM as a resource for self-empowerment and a tool for autonomy. As a loosely coupled field, CAM offers actors—in our case health-care providers such as nurses and therapists—more self-determination and autonomy than fields with strong ties do (cp. Granovetter 1973; Weick 1976). The strict regulations in hospitals regarding the practices of nurses are related to the fields of biomedicine and conventional nurseries: they do not include any rules regarding energy medicine or aura healing. There is no constraining authority to control nurses in these fields of CAM as long as they do not offend violently against the general hospital regulations. Therefore, CAM provides a route to "self-empowerment" for actors in the hierarchically organized medical field who see themselves as limited by their professions, as is often the case with nurses and therapists. The threshold for becoming an alternative therapist is considerably lower than the threshold to enter academic medicine. For a nurse seeking a career change, it is much easier to become a "polarity therapist" than to embark on medical studies.[43]

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43 People who follow a de-differentiating course of action publicly and explicitly lose their status in their original field: Cicely Saunders, who is immensely important for "spiritual care" and integrates medical and religious practices and ends, no longer has a strong standing as an academic theologian. Elisabeth Kübler-Ross, originally a doctor, also made de-differentiating moves by conceiving death in a way that is no longer accepted within academic medicine. Her ideas

CAM offers a way to enhance self-esteem and prestige in the eyes of patients and sometimes colleagues as well. As Homi Bhabha observed of agents with less hierarchical power:

"[...] there exist possibilities to reverse the cultural authorities we're facing, to adopt some aspects of it, and dismiss others. This leads to a hybridisation of the symbols of authority and turned into something of its own. Hybridisation to me does not simply mean mixing, but rather a strategic and selective appropriation of meaning, the creation of space for agents whose freedom and equality is threatened."[44] (Bhabha cited in Babka/Posselt 2012: 13)

CAM offers a "selective appropriation of meaning" that one may call a reflexive or hybrid curative culture (cp. Lüddeckens 2013). By integrating the metaphysical or transcendent aspects into medical care, CAM provides agents with the power to claim care beyond what is conventional and physical. The medical system makes this kind of self-empowerment possible, especially in palliative care. Where conventional medical reason has reached its limits, healing is no longer possible, and no more or at least less medical damage seems possible: thus, the field can be opened to alternative practices and interpretations.

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are regarded as esoteric precisely because they integrate the religious and medical perspectives.

44 Original wording: "[...] es [gibt] Möglichkeiten, die auferlegten kulturellen Autoritäten umzudrehen, einiges davon anzunehmen, anderes abzulehnen. Dadurch werden die Symbole der Autorität hybridisiert und etwas Eigenes daraus gemacht. Hybridisierung heißt für mich nicht einfach Vermischen, sondern strategische und selektive Aneignung von Bedeutungen, Raum schaffen für Handelnde, deren Freiheit und Gleichheit gefährdet sind." http://sciencev1.orf.at/science/news/14 9988, June 21, 2018.

5 CONCLUSION

We are witnessing the growing institutionalization of CAM in secular medical institutions in Switzerland, as in many other European countries. In palliative care units, the CAM tool kit is used when the differentiated "(bio)medicine" sub-system reaches the limits of its inherent logic. In cases where "nothing can be done anymore" with regard to the physical health of patients, medical staff face challenges to their professional habitus as care-givers.

I have argued that CAM is currently successful in European countries because of three characteristics it has. By responding to medical as well as religious or spiritual needs, and also by integrating aspects of alternative religion, CAM allows medical staff to serve not only the bodily but also the emotional, metaphysical, and transcendent needs of their patients. Thus, by using the CAM tool kit, medical staff are able to preserve their habitus as care-givers even at the end of life when nothing or less can be done for the well-being of their patients' physical bodies. As a loosely coupled field, CAM offers low-threshold access to training and application. It also serves as a resource of self-empowerment for patients and medical staff alike in relation to conventional biomedicine and its hierarchical structures.

The relevance of action strategies that refer to the CAM tool kit is growing in secular, biomedicine-oriented institutions in Switzerland. Complementing other cases from England and Scandinavia, I suggest that this increase may be understood as a process of the de-differentiation of medicine and religion in modern, European societies.

BIBLIOGRAPHY

Ahlin, Lars (2015): "The Growth of Alternative Therapy: A Valid Argument against the Secularisation Thesis?", in: Journal of Contemporary Religion 30(3), pp. 399–413.

Albanese, Catherine (1986): "Physic and Metaphysic in Nineteenth-Century America: Medical Sectarians and Religious Healing", in: Church History: Studies in Christianity and Culture 55(4), pp. 489–502.

Andritzky, Walter (1997): Alternative Gesundheitskultur: Eine Bestandsaufnahme mit Teilnehmerbefragung, Berlin: VWB-Verlag.

Astin, John A. (1998): "Why Patients Use Alternative Medicine: Results of a National Study", in: JAMA 279(19), pp. 1548–1553.

Atzeni, Ginam/von Groddeck, Victoria (2015): "Normality, Crisis and Recovery of narrating medical Professionalism", in: Tamara Journal of Critical Organisation Inquiry 13(1–2), pp. 25–40.

Babka, Anna/Posselt, Gerard (2012). "Vorwort", in: Anna Babka, Gerald Posselt (ed.), Homi K. Bhabha, Über kulturelle Hybridität: Tradition und Übersetzung, Wien: Turia & Kant, pp. 7–16.

Ballard, Karen/Elston, Mary Ann (2005): "Medicalisation: A Multi-dimensional Concept", in: Social Theory and Health 3(3), pp. 228–241.

Becker, Raymond/Sertel, Serkan/Stassen-Rapp, Isabel/Walburg, Ines (2010): Neue Wege in der Medizin: Alternativmedizin – Fluch oder Segen?, Heidelberg: Universitätsverlag Winter GmbH Heidelberg.

Beyer, Peter (1997). "Religion, Residual Problems, and Functional Differentiation: An Ambiguous Relationship", in: Soziale Systeme, 3(2), pp. 219–235.

Bishop, Felicity/Yardley, Lucy/Lewith, George T. (2007): "A Systematic Review of Beliefs Involved in the Use of Complementary and Alternative Medicine", in: Journal of Health Psychology 12(6), pp. 851–867.

Brown, Callum G. (2006): Religion and Society in Twentieth-Century Britain, Harlow (England): Pearson Longman.

Bull, Malcolm (1990): "Secularization and Medicalization", in: The British Journal of Sociology 41(2), pp. 245–261.

Buss, Eugen/Schöps, Martina (1979): "Die gesellschaftliche Entdifferenzierung", in: Zeitschrift für Soziologie 8 (4), pp. 315–329.

Casanova, José (1994): Public Religions in the Modern World, Chicago: The University of Chicago Press.

Conrad, Peter (1992): "Medicalization and Social Control", in: Annual Review of Sociology 18(1), pp. 209–232.

Cunningham, Andrew/Williams, Perry (2002): The Laboratory Revolution in Medicine, Cambridge: Cambridge University Press.

Dale, Cyndi (2014): The Subtle Body: An Encyclopedia of Your Energetic Anatomy, 1st edn. Boulder (CO): Sounds True.

Davie, Grace (2013): The Sociology of Religion, 2nd edn. London: Sage Publications.

Demjén, Zsófia/Semino, Elena/Koller, Veronika (2016). "Metaphors for 'Good' and 'Bad' Deaths: A Health Professional View", in: Metaphor and the Social World 6(1), pp. 1–19.

Eisenberg, David M./Davis, Roger B./Appel, Scott/Wilkey, Sonja/Van Rompay, Maria/Kessler, Ronald C. (1998): "Trends in Alternative Medicine Use in the United States, 1990–1997: Results of a Follow-Up National Survey", in: JAMA 280(18), pp. 1569–1578.

Ernst, Edzard (2008): Oxford Handbook of Complementary Medicine, Oxford: Oxford University Press.

Fegg, Martin J./Wasner, Maria/Neudert, Christian/Borasio, Gian Domenico (2005): "Personal Values and Individual Quality of Life in Palliative Care Patients", in: Journal of Pain and Symptom Management, 30(2), pp. 154–159.

Foucault, Michel (1973): The Birth of the Clinic, New York: Pantheon Books.

Freidson, Eliot (1988): Profession of Medicine: A Study of the Sociology of Applied Knowledge, 2nd edn. Chicago: The University of Chicago Press.

Frisk, Liselotte (2013). "A Small-Town Health Centre in Sweden: Perspectives on the Western Esotericism Debate", in: Egil Asprem/Kennet Granholm (eds.), Contemporary Esotericism, Sheffield; Bristol (CT): Equinox Publ., pp. 372–391.

Fuller, Robert C. (1989): Alternative Medicine and American Religious Life, New York: Oxford University Press.

Granovetter, Mark S. (1973): "The Strength of Weak Ties", in: American Journal of Sociology 78(6), pp. 1360–1380.

Hanegraaff, Wouter J. (2000): "New Age Religion and Secularization", in: Numen 47(3), pp. 288–312.

Harasawa, S./Miyoshi, A./Miwa, T./Masamune, O./Matsuo, Y./Mori, H. (1998): "Double-blind multicenter post-marketing clinical trial of TJ-43 Rikkunshito for the treatment of dysmotility-like dyspepsia", in: Igaku no Ayumi (J Clin ExpMed) 187, pp. 207–229. doi: 10.3389/fphar.2014.00271.

Harris, P. E./Cooper, K. L./Relton, C./Thomas, K. J. (2012): "Prevalence of Complementary and Alternative Medicine (CAM) Use by the General Population: A Systematic Review and Update", in: International Journal of Clinical Practice 66(10), pp. 924–939.

Harris, P./Rees, R. (2000): "The Prevalence of Complementary and Alternative Medicine Use Among the General Population: A Systematic Review of the Literature", in: Complementary Therapies in Medicine 8(2), pp. 88–96.

Heelas, Paul (2002): "The Spiritual Revolution: From 'Religion' to 'Spirituality'", in: Linda Woodhead/Paul Fletcher/Hiroko Kawanami/David Smith (eds.), Religions in the Modern World: Traditions and Transformations, London/New York: Routledge, pp. 357–377.

Heelas, Paul/Woodhead, Linda/Seel, Benjamin/Szerszynski, Bronislaw/Tusting, Karin (2005): The Spiritual Revolution: Why Religion Is Giving Way to Spirituality, Malden (MA): Blackwell.

Hunt, K. J./Coelho, H. F./Wider, B./Perry, R./Hung, S. K./Terry, R./Ernst, E. (2010): "Complementary and Alternative Medicine Use in England: Results from a National Survey", in: International Journal of Clinical Practice 64(11), pp. 1496–1502.

Jewson, Nicholas D. (1976): "The Disappearance of the Sick-Man from Medical Cosmology, 1770–1870", in: Sociology 10(2), pp. 225–224.

Johnston, Jay (2010): "Subtle Anatomy: The Bio–Metaphysics of Alternative Therapies", in: Elizabeth Burns Coleman (ed.), Medicine, Religion, and the Body, Leiden: Brill, pp. 69–103.

Jütte, Robert (1996): Geschichte der alternativen Medizin, München: C.H. Beck.

Kaptchuk, Ted J./Eisenberg, David M. (2001): "Varieties of Healing. 1: Medical Pluralism in the United States", in: Annals of Internal Medicine 135 (3), pp. 189–95.

Kelner, Merrijoy/Wellman, Beverly (2000): "Introduction. Complementary and alternative Medicine: Challenge and Change", in: Complementary and Alternative Medicine: Challenge and Change, New York: Routledge, pp. 1–24.

Knoblauch, Hubert (2008): "Spirituality and Popular Religion in Europe", in: Social Compass 55(2), pp. 140–153.

Koch, Anne (2015): "Alternative Healing as Magical Self-Care in Alternative Modernity", in: Numen 62(4), pp. 431–459.

Laermans, R./Verschraegen G. (2001): "The Late Niklas Luhmann on Religion: An Overview", in: Social Compass 48(1), pp. 7–20.

Lachmund, Jens/Stollberg, Gunnar (1995): Patientenwelten: Krankheit und Medizin vom späten 18. bis zum frühen 20. Jahrhundert im Spiegel von Autobiographien, Opladen: Leske + Budrich.

Luhmann, Niklas (1983): Medizin und Gesellschaftstheorie, in: Medizin, Mensch, Gesellschaft 8, pp. 168–175.

Luhmann, Niklas (1984): Soziale Systeme. Grundriß einer allgemeinen Theorie, Frankfurt am Main: Suhrkamp.

Luhmann, Niklas (1989): "Die Ausdifferenzierung der Religion", in: Gesellschaftsstruktur und Semantik: Studien zur Wissenssoziologie der modernen Gesellschaft, Vol. 3, Frankfurt am Main: Suhrkamp, pp. 259–357.

Luhmann, Niklas (1990): "Der medizinische Code", in: Soziologische Aufklärung, Vol. 5, Wiesbaden: VS Verlag für Sozialwissenschaften.

Luhmann, Niklas (1995): Social Systems, transl. by John Bednarz, Jr. with Dirk Baecker, Stanford: Stanford University Press.

Luhmann, Niklas (2002): Die Religion der Gesellschaft, Frankfurt am Main: Suhrkamp.

Lüddeckens, Dorothea (2004): "Neue Rituale für alle Lebenslagen: Beobachtungen zur Popularisierung des Ritualdiskurses", in: Zeitschrift für Religions– und Geistesgeschichte 1, pp. 37–53.

Lüddeckens, Dorothea (2013): "Alternative Heilverfahren als Religionshybride", in: Peter Berger/Klaus Hock/Thomas Klie (eds.), Religionshybride: Religion in posttraditionalen Kontexten, Wiesbaden: Springer VS, pp. 107–120.

Lüddeckens, Dorothea/Walthert, Rafael (2010): "Fluide Religion: Eine Einleitung", in: Dorothea Lüddeckens/Rafael Walthert (eds.), Fluide Religion: neue religiöse Bewegungen im Wandel. Theoretische und empirische Systematisierungen, Bielefeld: Transcript, pp. 9–17.

Martin, Hélène/Debons, Jérôme (2015): "CAM and Conventional Medicine in Switzerland: Divided in Theory, United in Practice", in: Nicola K. Gale/Jean V. McHale (eds.), Routledge Handbook of Complementary and Alternative Medicine: Perspectives from Social Science and Law, New York: Routledge, pp. 271–291.

Melton, John Gordon (1990): "Introductory Essay", in: John Gordon Melton/Jerome Clark/Aidan A. Kelly (eds.), New Age Encyclopedia, Detroit: Gale, pp. xiii–xxxv.

Mezger, Mirjam (2018): Religion, Spiritualität, Medizin: Alternative Religiosität und Palliative Care in der Schweiz, Bielefeld: Transcript.

Parsons, Talcott (2001): The Social System, London: Routledge.

Partridge, Christopher (2005): The Re-Enchantment of the West: Understanding Popular Occulture, London: Continuum.

Pawluch, Dorothy/Cain, Roy/Gillett, James (2000): "Lay Constructions of HIV and Complementary Therapy Use", in: Social Science & Medicine 51(2), pp. 251–264.

Pelikan, Jürgen M. (2007): "Understanding Differentiation of Health in Late Modernity by Use of Sociological Systems Theory", in: David V. McQueen/Ilona Kickbusch (eds.), Health and Modernity: The Role of Theory in Health Promotion, New York: Springer Science+Business Media, pp. 74–102.

Pelikan, Jürgen M. (2009): Ausdifferenzierung von spezifischen Funktionssystemen für Krankenbehandlung und Gesundheitsförderung oder: Leben wir in der "Gesundheitsgesellschaft"?, in: Österreichische Zeitschrift für Soziologie 34/2, 28–47.

Rueschemeyer, Dietrich (1977): "Structural Differentiation, Efficiency, and Power", in: American Journal of Sociology 83(1), pp. 1–25.

Saks, Mike (2003). Orthodox and Alternative Medicine: Politics, Professionalization and Health Care, London: Continuum.

Schlieter, Jens (2017): "Buddhist insight meditation (Vipassanā) and Jon Kabat-Zinn's 'Mindfulness-based Stress Reduction': an example of de-differentiation of religion and medicine?", in: Journal of Contemporary Religion 32/3, pp. 447–463.

Schoene, Wolfgang (1980): "Alternative Medizinen und Die Medizin: zum Kontrast Ihrer Sozialen Funktionsweisen", in: Medizin, Mensch, Gesellschaft 5(1), pp. 226–233.

Schützeichel, Rainer (2011): "'Doing Systems': eine handlungstheoretische Rekonstruktion funktionaler Differenzierung", in: Thomas Schwinn (ed.), Soziale Differenzierung: handlungstheoretische Zugänge in der Diskussion, Wiesbaden: VS, Verlag für Sozialwissenschaften, pp. 73–91.

Semino, Elena/Demjén, Zsófia/Koller, Veronika (2014): "'Good' and 'Bad' Deaths: Narratives and Professional Identities in Interviews with Hospice Managers", in: Discourse Studies 16(5), pp. 667–685.

Sered, Susan/Agigian, Amy (2008): "Holistic Sickening: Breast Cancer and the Discursive Worlds of Complementary and Alternative Practitioners", in: Sociology of Health & Illness 30(4), pp. 616–631.

Sinclair, Shane/Pereira, Jose/Raffin, Shelley (2006): "A Thematic Review of the Spirituality Literature within Palliative Care", in: Journal of Palliative Medicine 9(2), pp. 464–479.

Spielberg, Petra (2007): "Schul- und Komplementärmedizin: Miteinander statt Nebeneinander", in: Ärzteblatt 104(46), pp. A–3148 / B–2770 / C–2672.

Starr, Paul (1982): The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry, New York: Basic Books.

Stausberg, Michael (2004): "Reflexive Ritualisationen", in: Zeitschrift für Religions- und Geistesgeschichte 56, pp. 54–61.

Sutcliffe, Steven (2004): "The Dynamics of Alternative Spirituality: Seekers, Networks and 'New Age'", in: James R. Lewis (ed.), The Oxford Handbook of New Religious Movements, Oxford: Oxford University Press.

Sutcliffe, Steven (2014): "New Age", in: George D. Chryssides/Zeller, Benjamin E. (eds.), The Bloomsbury Companion to New Religious Movements, London: Bloomsbury Academic, pp. 41–45.

Swidler, Ann (1986) "Culture in Action: Symbols and Strategies", in: American Sociological Review 51(2), pp. 273–286.

Tiryakian, Edward A. (1985): "On the Signification of De-Differentiation", in: Shmuel Noah Eisenstadt/Horst Jürgen Helle (eds.), Macro-Sociological Theory (Perspectives on Sociological Theory, Vol. 1), London: Sage, pp. 118–134.

Tiryakian, Edward A. (1992): "Dialectics of Modernity: Reenchantment and Dedifferentiation as Counterprocesses", in: Hans Haferkamp/Smelser, Neil J. (eds.), The Temporalization of Social Order: Some Theoretical Remarks on the Change in "Change", Berkeley/Los Angeles: University of California Press, pp. 78–94.

Turner, Bryan (2008): The Body & Society: Explorations in Social Theory. Los Angeles: Sage.

Utriainen, Terhi (2010): "Agents of De-Differentiation: Women Care-Givers for the Dying in Finland", in: Journal of Contemporary Religion 25(3), pp. 437–451.

Vogd, Werner (2007): "Medizin und Wissen", in: Rainer Schützeichel (ed.), Handbuch Wissenssoziologie und Wissensforschung, Konstanz: UVK, pp. 579–587.

Wahlberg, Ayo (2007): "A Quackery with a Difference: New Medical Pluralism and the Problem of 'Dangerous Practitioners' in the United Kingdom", in: Social Science & Medicine 65(11), pp. 2307–2316.

Warner, John Harley (2003): Against the Spirit of System: The French Impulse in Nineteenth–Century American Medicine, Princeton (N.J.): Princeton University Press.

Warner, Robert (1998): "Orthodoxy and Otherness: Homeopathy and Regular Medicine in Nineteenth–Century America", in: Robert Jütte/Guenter B. Risse (eds.), Culture, Knowledge, and Healing: Historical Perspectives of Homeopathic Medicine in Europe and North America, Sheffield: European Association for the History of Medicine and Health Publications, pp. 5–29.

Weick, Karl E. (1976): "Educational Organizations as Loosely Coupled Systems", in: Administrative Science Quarterly 21(1), pp. 1–19.

Wolf, Ursula/Maxion-Bergemann, Stefanie/Bornhöft, Gudrun/Matthiessen, Peter F./Wolf, Martin (2006): "Use of Complementary Medicine in Switzerland", in: Forschende Komplementärmedizin 13 Suppl 2, pp. 4–6.

Yamashita, H./Tsukayama, H./Sugishita, C. (2002): "Popularity of Complementary and Alternative Medicine in Japan: A Telephone Survey", in: Complementary Therapies in Medicine 10(2), pp. 84–93.

Crossing Fields

Anthroposophical End-Of-Life Care in Switzerland

Barbara Zeugin, Dorothea Lüddeckens, Monika Schrimpf

ABSTRACT

This article presents results of a qualitative study based on fieldwork and interviews in an anthroposophical hospital. From a practice-theoretical perspective, the paper discusses the interferences of medicine, religion, and spirituality in the field of anthroposophical end-of-life care. It describes the main practices conducted throughout the different stages of end-of-life care in this hospital and relates them to their rationalizations by medical actors as well as to basic anthroposophical concepts. Besides, the authors analyze power struggles between different actors displaying various dispositions concerning conventional and anthroposophical medicine, the latter integrating religious and spiritual aspects. The paper concludes by arguing that (1) there is a shift of relevance with regard to body-oriented and discursive practices in the course of anthroposophical end-of-life care, with a stronger emphasis on body-oriented practices at later stages. Moreover, (2) body-oriented practices, if rationalized in a religious way, serve as a resource not only for patients, but for staff members, too. Finally, (3) the contested issue of administering pain-killers and sedatives at the end of life in this hospital revealed that in many cases, nurses, despite their inferior position compared to physicians, succeeded in their wish to act in discordance with anthroposophical principles.

1 INTRODUCTION[1]

In 2012, the Swiss people voted in favor of a popular petition to integrate anthroposophic[2] medicine, traditional Chinese medicine, homeopathy, neural therapy, and herbal medicine into the official list of services covered by obligatory health insurance. As a consequence, all expenses for these types of treatment will henceforth be covered, if they are provided or prescribed by trained physicians. This indicates a growing social acceptance of Complementary and Alternative Medicine (CAM)[3] in Switzerland as part of the established health-care system.[4]

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1   All the empirical data on anthroposophical end-of-life care used in this article come from a case study conducted by Barbara Zeugin within the broader context of a research project on Alternative Religiosity and its Consequences at the End of Life funded by the Swiss National Science Foundation (cp. www.nfp67.ch/ en/projects/module-4-cultural-concepts-social-ideals/project-lueddeckens,   July 4, 2018). We would like to convey our special thanks to all the managerial staff in the hospital where Zeugin conducted her fieldwork, to the leading internist, who introduced and mentored her, and to all employees and patients who welcomed her with open arms. Without their willingness to share their thoughts and experiences with her, this fieldwork would not have been possible. The research project was approved by the Kantonale Ethikkommission Zürich. Aside from the relevant literature, the few remarks in this article on conventional palliative care are based on Dorothea Lüddecken's fieldwork in a Swiss conventional palliative care unit conducted in 2016.

2   We decided to use the term "anthroposophic medicine" instead of "anthroposophical medicine" so as to acknowledge the most common emic language usage, in line with Kienle et al. (2006).

3   Gale and McHale's collection (2015) gives an overview of CAM, Jütte (1996) introduces the history of CAM, and Crawford (2003) discusses terminological issues.

4   The website of the Swiss Federal Office of Public Health provides information about all policies related to the incorporation of CAM into the public health sector (cp.   www.bag.admin.ch/themen/gesundheitspolitik/03153/index.html?lang=de, July 4, 2018). Puustinen (2014) has criticized the incorporation of anthroposophical medicine into the Swiss health-care sector by claiming that its religious orientation is incompatible with the principles of natural science.

Alongside these developments, the social sciences are also showing an increasing interest in CAM. Social scientists are either examining particular examples of CAM or else discussing its relationship to conventional medicine (cp. Jeserich 2010). Scholars in the Study of Religion, on the other hand, tend to scrutinize relationships between religion and medicine by referring mostly to discursive data material, that is, to written and oral data. Most of these studies discuss particular healing practices such as Ayurveda (cp. Koch 2006a, 2006b; Koch/Binder 2013; Lüddeckens 2018) or address the issue more generally (cp. Brown 2013; Koch 2015; Lüddeckens 2012, 2013). The latter approach often leads to the conclusion that, while CAM stems from specific religious traditions, it also forms an interface between religion and medicine. While this article agrees with this conclusion, it differs methodologically from these earlier studies, which restrict their analyses to the level of conceptualization by using only discursive data. Instead, this article attends not only to what people say but also to what they do, that is, to how they act.[5] Thus, the central focus is on the social practice of anthroposophical end-of-life care using one particular anthroposophical hospital as a case study.[6]

Adopting a practice-theoretical perspective on religion has proved to be a promising endeavor in recent research in the Study of Religion (cp. Echtler/Ukah 2016a; Utriainen 2013; Walthert 2014; Wood 2007; Wright/Rawls 2005). Within practice theory, Bourdieu's terms and concepts are quite prominent and allow not only varied sets of actions to be differentiated as specific to a certain group of people (habitus), but also their attribution to a specific realm (social field). Whereas scholars have already worked on the religious field (cp. Bourdieu 2000; Echtler/Ukah 2016b), this article deals with the intersection between it and the medical field.

This specific focus is due to the fact that anthroposophical end-of-life care unfolds in a particular historical, social, and institutional context that already indicates a position between (alternative) religion[7] and (convent-

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5   Cp. Mezger 2018.

6   A communication-theoretical approach may represent another way of escaping a conceptualizing view of CAM (cp. Zeugin 2017).

7   The term "alternative religion" is used in this paper as an etic category. In general, practitioners of anthroposophic medicine do not consider themselves to belong to

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ional) medicine[8]. The practice of anthroposophical end-of-life care combines the basic principles of conventional medicine with alternative religious beliefs and practices, as anthroposophic medicine has aimed to counter-balance the one-sided notion of conventional medicine since its beginnings:

"This is not an opposition against contemporary medicine working with scientifically acknowledged methods. We fully accept this medicine in her principles. And in our opinion what we offer should only be used by that practitioner of the art of medicine who can be considered a full physician according to these principles." (Steiner/Wegman 2014: 7)[9]

Anthroposophic medicine claims to undo the mechanistic and fragmentary conceptions of human beings that allegedly exist in contemporary conventional medicine by re-integrating "spiritual science" ("Geisteswissenschaft" in German) into medical practice. Steiner frequently used "Geisteswissenschaft" as a synonym of anthroposophy to highlight the aspect of spiritual science that goes along with the anthroposophical worldview. In this sense, "Geisteswissenschaft" means the aim and claim to describe "das Geistige", "the spiritual," exactly and methodically.[10]

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the realm of religion, nor to alternative religion. From an emic perspective, anthroposophy is seen at most as "spiritual".

8   We use "conventional medicine" in this paper as an etic category. German texts written by anthroposophical authors mainly use the term "Schulmedizin" or just "Medizin." Kienle, Kiene and Albonico use the term "scientific medicine", and remark that "Anthroposophic medicine considers itself to be an extension of scientific medicine" (2006: 4).

9   This translation and all following translations of texts originally in German are made by the authors of this article.

10 The English version of the official website of the "School of science" of the Anthroposophical Society at the Goetheanum explains: "In 1924 Rudolf Steiner developed a course of study based on meditative exercises that lead 'the spiritual in the human being to the spiritual in the universe.' This is the basis for the work of the School of Spiritual Science. It is also the background of the research, teaching, and training activities of the General Anthroposophical Section" (https://www.goetheanum.org/en/school-of-spiritual-science, March 8, 2018).

According to the subtitle of Steiner and Wegman's *Grundlegendes für eine Erweiterung der Heilkunst nach geisteswissenschaftlichen Erkenntnissen* (1977), their motive for founding anthroposophic medicine consisted in the desire to extend the art of healing through spiritual knowledge ("Erweiterung der Heilkunst nach geisteswissenschaftlichen Erkenntnissen"). Thus, combining conventional medicine with anthroposophy and thus with alternative religious beliefs and practices was intended from the outset.

From the perspective of the Study of Religion, anthroposophy can be categorized as a form of alternative religiosity*,* that is, as a contemporary religious phenomenon that in some ways represents an alternative to mainstream religions. The attribution of these forms of religion as alternatives points to the fact that alternative religions draw on sources that do not form part of the dominant canons of religious belief and practice (Knoblauch 2009: 104). Moreover, by referring to religiosity, the emphasis lies on individual rather than institutional forms of religion (cp. Luckmann 2005). In recent decades, alternative religious beliefs and practices have been widely diffused throughout society, with medicine and CAM leading the way (cp. Lüddeckens/Walthert 2010a, 2010b). Hence, the attribution of these forms of religion as "alternative" is increasingly losing its legitimacy. However, in contrast to other terms, it still has important advantages: unlike the terms "agnostic," "fuzzy," "popular religion" or "spirituality," "alternative" provides information about a form of religiosity's current position in the religious field.

The narrative of re-integrating "spiritual science," and therefore from an etic point of view (alternative) religion, into medicine is only plausible when the respective fields have already been subjected to processes of differentiation, as is true of conventional medicine and of caring for the terminally ill.[11] The continuing differentiation between religious and medical actors was strongly criticized (Kellehear 2007: 157), and, as a result, the conventional medical paradigm of palliative care developed as a counter-balance to the medicalization of dying and death (Walter 1994: 12–13). From its very beginning, (conventional) palliative care was not only informed by conventional medical care, it also included religion and spirituality ("spiritual care") in its treatment of the terminally ill and dying. This multidisciplinary approach to palliative care is often traced to Cicely Saunders and the hospice

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11 Lüddeckens (this volume) examines the interrelatedness of CAM with religion and medicine using the concept of de-differentiation.

movement (cp. Clark 2001; Wright/Clark 2012). In one of her lectures at Yale University in 1963, Saunders suggested introducing palliative care as a form of holistic care that involves the treatment of "physical, spiritual, and psychological discomfort" alike (Lutz 2011: 305).[12] By not simply delegating religious and/or spiritual care to actors within the established churches, concepts of palliative care hold everyone liable for caring for patients' religious and/or spiritual needs and they quite often make room for alternative religious practices and rationalizations.

2 THE ANTHROPOSOPHICAL MEDICAL SETTING

There is a broad range of academic publications about contemporary anthroposophic medicine from an insider's perspective. For example, Kienle et al. (2013) provide a general overview of anthroposophic medicine. In addition, there are more general publications by anthroposophical physicians, nurses, and therapists (cp. Bopp/Heine 2008; Fintelmann 2007; Kienle et al. 2006; Girke 2012; Glöckler 2010; Heusser 2011), as well as research articles on different methods of anthroposophic medicine (e.g., on the effectiveness of mistletoe therapy with cancer patients).[13] Heusser et al. (2006a, 2006b), von Dach (2001), and von Dach et al. (2009) focus specifically on end-of-life care. For accounts of the history of anthroposophic medicine, its origins and sources from an anthroposophical perspective, in particular the publications of the Ita Wegman Institute and of Peter Selg (2000a; 2000b), the head of the Ita Wegman Institute (http://www.wegmaninstitut.ch/, July 4, 2018) should be consulted.[14] There are only a few academic accounts from an outsider's

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12 One outcome of this conceptualization is the official definition of the World Health Organization: "Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual". (www.who.int/cancer/palliative/definition/en, July 4, 2018)

13 A list of other English publications is to be found on the webpage of the medical section of the Goetheanum: www.medsektion-goetheanum.org/en/home/books.

14 Cp. Glöckler et al. 2011.

perspective. Apart from book chapters on the history of anthroposophic medicine (Brügge 1984: 101–125; Jütte 1996: 237–261; Ullrich 2011: 158–165, Zander 2007: 1455–1578), scholarly discussions lack contemporary research on anthroposophic medicine from an etic point of view, although there are a few exceptions (Arman et al. 2008; Karschuck 2018; Ritchie 2001; Zeugin/Walthert 2016). To our knowledge, apart from Arman et al. (2008), who conducted qualitative interviews in a Swedish clinic, no qualitative study from a social scientific or Study of Religion perspective has ever been conducted in an anthroposophical hospital.[15]

Anthroposophic medicine[16] was founded by the physician Ita Wegman (1876–1943) and Rudolf Steiner (1861–1925).[17] Even though Steiner had already shown an interest in medical subjects in the first decades of the

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15 Ritchie (2001) provides a qualitative study of the National Centre for Social Research, an independent social research institution. The study was funded by the Anthroposophic Medical Trust and printed by Weleda. In this study, which adopts an etic perspective, the authors investigate six practices and one residential unit in GB that offer anthroposophical treatment in addition to general practice. By means of interviews with patients and medical staff, as well as an analysis of medical records, the authors address the questions of how anthroposophical treatment is perceived by medical staff working in general practice, how it is organized and delivered, and what impact it has on patients in terms of patient responses and clinical effects (ibid: 4).

16 The following paragraphs are based on emic sources, exemplary monographs that fall entirely within the contemporary field of anthroposophic medicine (cp. Glöckler et al. 2011; Girke 2012), and the website of the medical section at the School of Spiritual Science, Goetheanum, in Dornach, Switzerland (www.medsektion-goetheanum.org/home/anthroposophische-medizin, July 4, 2018). Even though the field of anthroposophic medicine is indeed heterogeneous, these self-portraits should be considered accurate, despite the difference in actors. For an overview of the contemporary practice of anthroposophic medicine, see "Facts and Figures on Anthroposophic Medicine Worldwide", www.ivaa.info/fileadmin/editor/file/Facts_and_Figures_AM_WorldwideJuly 2012_Final_Public_Light.pdf, May 8, 2018.

17 On other influential actors in the development of anthroposophic medicine, cp. Zander 2007: 1542–1544. On the significance of Wegman, see "Grundlegendes" ibid: 1538–1540.

twentieth century, the founding date is often located in the early 1920s, a decade that witnessed three events that had a lasting impact on anthroposophic medicine. First, Wegman and Steiner held medical courses for medical practitioners in Dornach, Switzerland (the centre of anthroposophy).[18] Secondly, Wegman founded the first anthroposophic hospital in Arlesheim, Switzerland, where medical research has been conducted ever since. Thirdly, in 1925, Wegman published the first monograph on anthroposophic medicine, written by herself and Steiner (Steiner/Wegman 1977).[19]

As mentioned above, Steiner and Wegman did not view anthroposophic medicine as being opposed to conventional medicine; rather, they conceptualized it as being in accordance with academic medical science and thus as an extension of conventional medicine, which anthroposophy complemented. Therefore, anthroposophic medicine is combined with conventional medical practices, each with their own rationalizations. This is why many anthroposophical medical actors favor the paradigmatic term "integrative medicine" (Glöckler et al. 2011: 564–567). While Steiner, Wegman, and others created new anthroposophical medical practices (e.g., rhythmic massage), they also adapted existing such practices to the medical setting (e.g., eurythmy therapy).[20] Since its beginnings, anthroposophic medicine has cared for the terminally ill, but it was not until recently that the conception of anthroposophical end-of-life care has emerged and received expression (cp. Girke 2012: 1051–1083; www.sterben.ch).

Within anthroposophic medicine, human beings are viewed as multi-layered. In his early works, Steiner mainly referred to an anthropology that consisted of seven bodies (2010: 19–36) and that goes back to theosophy. In the 1920s he started to elaborate an anthropology featuring four bodies (Zander 2007: 1495–1497). In this view, the human being consists of a fourfold body,

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18 https://www.goetheanum.org/en/, July 4, 2018.

19 This publication has now been translated online as "Fundamentals of Therapy: An Extension of the Art of Healing through Spiritual Knowledge" (cp. http://wn.rsarchive.org/Books/GA027/English/RSP1983/GA027_index.html, July 4, 2018).

20 Even though all these proprietary anthroposophic medical practices were more or less informed by anthroposophy, anthroposophy is not their only source. Some researchers, for example, have examined the connection between anthroposophic medicine and homeopathy (Jütte 1996: 237–261; Zander 2007: 1514–1522).

the physical body (shape, anatomy, organs, and all the other material aspects), the etheric body (the source of life and growth that endows us with thinking skills), the astral body (the carrier of consciousness and feelings), and the I-organization or higher self. The fourth body constitutes the individuality of the person or his or her spirit, which ultimately transcends life (Steiner/Wegman 1977: 7–19). This conception of the human being is linked to a specific conception of the afterlife, as the I-organization or higher self will not only outlast death, it will be reincarnated (Steiner 2010: 37–59).

Steiner's notion of the four bodies is closely related to the concept of the threefold nature of the human organism that distinguishes the nerve-sense system, the metabolic-limb system, and the rhythmic system. An anthroposophical medical article advocating the need for "rhythm studies" (Hildebrandt 1997) illustrates the close link between the models of the threefold nature and the fourfold (or sevenfold) body, as well as their foundation in religious concepts. In Steiner's own words:

"The rhythmic element in the four bodies [aspects of the human being] was implanted in man over long, long periods.... And we would recognize the rhythm of our human aspects in the movements of the heavenly bodies, which make a complete system." (20 July 1923, Dornach)

"One day man will also apply his own rhythm to the world, when he has reached the divine level." (21 Dec. 1908, Berlin)[21]

3 PRACTICE THEORY: METHODOLOGY, METHODS, AND DATA

3.1 A Practice-Theoretical Approach

According to a practice-theoretical approach, the social is only accessible when it is carried out in action. This is in line with Theodore R. Schatzki's definition of social practices as a "temporally unfolding and spatially

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21 The second quotation by Rudolf Steiner appears in his lecture "Über den Rhythmus der menschlichen Leiber", 1988: 158.

dispersed nexus of doings and sayings. […] To say that the doings and sayings forming a practice constitute a nexus is to say that they are linked in certain ways" (1996: 89). Thus, social practices are constituted by the performance of doings and sayings and the existence of a coherent system of knowledge about the links between these doings and sayings. Accordingly, they can be heuristically distinguished in terms of a) their use of language and b) their knowledge structures:

a) Social practices that exhibit a high use of language might be labeled discursive practices in so far as they "[...] embrace different forms in which the world is meaningfully constructed in language or in other sign-systems" (Reckwitz 2002: 254). Social practices do not necessarily have to involve language or other sign systems and might thus be labeled body practices, or non-discursive practices. However, a closer look at social reality reveals that social practices are only rarely either solely discursive or non-discursive. Rather, they exhibit a greater or lesser orientation towards language or the body, being either more communication/language- (and less body-) oriented or more body- (and less communication/language-) oriented.

b) Social practices often build on the ability of actors to rationalize their actions reflexively. What Giddens calls the rationalization of action means that "actors—also routinely and for the most part without fuss—maintain a continuing 'theoretical understanding' of the grounds of their activity" (1984: 5). This form of knowledge is the most common one, yet it is often not "directly accessible to the consciousness of actors" (Giddens 1984: 4). Although, as social scientists, we examine this knowledge either through observation or by explicitly enquiring about it, the implicit motivation of action is not discursively accessible (Giddens 1984: 6, but constitutes the "implicit sense of what someone actually wants" (Reckwitz 2003: 293).

3.2 Data and Data Collection

Adopting a practice-theoretical view of anthroposophic medicine has an impact on one's methodological approach: this qualitative study first looked at what is happening on the ground and then asked the actors to rationalize their

doings and sayings discursively.[22] Accordingly, this study combined the qualitative research methods of participant observation[23] and qualitative interviews.[24] Given that our main interest was in anthroposophic end-of-life care, the fieldwork focused on those hospital units that exhibited dying and death as crucial features, namely an oncological ambulatory and an oncology ward.

Zeugin actively participated in the field by means of a nursing internship and the job-shadowing of physicians, nurses, and therapists alike. This provided valuable insights into what happens behind closed doors (e.g., consultations between physicians and patients, appointments with therapists, anthroposophical medical treatments). Apart from participant observation, she blended in by experiencing certain anthroposophical medical practices herself, such as art therapy, rhythmic massage, poultices, and therapeutic eurythmy.[25] In addition, she conducted 25 interviews of an average duration of one hour with health professionals (nurses, physicians, therapists, social workers), pastors, and terminally ill and dying patients. Finally, she collected grey literature, online information, and internal documents.

3.3 An Anthroposophical Medical Hospital[26]

The anthroposophical hospital in which the fieldwork was conducted opened in the 1990s as a private clinic primarily providing anthroposophical medical

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22 Even though, following Bourdieu (2005: 18–19), this is legitimate, we have to pay attention to the fact that such rationalizations—concepts, beliefs and values—and their verbal manifestations in discourses might not occur if it were not for us.

23 Apart from general guidelines about participant observation (cp. Spradley 1980; Emerson et al. 2001; Franke/Maske 2011), Zeugin considered the term "focused ethnography" coined by Hubert Knoblauch (2001, 2002, 2005) to be an important reference point.

24 In order to enhance the comparability of all the interviews, Zeugin designed a qualitative interview technique that combines elements of narrative interviews as conceived by Fritz Schütze (1983) and elements of problem-centered interviews suggested by Andreas Witzel (1985, 2000).

25 For a similar approach, cp. Langford 2002.

26 The following description is primarily based on the hospital's discursive self-portrayal in grey literature and on their website.

treatment. In the late 1990s, the hospital was entered on the official list of hospitals, and since then it has been authorized and required to conduct primary health care, as well as emergency medical aid, like any other public health facility. Whereas its conventional medical treatment has always been covered by obligatory health insurance, formerly many anthroposophical medical treatments had to be financed by the patients themselves or by supplementary insurance. Only very recently, and as a result of the official recognition of anthroposophic medicine in 2009, has the hospital managed to introduce a lump-sum payment for anthroposophical treatments on a case-by-case basis.[27] Since then, the costs of anthroposophical medical practices have been covered by basic health insurance, provided that they are prescribed by a physician and are carried out for a patient on this financial basis.

A support association funded by donations and guided by members of the Anthroposophical Society bears some of the additional expenses associated with the hospital's orientation towards anthroposophic medicine from day one. For example, the support association pays for the employment of an anthroposophical nursing expert, who is responsible for training nurses in anthroposophical nursing, as they usually only have conventional training.

4 ANTHROPOSOPHICAL END-OF-LIFE CARE

As end-of-life care embraces more than just one's death bed, it is conducted at various stages of both conventional (Jonen-Thielemann 2012: 989–997) and anthroposophical end-of-life care. Corresponding to the anthroposophical concept of the end of life and to practice in the respective hospital, the following stages also cover the time after the death of the respective patient. The following description presents data from Zeugin's fieldwork in 2015.

4.1 Late Stage

At this time, most terminally ill patients are not permanently hospitalized, but are given outpatient treatment. Most conventional and anthroposophical curative treatments are reduced, and the provision of anthroposophical

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27 Cp. http://apps.swissdrg.org/manual40/drgs/54771e6ce4b0887aa13fd25c?locale =de, June 4, 2018.

medical treatment shifts away from oncological practices to relieving anthroposophical medical, nursing, and therapeutic practices.

Some of the body-oriented practices stay the same throughout all stages, but others are reduced,[28] and some vary over time and are attributed with different meanings, such as body wash care. No matter whether body-oriented practices lost importance or were continued, all options were usually rationalized by referring to anthroposophical concepts.

In reducing body-oriented practices, the argument was mostly based on the belief that too much touching prevents patients from "letting go" and accordingly from dying. This is expressed in the following quote from a rhythmic massage therapist:

"I've often experienced that patients who always loved rhythmic massage and who wanted to have it every day got to the point where every single touch was too much. And they say: No, I don't want that anymore. And mostly, this happens right before they really cross the threshold. Maybe because everything that is forced on the physical body from the outside reconnects them to it. That there is this feeling of letting go of their physical body." (Heike, rhythmic massage therapist, 8 June 2015)[29]

The remaining body-oriented practices were often explicitly rationalized using anthroposophical concepts, again with the importance of "letting go". The conception of letting go is found in Girke (2012: 1053), one of the very few accounts of end-of-life care written from an anthroposophical point of view. In this work, "letting go" is strongly linked to an alternative religious conception of the human being, as Girke refers to the fourfold articulation of

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28 According to the observations of Lüddeckens during her fieldwork in a conventional medical palliative care unit, the reduction in body-oriented practices is not specific to the anthroposophical setting: in conventional palliative care wards body-oriented practices, such as hygienic measures, also lose importance.

29 Original wording: "Ich hab noch oft erlebt, dass [...] Klienten, die es (rhythmic massage, BZ) immer geLIEBT haben und die JEden Tag gerne das wollten, dass es einen Punkt gibt, wo (.) jenste Berührung wie ihnen zu viel ist. Und die sagen dann, NEIN, ich will nicht mehr. Und das ist dann oft (-) kurz bevor sie wirklich über die Schwelle gehen. (-) [...] Vielleicht weil (.) alles, was da von Aussen auf den (-) Leib kommt, [Hm=hm] ja wieder ähm (1) sie mehr verbindet mit dem. Dass da dieses Gefühl ist, dass [...] sie lösen sich ja grad aus dem Leib."

the body by using it as an explanation for what is happening throughout the process of dying. For example:

"In death, the I, the astral and the etheric body detach from the physical organization. […] A […] manner of crossing a threshold between life and death concerns the consciousness and hence the nerve-sense system. Patients grow increasingly tired, which is associated with the separation of the fourfold body throughout the dying process." (Girke 2012: 1054, 1058)[30]

This anthroposophical perception of "letting go", first of the patients' physical body at the time of death, then of their etheric body during the following 72 hours, and finally after this time of their astral body, was also found in the hospital in this case study:

"In anthroposophy, there is the crossing of a threshold and afterwards the (transcendent) bodies let go of each other. [...] And after three days all that remains is the [...] corpse, right? And all the other bodies step by step let go of this physicality." (Lothar, physician, 30 April 2015)[31]

One example of this rationalization of a body-oriented practice is the conviction that certain directed ways of touching support patients in "letting go:"

We often perform the so-called pentagram embrocation. They really address the human being as a whole, in his or her individuality. And they strongly lead the person

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30 Original wording: "Im Tod verlassen das Ich, der astralische und der Ätherleib die physische Organisation." (Girke 2012: 1054) "Eine [...] Form des Überschreitens der Schwelle betrifft das Bewusstsein und das Nerven-Sinnes-System. Es entwickelt sich zunehmend eine Müdigkeit, die mit der Lösung der Wesensglieder im Sterbeprozess zusammenhängt" (Girke 2012: 1058).

31 Original wording: "Aus der Anthroposophie heraus gibt es ein SCHWELlenübertritt und danach [Hm=hm] lösen sich die verschiedenen Wesensglieder [...] ab. [...] Nach (.) drei Tagen ist dann nur noch der [...] Leichnam vorhanden, oder? [Hm=hm] Und die (-) äh anderen Wesensglieder (-) lösen sich in SCHRITten aus dieser Leiblichkeit [Hm=hm] heraus."

back to his or her real self, so as to facilitate the letting go when it comes to dying. (Heike, rhythmic massage therapist, 8 June 2015)[32]

While in this case, the embrocations are conceptualized as reassuring the wholeness and individuality of the patient as a precondition for "letting go", the next example instead emphasizes the calming effects of certain practices:

"Someone who has difficulties in letting go needs to get his underarms washed quite coldly. […] It calms and supports letting go." (Manuela, nurse, 22 May 2015)[33]

In this view, the process of "letting go" is facilitated by nurses acting calmly and silently, and deliberately touching, thus performing body care in a certain way.

From an anthroposophical perspective, one aspect of the person will transcend death. This aspect is referred to most often as the soul, the spiritual dimension, or the I, as anthroposophists would say, and just as frequently it is linked to the idea of reincarnation. The notion of "letting go" is also found in conventional medical palliative care contexts as one of its own core semantics. However, here it is merely a matter of the patient's need to let go of life: "As death nears, many people feel a lessening of their desire to live longer."[34] In the anthroposophical context, in contrast, "letting go" is clearly linked to conceptions of human beings and the afterlife.

At this stage, discursive practices that actively involve the patients are reduced, whereas discursive practices among the health professionals themselves increase slightly, rationalizing the body-oriented practices, as we will see in the following examples. An important discursive practice is the nursing case discussions, which are held weekly, last thirty minutes, and occur

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32 "Wir [...] machen dann manchmal auch die sogenannten [...] Pentagramm-Einreibungen. [...] Die wirklich dann auch (1) den Menschen ganz stark in seiner Gesamtheit (-) ansprechen, in seiner Individualität. Äh und ihn noch mal ganz stark zu sich führen, sodass manchmal das (-) äh Rauslösen dann, wenns (-) äh ins Sterben geht, [Hm=hm] leichter fällt."

33 All interview quotations and observation logs are translated by Barbara Zeugin. Original wording: "Öpper, wo Müeh hät zum losla, wo lang hät, (-) d Underärm chüel wäsche. [...] Es tuet beruhige und helfe LOSla, ja."

34 www.caregiver.org/advanced-illness-holding-on-letting-go, July 4, 2018.

under the premise that internal and oncology nurses are physically copresent. Additionally, the performance of this social practice builds on formal guidelines aimed primarily at the rationalization of action by producing a theoretical description of the fourfold articulation of the body. At the same time, these guidelines offer instructions for action by referring to the nurses' experiences of work and providing a list with features of each element of the fourfold body that guides them in their observations and their treatment of the patients. In preparation for the discussion of each case, one of the nurses is asked to fill in a table with her observations. The performance of the nursing case discussion is the anthroposophical nursing expert's responsibility, whereas the presenting nurse varies each time. In Zeugin's observations, the discussion unfolds as follows. While all the nurses sit in the nurses' station, one nurse describes a patient who is being somewhat "problematic" by using a guideline table of the fourfold bodies as a template for her presentation. In this table, the four bodies are adapted to the medical setting: the physical body is linked to visible, easily determinable aspects such as age, gender, and symptoms; the etheric body carries information about respiration, body heat, nutrition, and expulsion, as well as creativity, habits, and everyday rhythms; the astral body is to be found in the patient's experience and communication of pain and mood, as well as thinking, feeling, and wanting; and the last body, the ego or "I" of the human being, is exemplified as a patient's profession, all sorts of biographical information, and indications of self-awareness, e.g., regarding the finiteness of his or her being. After this presentation, the other nurses add their own observations. Finally, possible nursing interventions are discussed by making use of a conception of anthroposophical nursing called the "twelve gestures of care" in nursing.[35] The twelve gestures, such as Hüllen/or "grounding" and Harmonisieren or "harmonizing," are different objectives that can be achieved by several different nursing practices. In the case of a female who refused to eat in accordance with the results of her measuring each food item with a pendulum, the interventions included the following: sending in the (anthroposophist) nutritionist to discuss a balanced diet; the affection and love of nurses spending time with her; and a footbath

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35 This conception was developed by Rolf Heine on the basis of Steiner's belief in the twelve "senses" (cp. www.vfap.de/anthroposophische-pflege, July 4, 2018). The last sense, the "Ich-Sinn," is based on the ego of the fourfold body concept; cp. von Dach 2008.

in water containing rosemary in order to "ground her" because she seems too "spiritually minded": "She is so spiritually minded. […] She aspires to overcome her trauma so as to not have to go through it again in her next incarnation" (Nadja, nurse, 18 May 2015).[36]

Another discursive practice is the inter-professional biographical work[37] case discussion. Biographical work constitutes a crucial part of anthroposophic medicine, as of end-of-life care. According to the biographical counsellor, she first conducts a conversation with a patient to learn about his or her life story. This conversation follows the pattern of seven-year cycles ascribed to Rudolf Steiner. This pattern is again used throughout the biographical work-case discussion, as in the case of a 55-year-old woman with leukaemia. In this case, biographical work discussions brought together the attending physician, the key nurse, a physiotherapist, and a social worker, as well as representatives of all anthroposophical therapies. To begin with, they shared their initial impressions of the patient's current state. The physician said that she had recently delivered some computer tomography results and that the patient didn't behave normally: "She hugged me. I don't like that, but I didn't say anything. I think she is really longing for closeness" (Elisabeth, physician, 22 April 2015). The nurse adds that the patient seems very sensitive: "She reacted strongly to physical contact when I applied a rhythmic embrocation; it really exposed her emotions so strongly that I had to give her some tranquilizer" (Nora, nurse, 22 April 2015). Afterwards, the biographical counsellor retold the woman's life story in accordance with the pattern of seven-year cycles. Finally, the health professionals discussed what they had been listening to and concluded that the patient clearly lacked a basic sense of trust in her first seven years and that she had always cared more for others than for herself. From this the physician deduced the following need for action: "Anthroposophically speaking, her higher self needs shelter, warmth and protection. […] I'd recommend some nice warm poultices" (Elisabeth, physician, 22 April 2015).

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36 Original wording: "Sie ist so vergeistigt. […] Sie strebt an, ihr Trauma zu bewältigen, damit sie das los ist und das nicht noch einmal machen muss, wenn sie inkarniert wird."

37 "Biographical work" is an anthroposophical extension of conventional psychology complemented by the anthroposophical theory of reincarnation and anthroposophical anthropology; cp. Ritchie 2001: 78ff.; Burkhard 2002.

In both examples, body-practices involving the patient, such as a footbath and poultices, are the consequence of a discursive practice among health-care professionals.[38]

4.2 Final Stage

On the physical plane, the body starts shutting down and curative medical treatments become completely irrelevant. Even though the physicians are still engaged in both conventional and anthroposophical medical care, they withdraw from the sickbed, leaving nurses to be more present. Once a cure is definitely no longer an option and discursive abilities decline, body-oriented practices gain more and more momentum, such as rhythmic massage.

According to Margarethe Hauschka (1978), who was an assistant to Wegman, the founder of rhythmic massage, this form of massage combines Swedish massage techniques with anthroposophical spiritual science. Anthroposophical anthropology and the conception of the threefold nature of the human organism (nerve-sense system, metabolic-limb system, rhythmic system) are the main official rationalizations of this formalized set of practices (cp. Hauschka 1978: 92–100; see also above). Rhythmic massage, as its name suggests, is primarily aimed at the rhythmic system.

Whereas different practices of rhythmic massage are performed at several stages, the so-called *embrocation* is of great significance when it comes to patients who are very close to death.[39] In her fieldwork, Zeugin found that the pentagram embrocation is embedded in a wider scope of action. The following account is based on her own experience of a rhythmic massage therapist carrying out pentagram embrocation on her for illustrative purposes. While sitting on the massage table, the therapist explained that pentagram embrocation requires a subsequent rest of about twenty minutes to produce its effect fully. She further explained that this effect consists in bringing all parts of the body back together and making the patient "whole" again. The massage therapist fetched a piece of paper and, while drawing a pentagram, she continued her explanation as follows. The embrocation stems from

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38 In the second case, however, the discussion among the healthcare professionals was preceded by a biographical conversation with the patient.

39 Cp. von Dach (2001), Pflege an der Grenze des Seins, pp. 36 f.; also Layer 2006: 110-116.

Leonardo, but thanks to anthroposophy this picture was assigned to the etheric body, where the energy flow is positioned. As rhythmic massage operates at this level, blocked energy can be set free by indicating five essential points. According to what she had said in a previous interview, she aims to bring all the bodies together by pointing to these five positions on the physical body in the correct sequence. After the treatment, she started a conversation that led from the illnesses of the etheric body to the *Tibetan Book of the Dead*.

With regard to this therapeutic practice, a conventional medical rationalization of action is missing altogether: there is no reference to the relief of pain or any other distressing symptom, as required by the definition of palliative care, but it is primarily aimed at the patient letting go of her body and life in order to prepare for the afterlife.[40] The link to the "Tibetan Book of the Dead", a book that is widely popular for its content about support for the souls in the process of dying and their transition to the afterlife, even strengthened this aim.

This rationalization of action, i.e. letting go of the body and preparation for an afterlife, is part of the discursive knowledge of all health professionals in the hospital of Zeugin's fieldwork.[41] It comes into effect in the communication with the particular patient, provided that the latter can still be addressed and is conscious. Otherwise this body-oriented practice can be performed without any use of language.

4.3 Terminal Stage

Due to the increasing loss of agency that develops in the terminal stage, anthroposophical physicians and therapists noticeably back away from the death bed, leaving it mainly to the nurses to provide all sorts of primary and end-of-life care. Nurses now become more autonomous and independent

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40 See the "Therapeutic Rational" of massages with regard to the findings in the study of Ritchie: "Through achieving balance in physical functions, the therapist is able to influence and connect with the other 'higher' levels to promote greater balance and connection between them. Massage mainly works through the physical and etheric (or life forces) level which can then strengthen the soul (emotional) and spiritual levels (ego organisation)" (2001: 72).

41 For the Lucas Clinik in Arlesheim (CH), cp. von Dach 2001: 36 f.

from the physicians' instructions and surveillance. Often, they perform self-directed "little somethings", as one of the nurses explained:

"For me, the anthroposophical aspects just go with caring for the terminally ill. […] Not pampering them, but to give them a little treat—in another way." (Larissa, nurse, 26 March 2015)[42]

A prevalent and thus almost institutionalized instance of little somethings is the social practice of installing a rose-quartz lamp in patients' rooms. The lamps are not installed until the patient's death is foreseeable, yet from then onward they are lit permanently. While some nurses simply highlight the practice's aesthetic value, others argue that it supports the patient in letting go by providing a nice, warm, quiet ambience.

Furthermore, nurses increasingly relocate their doings and sayings towards a set of practices that are often referred to as "being with" when the dying process progresses.[43] Practices of "being with" are carried out so as to still be doing something, even though medically nothing can be done anymore. "Being with" comprises a multitude of practices, such as sitting at the patient's bedside, decorating his or her room, singing a song, narrating a story, holding the dying person's hand, and so on. Even family members are instructed just "to be with" their dying relatives in order—at least this is how the saying goes—to facilitate the process of letting go and thus promote dying. Hence, "being with" is strongly linked to conceptions of a good death, the human being, and the afterlife in the form of the metaphor of letting go.

During the terminal stage, practices and their rationalizations are even more detached: the latter are not discursively communicated in contact with the patients, but only in interprofessional conversations or in exchanges with the researcher.

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42 Original wording: "Und für mich ghört das Anthroposophische dänn eifach au dezue. [...] Nöd verhätschlä, aber (.) ähm (1) eifach nomal öppis chlises Guets tue, uf än anderi Wiis."

43 Cp. Zeugin/Walthert 2016.

4.4 After Death

Once a patient has died, there is still work for the physicians and nurses to do until the state funeral office takes over. After a physician has issued a death certificate, the nurses are in charge of most post-mortem care practices, that is, going through the formalities, dealing with family members, and burning incense in the patient's room. It is common practice to let the deceased patients rest for some hours before preparing them for the laying out. Usually one nurse prepares the deceased without the bereaved being present and performs individual actions like closing the deceased's eyes and washing and clothing him or her quietly without moving the body unnecessarily. The latter aspect accords with two differing rationalizations of action, one saying that things are done like this out of sheer respect, the other that the souls need to let go of their bodies and thus need quiet.[44]

The deceased are laid out in the in-house mortuary for three days. This temporal determination is in line with Rudolf Steiner's conception of a panorama of the past life that follows death and lasts around two to three days. Whereas the physical body leaves the person at the time of death, the etheric body splits off during this subsequent period (Steiner 2001: 140).

"There is a period of rest, and in it, the bodies […] let go of their physicality. I believe we overestimate ourselves if we believe we have a great impact on this process of letting go. It is connected, is connected to the person's biography, right? […] Well, I believe there is this frame, and we do not strictly lay out the deceased's body for three days, but if possible." (Lothar, physician, 30 April 2015)[45]

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44 Both kinds of rationalizations can be found in conventional palliative care contexts as well. However, in most cases, the deceased are prepared for their "departure" within short time of their death and incense is only burnt if a staff member chooses to do so as an individual.

45 Original wording: "Es gibt eine bestimmte Ruhephase, (.) in der (.) diese Leiblichkeit (.) sich [...] lösen kann. Und ich glaub, wir überschätzen uns, wenn wir glauben, dass wir in diesen Ablösungsprozess (.) viel bewirken können. [Ok] Es hängt das hängt mit der Biographie dieses Menschen zusammen, [Ja] oder? [...] Also ähm (3) ich glaub, (2) es gibt den Rahmen, wir machen es auch nicht prinzipiell so, dass wir Menschen dann drei Tage aufbahren."

As these words from a physician in a leading position indicate, laying out the deceased for three days is rationalized by means of the notion of letting go of the various bodies, i.e. as an anthroposophical practice. However, whereas he considers this action as supporting the process of letting go, to him it is not necessarily a precondition.[46] This stance is in line with actual practice in the hospital, which is also influenced by economic and other practical considerations resulting from its designation as a public hospital: whereas laying out the body for three days is the usual practice, the duration may be reduced, or it may not take place at all when there are more deceased than rooms for laying out, or when the deceased or his relatives do not approve of it. However, if possible the practice is performed in its original form.

In addition, all health professionals are invited to participate in a collective farewell ritual that is primarily targeted at the health professionals themselves, though the deceased's family is invited too. The deceased is laid out in the middle of the small room, specifically reserved for this purpose. The room is decorated with candles and flowers, and the attendees surround the coffin. The actual farewell ritual starts with a gong being sounded, and two tunes are chosen and performed by the health professionals.[47] After the singing, the physician provides the deceased's biography, focusing on the description and interpretation of his or her dying process and the health professionals' share in it. Depending on the physician's personal assessment of the religiousness of the deceased, he may say the Lord's Prayer. The ending of the ceremony is again marked by the same songs. This stage, where the medical staff are still involved, is marked by religious ritualistic practices and other discursive practices, all of them in line with anthroposophical rationalizations.

During the successive stages of anthroposophical end-of-life care, from the late stage till the terminal stage, body-oriented practices in relation to discursive practices in contact with the patient gain momentum. However,

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46 He pointed out that the separation of the four bodies also takes place when people die a painful death and cannot be laid out, for example, when they are buried alive in an earthquake.

47 The first canon, "Dona Nobis Pacem" ("Give us peace"), originates from the last words of the Roman Catholic mass of Agnus Dei; the second tune, "Harmonie der Sterne" ("Harmony of the stars"), by the German songwriter Werner Gneist, explicitly concerns God, creation, and the meaning of life.

death seems to be the turning point, where body-oriented practices with regard to the deceased patient are reduced decisively, while discursive practices with anthroposophical rationalizations among the healthcare professionals become central. At this stage, the difference between anthroposophic care as including care for the deceased and conventional medical care which ends when the patient has passed away is most obvious.

5 RELIGIOUS RATIONALIZATION IN END-OF-LIFE CARE

As the description above indicates, it is a distinctive feature of anthroposophic medicine that it provides religious rationalizations that enable healthcare professionals to maintain their agency even if medical rationalizations do not support further actions.

In conventional palliative care, less and less action is carried out over the course of the dying process.[48] This is due to the fact that many conventional medical practices are no longer of effect and communication becomes more difficult, with patients losing their communication skills or their consciousness. However, in the case of the anthroposophical medical care in our case study, health professionals continue providing care by focusing their action on more body-oriented practices, as we have seen above.

While some more communication-oriented medical practices, such as psychotherapeutic interventions ("biographical work"), end completely, others vary over time and become more body-oriented: eurythmy therapy,[49] for example, becomes more passive and has fewer communicative instructions as death approaches, as patients are not required to engage in physical activities by themselves anymore; rather, the eurythmy therapist conducts the

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48 Cp. Zeugin/Walthert (2016) for an account of the relocation of action against the backdrop of hospice end-of-life care.

49 Eurythmy is an anthroposophical expressive art and movement therapy. "The therapeutic rationale" of eurythmy therapy appears in the findings of Ritchie as follows: "As with all treatments, the overall therapeutic rationale and subsequent processes are very much dependent on the individual patient and relate to a key principle of developing the potential of the person" (2001: 76).

physical activities for them either by moving the patient's body parts or by taking over the exercise completely and performing it herself.

By means of such non-discursive practices, the health professionals reclaim agency, which seems to decline increasingly in the face of death. Even when it appears that nothing can be done anymore because the patient is going to die anyway, this allows health professionals to still do something for their patients and not just stand by idly.

A typical rationalization of eurhythmy therapy is as follows: "Unconsciously experienced states of restlessness decrease and give way to a peaceful state of mind. All these are important means in order to commit oneself to the next steps and the new spiritual space connected to death."[50]

Emphasis on these body-oriented practices is backed up by way of rationalization based on an anthroposophical understanding of the dying process. With regard to the various activities in the different stages mentioned above, the healthcare professionals often refer to explanations pertaining to anthroposophical concepts such as the pattern of the seven-year cycles, the fourfold body, and the departure and reincarnation of the soul.

In these explanations, particular emphasis is placed on the notion of "letting go": Throughout the dying process, people have to let go not only of their lives, but of their bodies too. This notion is used to rationalize the body care, rhythmic massage, the "little somethings" such as the rose quartz lamp, and even the effort to avoid moving the body immediately after death. This kind of religious rationalization enables health professionals to continue providing care without focusing their actions on healing and without restricting their focus on the physical existence of their patients. Instead, the idea of easing the separation of the bodies and the soul's transition into the afterlife gains importance. As already noted, this relates to a specific conception of human beings and the afterlife, as well as showing that the health professionals in the anthroposophical hospital feel accountable for this kind of religious or spiritual care. It is this rationalization of action that distinguishes the

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50 http://www.sterben.ch/Heileurythmie.81.0.html, February 7, 2018. Original wording: "Auch unbewusste Unruhezustände lassen nach und weichen einer **friedvollen Seelenstimmung**. Das alles sind wichtige Hilfen, um sich auf die nächsten Schritte und den neuen geistigen Raum einzulassen, der mit dem Tod verbunden ist."

practice of anthroposophical end-of-life care from conventional medical settings, where end-of-life care might also feature a transition from communicative to more bodily-oriented practices, yet without this very specific anthroposophical rationalization. Therefore, in this setting, where religion and medicine intersect, reference to the religious dimension provides a fundamental basis for how therapeutic practices are rationalized.

These examples illustrate the ways in which actors in anthroposophic end-of-life care, unlike those in conventional medicine, act according to the rules not only of the medical field but also of the alternative religious field of anthroposophy, showing how they gain agency by means of this double orientation.

The body-oriented practices, like the poultices and the footbath in the examples given above, are in most cases conducted because of instructions from the interprofessional nursing case and biographical work discussions. In most cases, the nurses did not rationalize these practices with anthroposophical concepts in contact with the patients. The first patient will probably never know that she was given a footbath so as to "be grounded" as a supportive measure with regard to her future reincarnation, any more than the second patient will know that the poultices will protect her "higher self". In the stages in which the discursive practices are reduced there is consequently less communication about religion. However, religion is practiced by means of footbaths, poultices, the ways of performing body care, and so on.

6 POWER STRUGGLES

According to Bourdieu, fields are internally structured by actors' struggles for power.[51] The valid set of rules of acting and of the distribution of power are the main bones of contention between leading actors who hold a monopoly of power and novices or oppressed actors who are trying to gain power (Bourdieu 2014: 107). In the case of end-of-life care in our case study, the rules of both conventional and anthroposophic medicine are at stake. There are practices based on conventional medical dispositions and others based on

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51 For a short but concise explanation of Bourdieu's conceptualization of field, (symbolic) power, and forms of capital as manifest in habitus, material goods, and institutionalized forms, see Rageth this volume.

anthroposophical dispositions and situations where struggles over the validity of different sets of rules occur. The actors involved embody a conventional medical habitus and an anthroposophical habitus to different degrees. Moreover, they have different degrees of symbolic power with regard to their anthroposophical expertise and institutional status.

Thus, the question of how, under these specific circumstances, the respective power struggles can be understood arises.[52] Most of the actors' struggles over power have to do with the fact that the actors orient themselves to the set of rules of more than one social field. While all actors play by the main set of rules of anthroposophical end-of-life care, they relate differently to conventional medicine and anthroposophy respectively. Even though in our case the anthroposophical medical treatment is provided by physicians, nurses, and therapists alike, a nurse who mainly refers to the conventional medical set of rules is likely to perform fewer anthroposophical medical practices and to rationalize them in a less anthroposophical manner than a nurse who relates more to anthroposophy, such as the anthroposophical nursing expert.

All nurses are trained in conventional medical nursing, yet, apart from the in-house training, they have hardly any education in anthroposophical nursing. Accordingly, they are most likely to relate to the set of rules for conventional medicine in cases where the two fields are in conflict.

In contrast to the nurses, the physicians all have a general interest in CAM, and more than half of those who engage in end-of-life care have degrees in anthroposophic medicine in addition to their conventional medical education. The nurses and physicians who have this kind of double training occupy powerful positions within their own occupational groups, as well as throughout the hospital. For example, all attending physicians on the hospital management board are trained in anthroposophic medicine and are well-known practitioners of it. Therapists, finally, are greatly involved in acting on anthroposophical principles, as they have all been trained by an anthroposophical institution and are also likely to relate to anthroposophy,

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52 As Bourdieu explains: "The struggles which take place within the field are about the monopoly of the legitimate authority (specific authority) which is characteristic of the field in question, which means, ultimately, the conservation of the structure of the distribution of the specific capital" (1995: 73).

irrespective of their professional engagement in the medical setting.[53] Physicians, therapists, and the anthroposophical nursing expert, socialized within the anthroposophical field, consequently tend to act in a respective habitus and prefer anthroposophical practices in cases of conflict.

The continuing power struggle of the actors involved in the practice of anthroposophical end-of-life care may be illustrated by attempts made by the anthroposophical nursing expert to control the doings and sayings of nurses in caring for the terminally ill and dying. By means of the nursing case discussions, the anthroposophical nursing expert tried to impose a collective nursing habitus by directing it towards the anthroposophical set of rules. That she was allowed to do this reflects the fact that she was accorded greater power than the regular nurses. This further demonstrates that the hospital's management and the supporting foundation—leading actors—who have not assigned a conventional medical nurse to administer further training are upholding the anthroposophical set of rules in doing so.

However, the nursing expert's influence on the nurses remains limited in so far as in most cases the nurses do not transfer the anthroposophical dispositions taught in the actual case discussions to other cases. Furthermore, it must be noted that the practice of the nurses is informed by anthroposophical dispositions only when they consider it not to be in conflict with conventional medical practice, despite the instructions of the anthroposophical nursing expert. This way of acting is in line with Bourdieu, who argues that the intentional communication and teaching of any habitus is exceptional and bound to fail (1997: 165–169). The reasons for this are twofold. First, the incorporation of objective structures involves a lengthy process of implicit learning, which for most nurses took place in the realm of conventional nursing, not in anthroposophical care. Secondly, those forms of habitus are the most effective that are not informed by intention. Due to their socialization within conventional nursing, the nurses implicitly acquired learning about certain norms that led to certain dispositions with regard to practices. In contrast to this implicit learning, the intentional teaching of the nursing expert is less influential in conflict situations, as the crucial example below will demonstrate.

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53 A last group of actors are the terminally ill and dying patients themselves. Due to the article's terms of reference, however, they will not be dealt with specifically here.

The practice of administering pain-killers and sedatives at the end of life poses a problem for anthroposophical end-of-life care. While many nurses openly argued in favor of this practice, anthroposophical physicians tended to be reluctant to follow it, while the hospital management did not participate in any explicit discourse on the matter. One important rationalization for the physicians' reluctance is the emphasis on the patient having a clear mind so as to have an opportunity for transformation and inner growth and to be able to extract experience until the very end, which is gainful for the afterlife.[54] Therefore, as patients should be able to experience this transitional period consciously, anthroposophical medical care tries to avoid the use of sedating painkillers: "The aim is to pass away with the least required pain medication and a mind as conscious as possible" (Lothar, physician, 30 April 2015).[55] In this context, it important to realize that the anthroposophical physicians shared the anthroposophical view that dying is not something to be prevented at all costs and that death is not dreadful. On the contrary, the time of death appears as a significant and wonderful moment in an anthroposophical view (Steiner 1980: 327–328). Another rationalization articulated in the hospital where Zeugin's fieldwork was conducted consisted in the conviction that the

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54 This rationalization, expressed by the physicians in our case study, is in accordance with anthroposophic medical theory. Cp. Floriani 2016: 99–100; Girke 2012: 1062–1064, Glöckler 2008: 471–472; Karschuck 2018: 136–144.

55 Original wording: "Also das Ziel ist schon, [...] mit möglichst wenig (.) SCHMERzmittel bei möglichst grossem Bewusstsein diesen Schritt zu gehen." The same physician explained further that many patients appreciated a state of painlessness: "It is as if their pain is receding and their spiritual life gains freedom" (Lothar, physician, 30.4.2015); original wording: "Der Schmerz tritt wie in den HINtergrund [Ja] und damit ist mein Geistesleben eigentlich freier". The goal to administer as few painkillers as possible is in accordance with von Dach 2001: 34–37. Floriani (2016) refers to Bott (1996) here: "According to the anthroposophic approach, humans are on a path of spiritual evolution, wherein disease can play a central role in their terrestrial fates as part of a process of transformation and inner cures, with particular transformative power during the process of dying. In other words, disease is understood as means of transformation and spiritual development" (ibid: 99–100). For anthroposophical concepts, cp. Girke 2010; 2012: 426, 1052–3.

dying need fewer painkillers in order to ease their pain, as they are already letting go of their bodies during the dying process.[56]

Nurses, on the other hand, mostly preferred to administer pain-killers and sedatives and used conventional medical rationalizations in doing so, concentrating on the physical needs and psychological conditions of their patients. By emphasizing their greater presence at the dying patients' sick-beds, they claimed to know their patients' wishes and needs, leading them to argue for the benefits of the conventional medical treatment of administering pain-killers and sedatives.

The anthroposophical physicians were powerful actors within this anthroposophical hospital because they acquired more symbolic power than other health professionals: they were officially in charge of implementing anthroposophy in the hospital, and they had both conventional and anthroposophical medical degrees and titles that equipped them with institutionalized cultural capital (cp. Bourdieu 1986). The nurses, by contrast, had less institutionalized capital and symbolic power than the physicians who administer and supervise their actions. From their positions of symbolic power, the latter tried to control the practice of anthroposophical end-of-life care by rationalizing it in an anthroposophical manner.

However, although the nurses possess less symbolic power than the anthoposophical physicians, in many cases they prevailed. A close look at the actual practice indicates that although, at a rough guess, the administration of pain-killers and sedatives is still less common in this anthroposophical hospital than in conventional medical health facilities, it is still more common than anthroposophic medical actors intend. Their symbolic power ultimately seems less than originally anticipated. Thus, when it comes to the practice of administering pain-killers and sedatives within the practice of anthroposophical end-of-life care, it is the anthroposophical physicians in this case who are the "oppressed actors," most probably because they orient themselves towards the alternative religious field instead of the conventional medical (or economic) field.

The reasons for this finding are threefold. First, the nurses tried to act in conflicting situations in accordance with their own habitus, which was the conventional medical one. Secondly, they were closer to the patients at the crucial time during the terminal stage once the physicians had more or less

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56 Cp. Girke 2012: 1061.

backed away from the death bed. Thirdly, the hospital management ulti-
mately turns the scales, even when it does not adopt a position on this issue
discursively. Rather, as representatives of the hospital, its members are held
responsible for its management and viability. In their doings and sayings,
moreover, conventional medical and economic rationalizations go hand in
hand: being governed by the public health sector's standards and the eco-
nomic habitus according to which time is money, they quite inadvertently
prefer the administration of pain-killers and sedatives because it is less time-
consuming than any anthroposophical end-of-life care practice and also ac-
cords with the prevailing rules and regulations.

7 CONCLUSION

Anthroposophical end-of-life care belongs to both fields: from an emic per-
spective anthroposophic medicine complements conventional medicine with
spiritual knowledge, while from an etic perspective it pursues medical as well
as spiritual and religious goals. This study, based on fieldwork in an anthro-
posophical hospital, has provided three main insights about social practices
in the intersection between the religious and the medical fields.

First, in the course of anthroposophical end-of-life care, body-oriented
practices that are rationalized by anthroposophical religious concepts gain
momentum in relation to discursive practices in contact with the patients.
After death, discursive practices among healthcare professionals gain in im-
portance, while body-oriented practices with regard to the deceased lose in
importance.

Secondly, by rationalizing their actions in a religious (anthroposophical)
way amongst themselves, healthcare professionals not only explain their ac-
tions, they also regain agency in the face of a terminal illness backed up by
the institution. Body-oriented practices with anthroposophical rationaliza-
tions therefore serve as a resource not only for patients but for staff members
too, enabling the latter to support their patients even when, from a conven-
tional medical point of view, nothing can be done anymore. From an anthro-
posophical perspective, not only does the physical body have to be taken care
of but other non-empirical bodies also have to be taken into account. One of
the main references in this regard is the notion that patients need to let go of
their various bodies throughout the dying process and beyond death and are

in need of support. Other rationalizations are the support of the souls' preparation for the afterlife by taking care of the transcendent bodies and transcendent aspects of the dying patients.

It is important to note that, in the later stages of end-of-life care, anthroposophical rationalizations occur in inter-professional communication, or in communication with the researcher, and only rarely in communication with the patients. Nevertheless, even though religion might not be a topic of staff-patient conversations, it is still practiced in the form of massages, baths, poultices, so-called "little somethings," and further body-oriented practices.

Thirdly, the examples in this study have shed light on the social context within which anthroposophical end-of-life care is carried out. The healthcare professionals are constantly contending with each other over the distribution of power and the appropriate set of rules to follow. Yet, anthroposophical end-of-life care-providers are not only contending with each other over their respective social positions within a particular social field, they are also struggling over the different fields of (conventional) medicine and (alternative) religion. It is the anthroposophical foundation of anthroposophical end-of-life care that causes its actors to become involved in additional work and expense, as they not only act in accordance with the conventional medical field, but also orient themselves towards anthroposophy's own set of rules. Whereas this mostly occurs without problems, the need to play by two different set of rules at the same time makes the practice of anthroposophical end-of-life care liable to conflict.[57]

As we have seen, those physicians and nurses who are also trained in anthroposophic medicine generally have a higher social status. This does not mean, however, that they are more powerful in practice. As indicated by the practice of administering pain-killers and sedatives, the actions of nurses are determined rather by the habitus they have acquired in their conventional medical training than by the influence of the anthroposophically trained nursing expert or physicians, notwithstanding her or their higher social position.

Given that the hospital in question is an anthroposophical institution, one might have expected that in cases of conflict medical treatment would be in

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57 This is all the more the case when it comes to discursive practices, such as an open discussion about administrating painkillers and sedatives, because discourses require greater explanation and thus more easily uncover conflicting issues and demands for autonomy.

line with anthroposophical principles. In that case, in the example of pain-killers and sedatives at the end of life, the position of the anthroposophical physicians would prevail. This is especially the case since anthroposophical physicians have more symbolic power than nurses because of their institutional position and their anthroposophical expertise. However, Zeugin's fieldwork revealed that in many cases the nurses successfully negotiated with the physicians in charge in favor of giving pain-killers and sedatives. Hence, often the nurses' position was implemented at the bedside.

We argue that there are three explanations for this:

a) Nurses are closer to the patients in terms of time, body care, and emotional contact during the last stages of life. This might be even more the case in anthroposophical end-of-life care because more body-oriented care practices are performed in this period, as we have outlined above.

b) Nurses tend to act according to their conventional medical habitus in cases of conflict between anthroposophical and conventional medical practices and their respective rationalizations.

c) The hospital's management, including the most influential physicians, who are anthroposophically oriented, has to keep the financial conditions of the hospital in mind. However, the financial challenges are rooted partly in the hospital's specialization in anthroposophic medicine, which goes along with additional remedies and technical facilities, as well as the greater expenditure of time involved in care. Examples are the applying of a poultice or a rhythmic embrocation instead of administering pain-killers and sedatives at the end of life.

Thus, the anthroposophical hospital in question stands between the demands of the public health sector, its patients' needs and demands, the caregivers' attendance, and the anthroposophical orientation of its supporting foundation. All these interests mingle when it comes to anthroposophical end-of-life care, as they are apparently not located within the boundaries of any one social field.

BIBLIOGRAPHY

Arman, Maria/Ranheim, Albertine/Rehnsfeldt, Arne/Wode, Kathrin (2008): "Anthroposophic health care—different and home-like", in: Scandinavian Journal of Caring Sciences 22/3, pp. 357–366.

Bopp, Annette/Heine, Rolf (2008): Anthroposophische Pflege. Kulturaufgabe, Verpflichtung, Notwendigkeit, Dornach: Published Online, http://www.apis-saes.ch/fileadmin/_migrated/content_uploads/Flyer_Anthr._Pflege_DE1.pdf.

Bott, Victor (1996): Spiritual Sciences and the Art of Healing: Rudolf Steiner's Anthroposophical Medicine, Rochester: Healing Arts Press.

Bourdieu, Pierre (1986): "Forms of Capital", in: John G. Richardson (ed.), Handbook of Theory and Research for the Sociology of Education, New York: Greenwood Press, pp. 241–258.

Bourdieu, Pierre (1995): "Some Properties of Fields", in: Pierre Bourdieu (ed.), Sociology in Question, London/Thousand Oaks/New Delhi: Sage Publications, pp. 72–77.

Bourdieu, Pierre (1997): Méditations pascaliennes, Collection Lieber, Paris: Seuil.

Bourdieu, Pierre (2000): "Genese und Struktur des religiösen Feldes", in: Pierre Bourdieu (ed.), Das religiöse Feld. Texte zur Ökonomie des Heilsgeschehen, Konstanz: UVK Universitätsverlag Konstanz, pp. 39–110.

Bourdieu, Pierre (2014): "Über einige Eigenschaften von Feldern", in: Pierre Bourdieu (ed.), Soziologische Fragen, Frankfurt: Suhrkamp, pp. 107–114.

Brown, Candy G. (2013): The Healing Gods: Complementary and Alternative Medicine in Christian America, Oxford: Oxford University Press.

Brügge, Peter (1984): Die Anthroposophen: Waldorfschulen, Biodynamischer Landbau, Ganzheitsmedizin, Kosmische Heilslehre, Reinbek: Rowohlt.

Burkhard, Gudrun (2002): Biographical Work, Edinburgh (UK): Floris Books.

Clark, David (2001): "Religion, Medicine, and Community in the Early Origins of St. Christopher's Hospice", in: Journal of Palliative Medicine 4 (3), pp. 353–360.

Crawford, Gregory A. (2003): "Complementary and Alternative Medicine", in: Reference & User Services Quarterly 42 (4), pp. 296–306.

Echtler, Magnus/Ukah, Asonzeh (eds.) (2016a): Bourdieu in Africa: Exploring the Dynamics of Religious Fields, Leiden/Boston: Brill.

Echtler, Magnus/Ukah, Asonzeh (2016b): "Introduction: Exploring the Dynamics of Religious Fields in Africa", in: Magnus Echtler/Asonzeh Ukah

(eds.), Bourdieu in Africa: Exploring the Dynamics of Religious Fields, Leiden/Boston: Brill, pp. 1–32.

Emerson, Robert M./Fretz, Rachel I./Shaw, Linda L. (2001): "Participant Observation and Fieldnotes," in: Paul Atkinson/Amanda Coffey/Sara Delamont/John Lofland/Lyn Lofland (eds.), Handbook of Ethnography, London: Sage Publications, pp. 352–368.

Floriani, Ciro Augusto (2016): "Alternative and Complementary Therapies", in: Alternative and Complementary Therapies, Vol. 22 Issue 3: June 7, 2016, http://doi.org/10.1089/act.2016.29055.caf.

Fintelmann, Volker (2007): Intuitive Medizin: Anthroposophische Medizin in der Praxis. Grundlagen. Indikationen. Therapiekonzepte, Stuttgart: Haug.

Franke, Edith/Maske,Verena (2011): "Teilnehmende Beobachtung als Verfahren der Religionsforschung", in: Stefan Kurth/Karsten Lehmann (eds.), Religionen erforschen: Kulturwissenschaftliche Methoden in der Religionswissenschaft, Wiesbaden: VS Verlag für Sozialwissenschaften, pp. 105–134.

Gale, Nicola K./McHale. Jean V. (eds.) (2015): Routledge Handbook of Complementary and Alternative Medicine: Perspectives from Social Science and Law, London: Routledge.

Giddens, Anthony (1984): The Constitution of Society: Outline of the Theory of Structuration, Berkeley: University of California Press.

Girke, Matthias (2012): Innere Medizin: Grundlagen und therapeutische Konzepte der anthroposophischen Medizin, Berlin: Salumed Verlag.

Glöckler, Michaela/Girke, Matthias/Matthes, Harald (2011): "Anthroposophische Medizin und ihr integratives Paradigma", in: Rahel Uhlenhoff (ed.), Anthroposophie in Geschichte und Gegenwart, Berlin: Berliner Wissenschafts-Verlag, pp. 515–611.

Glöckler, Michaela (ed.) (2010): Die anthroposophisch-medizinische Bewegung. Verantwortungsstrukturen und Arbeitsweisen, Dornach: Verlag am Goetheanum.

Glöckler, Michaela (2008): "Schmerz verstehen und behandeln", in: Der Merkurstab, pp. 469–473.

Hauschka, Margarethe (1978): Rhythmische Massage nach Dr. Ita Wegman: Menschenkundliche Grundlagen, Boll: Schule für künstlerische Therapie und Massage.

Heusser, Peter (2011): Anthroposophische Medizin und Wissenschaft: Beiträge zu einer integrativen medizinischen Anthropologie, Stuttgart: Schattauer.

Heusser, P./Berger Braun, S./Ziegler, R./Helwig, S./van Wegberg, B./ Cerny, T. (2006a): "Palliative in-patient cancer treatment in an anthroposophic hospital: I. Treatment Patterns and Compliance with Anthroposophic Medicine", in: Forschende Komplementärmedizin 2006;13, pp. 94–100, http://www.hiscia.ch/uploads/media/Heusser_et_al_2006a.pdf.

Heusser, P./Berger Braun, S./Bertschy, R.M./Ziegler R./Helwig S./Wegberg B./Cerny T. (2006b): "Palliative in-patient cancer treatment in an anthroposophic hospital. II. Quality of life during and after stationary treatment, and subjective treatment benefits", in: Forschende Komplementärmedizin 2006;13, pp. 156–166, https://www karger com/Article/Pdf/ 92448.

Hildebrandt, Gunther (1997): Need for Rhythm Studies in Anthroposophic and Goethean Science, Published Online, http://www.anthromed.org/Article.aspx?artpk=293, 18 May 2018.

Jeserich, Florian (2010): "Spirituelle/religiöse Weltanschauungen als Herausforderung für unser Gesundheitswesen: Am Beispiel der Homöopathie", in: Raymond Becker/Serkan Sertel/Isabel Stassen-Rapp/Ines Walburg (eds.), "Neue" Wege in der Medizin: Alternativmedizin – Fluch oder Segen?, Heidelberg: Universitätsverlag Winter, pp. 203–227.

Jonen-Thielemann, Ingeborg (2012): "Terminalphase", in: Eberhard Aulbert/Friedemann Nauck/Lukas Radbruch (eds.), Lehrbuch der Palliativmedizin, Stuttgart: Schattauer, pp. 989–997.

Jütte, Robert (1996): Geschichte der alternativen Medizin: Von der Volksmedizin zu den unkonventionellen Therapien von heute, Munich: C.H. Beck.

Karschuck, Philipp (2018): "Anthroposophische Palliativmedizin im Kontext gegenwärtiger Transformationsprozesse in der alternativen Medizin der Schweiz", PhD Thesis, University of Fribourg, Switzerland (not published).

Kellehear, Allan (2007): A Social History of Dying, Cambridge: Cambridge University Press.

Kienle, Gunver S./Kiene, Helmut/Albonico, Hans U. (2006): Anthroposophic medicine: effectiveness, utility, costs, safety, Stuttgart: Schattauer.

Kienle, Gunver S./Albonico, Hans-Ulrich/Baars, Erik/Hamre, Harald J./Zimmermann, Peter/Keine, Helmut (2013): "Anthroposophic Medicine: An Integrative Medical System Originating in Europe", in: Global Advances in Health and Medicine 2 (6), pp. 20–31.

Knoblauch, Hubert (2001): "Fokussierte Ethnographie: Soziologie, Ethnologie und die neue Welle der Ethnographie", in: sozialersinn 1 (1), pp. 123–141.

Knoblauch, Hubert (2002): "Fokussierte Ethnographie als Teil einer soziologischen Ethnographie: Zur Klärung einiger Missverständnisse", in: sozialersinn 2 (1), pp. 129–135.

Knoblauch, Hubert (2005): "Focused Ethnography", in: Forum: Qualitative Social Research 6 (3), p. 44.

Knoblauch, Hubert (2009): Populäre Religion: Auf dem Weg in eine spirituelle Gesellschaft, Frankfurt: Campus Verlag.

Koch, Anne (2006a): "Ayurveda: Zur Attraktivität eines alternativen Heilsystems", in: Verena Wetzstein (ed.), Was macht uns gesund? Heilung zwischen Medizin und Spiritualität, Freiburg im Breisgau: Verlag der Katholischen Akademie der Erzdiözese Freiburg, pp. 57–75.

Koch, Anne (2006b): "Wie Medizin und Heilsein wieder verwischen: Ethische Plausibilisierungsmuster des Ayurveda im Westen", in: Zeitschrift für medizinische Ethik 52 (2), pp. 169–182.

Koch, Anne (2015): "Alternative Healing as Magical Self-Care in Alternative Modernity", in: Numen 62 (4), pp. 431–459.

Koch, Anne/Binder, Stefan (2013): "Holistic Medicine between Religion and Science: A Secularist Construction of Spiritual Healing in Medical Literature", in: Journal of Religion in Europe 6, pp. 1–34.

Langford, Jean (2002): Fluent bodies: Ayurvedic remedies for postcolonial imbalance, Durham/London: Duke University Press.

Layer, Monika (ed.) (2006): Handbook for Rhythmical Einreibungen. According to Wegmann/Hauscka, Forest Row: Temple Lodge.

Luckmann, Thomas (2005): Die unsichtbare Religion, Frankfurt: Suhrkamp Verlag.

Lüddeckens, Dorothea (2012): "Religion und Medizin in der europäischen Moderne", in: Stausberg, Michael (ed.): Religionswissenschaft, Berlin: De Gruyter, pp. 283–297.

Lüddeckens, Dorothea (2013): "Alternative Heilverfahren als Religionshybride", in: Peter Berger/Klaus Hock/Thomas Klie (eds.), Religions-

hybride: Religion in posttraditionalen Kontexten, Wiesbaden: Springer VS, 107–119.

Lüddeckens, Dorothea (2018): "'Imagined Origin': Ayurveda, Reiki und Traditionelle Chinesische Medizin", in: Martin Tulaszewski/Klaus Hock/Thomas Klie (eds.), Was heilt – Krankheitsdeutung zwischen Religion, Medizin und Heilkunde, Bielefeld: Transcript, 2019 (forthcoming).

Lüddeckens, Dorothea/Walthert, Rafael (2010a): "Das Ende der Gemeinschaft? Neue religiöse Bewegungen im Wandel", in: Dorothea Lüddeckens/Rafael Walthert (eds.), Fluide Religion: Neue religiöse Bewegungen im Wandel, Bielefeld: transcript Verlag, pp. 19–53.

Lüddeckens, Dorothea/Walthert, Rafael (2010b): "Fluide Religion: eine Einleitung", in: Dorothea Lüddeckens/Rafael Walthert (eds.), Fluide Religion: Neue religiöse Bewegungen im Wandel, Bielefeld: transcript Verlag, pp. 9–17.

Lutz, Stephan (2011): "The History of Hospice and Palliative Care", in: Current Problems in Cancer 35 (6), pp. 304–309.

Mezger, Mirjam (2018): Religion, Spiritualität, Medizin. Alternative Religiosität und Palliative Care in der Schweiz, Bielefeld: Transcript.

Puustinen, Raimo (2014): "From Physical Bodies to Astral Bodies: Theoretical Problems in Anthroposophic Medicine", in: Focus on Alternative and Complementary Therapies 19 (1), pp. 22–26.

Reckwitz, Andreas (2002): "Toward a Theory of Social Practices: A Development in Culturalist Theorizing", in: European Journal of Social Theory 5 (2), pp. 243–263.

Reckwitz, Andreas (2003): "Grundelemente einer Theorie sozialer Praktiken: Eine sozialtheoretische Perspektive", in: Zeitschrift für Soziologie 32 (4), pp. 282–301.

Ritchie, Jane; Wilkinson, Jane; Gantley, Madeleine; Feder, Gene; Carter, Yvonne; Formby, Juliet (2001, unpublished): A Model of Integrated Primary Care: Anthroposophic Medicine. National Centre for Social Research. Department of General Practice and Primary Care, St Bartholomew's and the Royal London School of Medicine and Dentistry, Queen Mary, University of London.

Schatzki, Theodore R. (1996): Social Practices: A Wittgensteinian Approach to Human Activity and the Social, Cambridge: Cambridge University Press.

Schütze, Fritz (1983): "Biographieforschung und narratives Interview", in: Neue Praxis 13 (3), pp. 283–293.

Selg, Peter (2000a): Anfänge anthroposophischer Heilkunst: Ita Wegman, Friedrich Husemann, Eugen Kolisko, Frederik Willem Zeylmans van Emmichoven, Karl König, Gerhard Kienle, Dornach: Philosophisch-anthroposophischer Verlag am Goetheanum.

Selg, Peter (2000b): "Eine kurze Skizze der Geschichte anthroposophischer Medizin bis zum Tod Rudolf Steiners (1925)", in: Peter Selg (ed.), Anthroposophische Ärzte: Lebens- und Arbeitswege im 20. Jahrhundert. Nachrufe und Kurzbiographien, Dornach: Verlag am Goetheanum, pp. 25–76.

Spradley, James P. (1980): Participant Observation, New York: Holt, Rinehart and Winston.

Steiner, Rudolf (1980): Das Geheimnis des Todes: Wesen und Bedeutung Mitteleuropas und die europäischen Volksgeister, Dornach: Rudolf Steiner Verlag.

Steiner, Rudolf (1988): Geisteswissenschaftliche Menschenkunde. Neunzehn Vorträge, gehalten in Berlin zwischen dem 19. Oktober 1908 und 17. Juni 1909, Dornach: Rudolf Steiner Verlag.

Steiner, Rudolf (2001): Das Hereinwirken geistiger Wesenheiten in den Menschen, Dornach: Rudolf Steiner Verlag.

Steiner, Rudolf (2010): Theosophie: Einführung in übersinnliche Welterkenntnis und Menschenbestimmung, Rudolf Steiner Online Archiv: http://anthroposophie.byu.edu, July 4, 2018.

Steiner, Rudolf/Wegman, Ita (1977): Grundlegendes für eine Erweiterung der Heilkunst nach geisteswissenschaftlichen Erkenntnissen, Dornach: Rudolf Steiner Verlag.

Ullrich, Heiner (2011): Rudolf Steiner: Leben und Lehre, Munich: C.H. Beck.

Utriainen, Terhi (2013): "Doing Things with Angels: Agency, Alterity and Practices of Enchantment", in: Steven Sutcliffe/Ingvild Saelid Gilhus (eds.), New Age Spirituality. Rethinking Religion, Durham: Acumen Publishing, pp. 242–255.

Von Dach, Christoph (2001): "Pflege an der Grenze des Seins. Ein Erfahrungsbericht aus der anthroposophischen Pflege", in: Anthrosana. Das Sterben ist auch Geburt. Berichte und Gedanken zu Sterben und Tod, hg.

von Anthrosana – Verein für Anthroposophisch Erweitertes Heilwesen, Band 203, Arlesheim, pp. 34–37.

Von Dach, Christoph (2008): "The twelve nursing balms. Die zwölf pflegerischen Gesten", in: Krankenpfelge. Soins infirmiers, Vol. 101 (3), pp. 25–27.

Von Dach, Christoph/Heine, Rolf/Heiligtag, H.-Richard (2009): "Anthroposophische Pflege von Krebskranken", in: Der Merkurstab/4, pp. 330–343.

Walter, Tony (1994): The Revival of Death, London/New York: Routledge.

Walthert, Rafael (2014): "Ritual and Discursive Practices: Community and Body in a Bourdieuian Perspective", in: Alexander Darius Ornella/ Stefanie Knauss/Anna-Katharina Höpflinger (eds.), Commun(icat)ing Bodies: Body as a Medium in Religious Symbol Systems, Zürich: Pano Verlag, pp. 187–211.

Witzel, Andreas (1985): "Das problemzentrierte Interview", in: Gerd Jüttemann (ed.), Qualitative Forschung in der Psychologie: Grundfragen, Verfahrensweisen, Anwendungsfelder, Weinheim/Basel: Beltz Verlag, pp. 227–255.

Witzel, Andreas (2000): "The Problem-Centered Interview", in: Forum: Qualitative Social Research 1(1), p. 22.

Wood, Matthew (2007): Possession, Power, and the New Age: Ambiguities of Authority in Neoliberal Societies, Aldershot: Ashgate.

Wright, Bonnie/Warfield Rawls, Anne (2005): "The Dialectics of Belief and Practice: Religious Process as Praxis", in: Critical Sociology 31 (1–2), pp. 187–211.

Wright, Michael/Clark, David (2012): "Cicely Saunders and the Development of Hospice Palliative Care", in: Harold Coward/Kelli I. Stajduhar (eds.), Religious Understandings of a Good Death in Hospice Palliative Care, Albany: State University of New York Press, pp. 11–28.

Zander, Helmut (2007): Anthroposophie in Deutschland: Theosophische Weltanschauung und gesellschaftliche Praxis 1884–1945, Göttingen: Vandenhoeck & Ruprecht.

Zeugin, Barbara (2017): "Is CAM Religious? The Methodological Problems of Categorizing Complementary and Alternative Medicine in the Study of Religion", in: Bulletin for the Study of Religion 46 (1), pp. 6–8.

Zeugin, Barbara/Walthert, Rafael (2016): "Des pratiques verbales aux pratiques rituelles: Religiosité dans les maisons de soins palliatifs en

Suisse", in: Pierre-Yves Brandt/Jacques Besson (eds.), Spiritualité en milieu hospitalier, Psychologie et spiritualité, Geneva: Labor et Fides, pp. 157–173.

LINKS

http://apps.swissdrg.org/manual40/drgs/54771e6ce4b0887aa13fd25c?locale=de, January 10, 2017.

http://paracelsus-spital.com, January 10, 2017.

www.bag.admin.ch/themen/gesundheitspolitik/03153/index.html?lang=de, May 29, 2016.

www.caregiver.org/advanced-illness-holding-on-letting-go, July 29, 2016.

www.medsektion-goetheanum.org/en/home/books, July 28, 2016.

www.medsektion-goetheanum.org/home/anthroposophische-medizin, March 31, 2016.

www.nfp67.ch/en/projects/module-4-cultural-concepts-social-ideals/project-lueddeckens, July 31, 2016.

www.sterbekultur.ch/index_htm_files/4.2%20Aufbahrung%20und%20Totenwache.pdf, July 31, 2016.

www.sterben.ch, July 28, 2016.

www.vfap.de/anthroposophische-pflege, February 10, 2016.

www.who.int/cancer/palliative/definition/en, June 04, 2016.

www.ivaa.info/fileadmin/editor/file/Facts_and_Figures_AM_Worldwide July2012_Final_Public_Light.pdf , May 18, 2018.

Mapping the Boundaries between Science and Religion

Psychology, Psychiatry, and Near-Death Experiences

Stephanie Gripentrog

ABSTRACT

In contemporary religious landscapes, entanglements between the field of religion and the field of psychology and psychiatry are manifold. In this paper, the psychological school of "Transpersonal Psychology" (TP) and specifically the work of the psychiatrist and LSD researcher Stanislav Grof is introduced in order to illuminate the interferences between psychological or therapeutic discourses and religious discourses. Of particular interest are psychological approaches to Near-Death Experiences (NDE) and the way in which they become productive of religious imaginary. In this way, this paper will outline the boundaries between science and religion, or rather the fluidity of such boundaries, using the example of a specific discourse as manifested in scholarly approaches to Near-Death Experiences in Transpersonal Psychology.

1 INTRODUCTION

Of all the scientific disciplines that have dealt with the topic of near-death experiences (NDEs), psychology and psychiatry have played a special role. The first scientific studies of the topic in the twentieth century were both

written by psychiatrists.[1] At the same time, psychological explanations of Near-Death Experiences (NDE)[2] form only one group of many, as yet fragmentary attempts to explain them scientifically. The aim of this article is to examine the relationship of a very specific and contested psychological school—"Transpersonal Psychology" (TP)—to religion, as exemplified by its approach to NDEs.

Given the proximity of NDE research to religion, as well as its dissemination in society in general, the topic is a complex one. Anyone who wants to examine the approaches of psychology and psychiatry to NDEs from the perspective of the academic Study of Religion will therefore have to limit the study to just a few aspects. Accordingly, this article is structured as follows.

I begin with an examination of the concept of experience as a key idea in the psychology of religion, which will be exemplified by a brief analysis of the work of William James in this area. The writings of this "classical" author are more than one hundred years old, but they are still one of the key reference points for more recent branches of psychology that deal with NDEs. In addition, James's concept of religious experience can still be seen as groundbreaking in contemporary discussions of this topic.

The subsequent section introduces the concept of Transpersonal Psychology, which is considered marginal within academic psychology and has given rise to controversies regarding whether it even is a legitimate part of it. Nonetheless, it is above all here where the issues of peak and border experiences in general and of NDEs in particular have been argued to be therapeutically fruitful and have become the vehicle for a new form of dealing with death, which, for good reasons, can be called religious. Special attention will therefore be paid to the interference between psychological or therapeutic discourses and religious discourses, using the work of the psychiatrist and LSD researcher Stanislav Grof as an example to illustrate this in detail.

The analysis will be completed by some reflections on the extent to which the phenomenon of NDEs can also be described as a new and very specific

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1   Elisabeth Kübler-Ross and Raymond Moody were instrumental in shaping early research on NDE, as well as the term itself.

2   For contemporary psychiatric and psychological research, cp. Khanna/Greyson 2014: 1605–1615; Britton/Bootzin 2004: 254–258; Wren-Lewis 2004: 90–92. For an example of an approach from medical anthropology, cp. Corazza 2008.

form of contemporary religiosity, as well as on the role that TP and psychotherapy play in this context.

The treatment of the issue in this article is therefore twofold: on the one hand, the topic is presented from the perspective of the psychology of religion; on the other hand, discourses of TP about NDEs as a *religious* phenomenon are analyzed from the perspective of the academic Study of Religion.

2 ON THE CONCEPT OF EXPERIENCE

The concept of NDEs has constantly been questioned since the beginning of research on the topic. Reasons for this include the fact that a lot of people actually report features of an NDE without having been close to death at all (van Lommel 2001: 2039–2045). Thus, the term loses its *differentia specifica* in relation to other extraordinary experiences, most notably so-called out-of-body experiences, on which a lot of research is currently being conducted and which are frequently, though not always, reported as part of an NDE (Blanke et al. 2016: 323–347). At the same time, recent neurological research also shows that out-of-body experiences and NDEs "may share important functional and brain mechanisms, but clearly point towards distinct mechanisms as well" (ibid: 333).

Since Moody's study (1975), which listed fifteen different aspects (although none of them had featured fully in any of the 150 cases he analyzed), various attempts have been made to develop a phenomenology of the most important characteristics of an NDE (Blanke et al. 2016: 331). Further problems stand in the way of a definition, especially cultural and regional variations in recorded experiences[3] and the fact that they are only accessible through the medium of language or imagery.

What is more important for the purposes of this paper is the observation that the notion of NDEs, whether clear or meaningful or not, serves as a fundamental concept not only in scientific research, but also in the respective social discourse and practices, regardless of any possible inconsistencies with regard to its meaning. Here, Mieke Bal's reflections on concepts are helpful:

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3   For further literature see, for example, the study by Hubert Knoblauch (1999) comparing the NDEs of East and West Germans.

"Mostly, they are considered abstract representations of an object. But, like all representations, they are neither simple nor adequate in themselves. They distort, unfix, and inflect the object. [...] In fact, concepts are, or rather *do,* much more. If well thought through, they offer miniature theories, and in that guise, help in the analysis of objects, situations, states, and other theories. [...] They travel—between disciplines, between individual scholars, between historical periods, and between geographically dispersed academic communities. Between disciplines, their meaning, reach, and operational value differ." (Bal 2009: 11–12)

Thus, the concept of NDEs should be understood as one that moves between different disciplines and that facilitates their interdisciplinary dialogue, precisely because it is more than a simple word, though also less than an elaborate theory (ibid: 15).

The debates on the general concept of experience in both the psychology of religion and the Study of Religion have been similarly complex, especially because it has been so crucial to both disciplines. The related debate already started when the psychology of religion began to emerge as an empirical science in the United States around 1900. William James, one of its key representatives, dealt with it in detail in his much-read work, *The Varieties of Religious Experience*. At that time, the spiritualist movement was in full blossom, with attempts being made to contact the dead in the hereafter by means of spiritualist mediums in séances where occultist practices such as table-turning were highly popular.

Frequently at this time, renowned psychologists and psychiatrists were also present at the séance tables, trying to find alternative explanations for the observed phenomena and, in the process, triggering highly controversial discussions about the status and role of psychology and psychiatry as scientific disciplines.[4] Thus, psychology and psychiatry were already involved in the search for an alternative, scientific approach to the so-called "beyond" long before modern research on NDEs started. James was among those psychologists whose theories were heavily based on analysis of such extraordinary phenomena, and his work, *The Varieties of Religious Experience*, is full of examples of this kind.

However, one key element in his reflections is the question of the actual object of research in the psychology of religion and the ontological status of

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4   For further literature see Treitel 2004 or also Gripentrog 2016.

the object of religious experience itself. Discussing this question in detail, he points out that it is not the task of science to provide evidence regarding questions of religious truth, let alone the ontological status of objects of religious experience. Rather, science must limit itself to the description of the experiences of those who "apprehend themselves to stand in relation to whatever they may consider the divine" (James 1902: 32). What is of special interest to him, then, is the intensity of this experience, which those affected describe as an increased perception of reality, a reality "which no adverse argument, however unanswerable by you in words, can expel from your belief" (ibid: 72). Thus, he writes:

"All our attitudes, moral, practical or emotional, as well as religious, are due to the "objects" of our consciousness, the things which we believe to exist, whether really or ideally, along with ourselves. Such objects may be present to our senses, or they may only be present to our thought. In either case, they elicit from us a *reaction*; and the reaction due to things of thought is notoriously in many cases as strong as that due to sensible presences. It may be even stronger." (ibid: 53)

Hence, James is not concerned with deciding whether a "real" object corresponds to such an experience or, if so, what kind of object. Rather, answering this question seems wholly irrelevant to the value of such an experience. Instead, both real and ideal objects are simply objects of consciousness that, as such, "coexist" within us. James, writing as a philosopher here, anticipated an important insight of contemporary brain research at this point, which has confirmed that the same brain areas are active in imagining as in visually perceiving a real object (Traut 2015: 33). For the brain, it seems to make no difference if something is just imagined or actually experienced.

Thus, for James and his question about the ontological status of the object of religious experience, this means that it does not really matter whether the experience is real or to what extent. In the first of his twenty lectures that make up *Varieties*, he discusses the closeness of religious experiences to pathological ones, a topic that has also been discussed with regard to NDEs. In doing so, he states explicitly that there is no real possibility of making a clear distinction between them. In particular, "'geniuses' in the religious line" frequently show, as James puts it, "symptoms of nervous instability" and are therefore often "subject to abnormal psychical visitations" (James 1902: 8). At the same time, this might be precisely the reason for their special

religious meaning, because "often […] these pathological features in their career have helped to give them their religious authority and influence" (ibid: 8). The physiological and possibly even pathological causes of such experiences are therefore not relevant to James compared to their consequences for the life of the person having them (ibid: 51).

At any rate, from James's point of view, the emotional reactions triggered by such "objects of consciousness" can be extremely intense. He writes:

"They are as convincing to those who have them as any direct sensible experiences can be, and they are, as a rule, much more convincing than results established by mere logic ever are. […] if you do have them, and have them at all strongly, the probability is that you cannot help regarding them as genuine perceptions of truth, as revelations of a kind of reality which no adverse argument, however unanswerable by you in words, can expel from your belief." (ibid: 72)

The subjective power of the persuasion of such experiences seems to be overwhelming and can scarcely be questioned anymore. What James describes here can easily be matched with numerous reports of NDEs, and it also highlights an aspect that is repeatedly discussed in current research: the claim of those concerned that such experiences were, so to speak, "more real than real". In their 2013 neuroscientific study, Thonnard et al. (2013) state that the clarity of memories of NDEs often exceeds the actual experience of them:

"A recent study compared NDE memories to real and imagined memories, including non-NDE coma memories. It was found that NDE memories had richer content than all other types of memories, including better clarity and more self-referential and emotional information, suggesting that memories of NDEs are more akin to flashbulb memories and hallucinatory experiences than imagined events. These characteristics seem related to the content of the memory per se, rather than medical factors or actual closeness to death, and help understand why such experiences are often perceived as 'super real,' even more so than real recent events."
(Thonnard et al. as cited in Blanke et al. 2016: 334)

But how can a scientific description deal with this kind of recourse to experience—an experience that claims to be even "more real than real"? Despite the continuing popularity of James's approach, the conceptualization of religion based on the concept of experience has found no lasting success. Even

though it was established as a key term in the first half of the twentieth century, especially in the discipline of the phenomenology of religion, it was more or less abolished as "too religious" in the course of the reorientation of the academic Study of Religion as a cultural science in the second half of that century (Gladigow 1988: 6–37).

In the case of both religious experiences and NDEs, the question also arises under what conditions such "experiences" can be scientifically described at all. The German sociologist and scholar of the Study of Religion Volkhard Krech has therefore proposed a different approach following his research on conversion, one that highlights the aspect of *communication* instead of experience. In his view, one implication of adopting a communicative paradigm is that religious experience should not be understood (at least not exclusively) as a consciousness-like structure that is inaccessible to communication and thus to the sociological perspective, but instead as something that is constituted by communication and therefore is to be understood as a social fact (Krech 2005: 358).

Such experiences may be conceived, described, or even made visible through imaging procedures, as they are never *directly* accessible to research. The possibility of scientific, intersubjective access thus ends with the *expressed* (mostly linguistically), *mediated* experience. Looked at in this fashion, new, interdisciplinary approaches become relevant that deal, for example, with questions of the narrative format of an NDE or the relationship between narrative and experience in their mutual reciprocity.

But what are recent psychological studies on NDEs dealing with if not with the question of experience? Here, questions about the relationship between mental health and the occurrence of NDEs have become very prominent. In his research, Kenneth Ring, for example, asked whether people reporting an NDE differed in any way from the normal population in terms of their mental health. They were found to be no less healthy than the control group, but still differed from them in certain other respects (cp. Ring 1980; Greyson 1999: 7–19). This involved, for example, an increased susceptibility to hypnosis, the ability to remember dreams better and the ability to use imagination (cp. Irwin 1985). There also seemed to be an accumulation of traumatic childhood experiences among this group, with feelings of alienation from the environment as a consequence (cp. Ring 1992).

Previous psychological research on NDEs has primarily dealt with the question of how such experiences can be explained, suggesting that NDEs

could be a mental defense mechanism initiated by confrontation with imminent death (Vaitl 2012: 157).

Another explanation that goes in a similar direction sees memories of the birthing process at work during the tunnel experience (Gabbard/Twemlow 1991: 41–47). Grof's approach is similar but will be discussed later in detail. Depersonalization theory also invokes a defence mechanism as an explanation; due to an acute situation of crisis, the organism is put into a state of alarm, which causes dissociation of the crisis situation. This prevents the individual from being forced to live through its full drama (Vaitl 2012: 157).

However, Dieter Vaitl, summing up the various approaches to psychological explanation, points out that there is still no explanation of the discrepancy between physiological restriction and the complexity of experience (2012: 156). Thus, important questions regarding explanations for these phenomena remain unanswered.

The following analysis will be less concerned with making a further attempt to provide such clarifications than with describing a very specific psychological and psychiatric approach to the topic. The notion of TP that is invoked here is characterized by its comprehensive claim to be able to explain the occurrence of such experiences in their entirety, while at the same time being largely excluded from academic psychology as unscientific. It is, therefore, in no way representative of the history of psychological and psychiatric engagement with the topic of NDEs, though historically it is still located at the inception of NDE research.

3 ON "TRANSPERSONAL PSYCHOLOGY"

So-called "Transpersonal Psychology" represents a special case within modern academic psychological research (Walach et al. 2005: 405–415). As a psychological movement founded in the late 1960s, it mainly defined itself through its organ of publication, the *Journal of Transpersonal Psychology*, and its related society, the *Transpersonal Association*. However, it can hardly be characterized as a homogeneous movement, nor even as a school. Instead, its origins can best be described as heterogeneous (ibid: 405). Different authors influenced its emergence, conceiving TP in very different ways. These include especially Antony Sutich, who wrote the constitutive article of the discipline in the first volume of the *Journal* in 1969, Stanislav

Grof, who became known to the public mainly through his research on LSD, Abraham Maslow, the creator of the so-called hierarchy of needs, and above all the autodidact Ken Wilber, who began to develop a system of TP in the mid-1970s.

Both Sutich and Maslow characterized TP as the "fourth force" coming at the end of an upward development, with behaviorism as the first force, psychoanalysis as the second and humanistic psychology as the third. As such, they understood it as completing and absorbing the previous stages of psychological theorizing and therapy. For Maslow, this implied an explicit reference to transcendence, which was also to be part of his new psychological anthropology and its corresponding therapy. He wrote: "Without the transpersonal, we get sick, violent and nihilistic, or else hopeless and apathetic." (Maslow 1968: iii–iv)

For Maslow, the starting point of this approach was an explicitly anti-materialist anthropology. He did not orient himself to the average or the mentally ill, but to the concept of a healthy, even above-average human, who has fully developed his or her potential, a process he called "self-realization". In his opinion, only very few people have ever achieved this level. Maslow said in a lecture in 1962:

"When I started to explore the psychology of health, I picked out the finest, healthiest people, the best specimens of mankind I could find, and studied them to see what they were like. […] I found that these individuals tended to report having had something like mystic experiences, moments of great awe, moments of the most intense happiness or even rapture, ecstasy or bliss." (1962: 9)

These remarks of Maslow's remind the reader strongly of William James's suggestion to deal not with the experiences of the average religious human being, but with the most outstanding, extraordinary cases instead. The reason for this, according to James, is that the essence of religion and religious experience can best be studied with reference to extreme cases (1902: 8). Similarly, it recalls Maslow's specific conceptualization of the concept of experience through which TP acquires its profile in relation to other branches of psychology and psychotherapy. Again, the reference to William James is obvious. Maslow calls such experiences—these moments of great awe, intense happiness, ecstasy, and bliss—*peak experiences* (Maslow 1964).

But what role do NDEs play in this regard? Their relationship to the approach described above will be explained below, using the example of another important representative of TP, Stanislav Grof.

4 STANISLAV GROF'S RESEARCH ON LSD AND ITS RELATIONSHIP TO NEAR-DEATH EXPERIENCES

In 1943, the Swiss chemist Albert Hofmann discovered the substance LSD and, at first through self-experiment, experienced its enormous effect on the human psyche (Hofmann 1979). The Czech psychiatrist and psychotherapist Stanislav Grof was one of the first to receive samples of the new substance from Basel. One of his main questions was about the therapeutic potential of LSD, as it was initially considered to be a means of generating model psychoses that could be explored and then possibly cured (Grof 1980). Very soon, Grof also started to be interested in the potential significance of the substance for the dying. Thus, in 1974 he took over the leadership of the so-called *Spring Grove Program* at the Maryland Psychiatric Research Centre, USA,[5] from Walter Pahnke, who himself had already become well known for his so-called *Good Friday Experiment* (Pahnke 1966: 85–106). Originally, the program had been dedicated to the effects of LSD on schizophrenics and alcoholics, but in 1966, the research was thematically reoriented, initiated through an employee of the Research Department who had fallen severely ill with cancer and decided to test the effects of LSD in view of her approaching death.

This was the third attempt worldwide to treat terminally ill cancer patients with LSD and it was scientifically documented. Its impressive results (Pahnke et al. 1970: 1856–1863) initiated a new research project on the effects of LSD on such patients. For two decades, the Maryland Psychiatric Research Center and its research facility became the site of intense research on LSD. The very first pilot study produced astonishing results,[6] which the authors themselves directly related to Maslow's concept of *peak experiences*:

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5   More on the history of this program cp. Yensen/Dryer 1995: 73–101.

6   Cp. Richards et al. 1972: 121–149.

"It has been our clinical impression that the most dramatic therapeutic changes followed sessions in which the patient experienced an intense psychedelic peak experience, the phenomenological description of which corresponded to the categories of (1) unity, (2) transcendence of time and space, (3) objectivity and reality, (4) sense of sacredness, (5) deeply felt positive mood and (6) ineffability […] Profound experiences of this kind were described by approximately 25% of the patients in this study. These patients were often those who seemed most completely free of a fear of death following their sessions." (Richards et al. 1972: 142)

The assumptions based on this research were that LSD, combined with good therapeutic support for cancer patients close to death, could help to relieve them of anxiety and associated symptoms. As the passage quoted above makes clear, the aspect of the *peak experience* was decisive right from the start. The authors describe it using terms such as unity, transcendence of space and time, objectivity and reality, a sense of holiness, deeply positive moods, and ineffability; aspects that can all also be found in phenomenological descriptions of NDEs.

These similarities become even more obvious in *The Human Encounter with Death*, which Grof published together with Joan Halifax in 1977. This work was published only two years after Moody's *Life after Life*, (cp. 1975) and Elisabeth Kübler-Ross, in her foreword to Grof and Halifax's volume, explicitly pointed out the close connection between the two pieces of research (cp. Grof/Halifax 1977). Also, the two authors themselves repeatedly referred to Moody's work (cp. Grof/Halifax 1977). The reports they collected and presented in their volume on the experiences of patients treated with LSD include out-of-body experiences as well as various forms of life review, encounters with the dead, and even a light identified as "divine."[7] Some of the patients who had both an LSD experience and an NDE confirmed the striking similarities between them:

"During the operation Ted had two cardiac arrests resulting in clinical death and was resuscitated on both occasions. [...] At the same time, however, he was involved in a number of unusual experiences. [...] The initial darkness was replaced by brilliant light, and he was able to approach it and fuse with it. The feelings he described on experiencing the light were those of sacredness and deep peace. [...] Before we left

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7   For further similarities, cp. Bryant 2003: 143–144.

him that day, he emphasized how glad he was that he had had three LSD sessions. He found the experience of actual dying extremely similar to his psychedelic experiences and considered the latter excellent training and preparation. 'Without the sessions I would have been scared by what was happening, but knowing these states, I was not afraid at all.'" (Grof/Halifax 1977: 181–182)

Despite these remarkable parallels, Grof and Halifax also pointed out that there is an important difference, at least from the accounts in Moody's work: the descriptions of his cases lacked mythological elements, or, as Grof and Halifax put it, the "cartoon sky" of LSD experiences, with all its multiform expressions of archetypal images of deities and demons.

But how can these parallels be explained? According to Grof and Halifax:

"Observations from psychedelic research, as well as data from history, comparative religion and anthropology, seem to indicate that we all harbour functional matrices in our unconscious minds that contain an authentic encounter with death. Activation of these unconscious structures by psychoactive drugs, or by nondrug factors and techniques, results in a dramatic experience of death that, in terms of its intensity, is indistinguishable from actual dying." (ibid: 9)

It is this explanation that will be discussed in more detail below. In the course of his more than fifty years of research, Grof developed a new and very specific model of the human psyche, which he also uses to explain NDEs. Furthermore, his approach ultimately embodies the comprehensive claim to put psychology and psychotherapy on a completely new basis and, at the same time, to initiate a scientific paradigm shift (Grof 2012: 137–163). He writes:

"In the last five decades, various avenues of modern consciousness research have revealed a rich array of 'anomalous' phenomena—experiences and observations that have undermined some of the generally accepted assertions of modern psychiatry, psychology, and psychotherapy concerning the nature and dimensions of the human psyche, the origins of emotional and psychosomatic disorders, and effective therapeutic mechanisms. Many of these observations are so radical that they question the basic metaphysical assumptions of materialistic science concerning the nature of reality and of human beings and the relationship between consciousness and matter." (ibid: 138)

The consequences of this for the roles of psychology, psychiatry, and psychotherapy in the "religious field" will be discussed in section five.

At this point, it is appropriate to explain the matrices mentioned by Grof in more detail. He has constantly elaborated this model to this day, which is an essential result of his work, taking into account the experiences of numerous clients, comparisons between whom revealed nothing less than the need for a new cartography of the psyche (cp. Grof 1975). Due to his research on extraordinary states of consciousness, he has extended the traditional view of the psyche into two further major areas (see Fig. 1).

Fig. 1. Sketch of Grof's cartography of the human psyche.
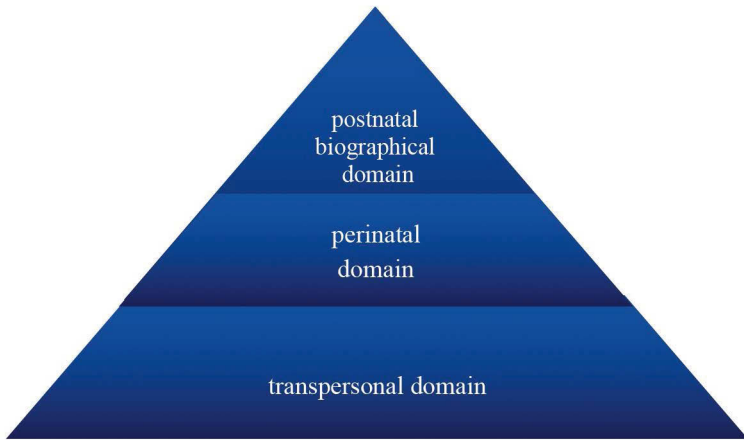
Source: Illustration by Stephanie Gripentrog based on Grof (1975).

Beyond content from the postnatal biographical level (from birth to adulthood), people in exceptional states of consciousness can gain access to the area of birth (experiences in the womb and during birth = perinatal domain) and the so-called transpersonal domain. He compares the experiences of these domains with those of mystics and shamans, as well as with C.G. Jung's concept of the collective unconscious. Two aspects are of further importance to him: the so-called COEX systems, and *Basic Perinatal Matrices*. COEX systems are *systems of condensed experience*:

"A typical COEX system consists of many layers of unconscious material that share similar emotions or physical sensations; the contributions to a COEX system come from different levels of the psyche.

More superficial and easier available layers contain memories of emotional or physical traumas from infancy, childhood, and later life. On a deeper level, each COEX system is typically connected to a certain aspect of the memory of birth, a specific BPM; the choice of this matrix depends on the nature of the emotional and physical feelings involved. […] The deepest roots of COEX systems underlying emotional and psychosomatic disorders reach into the transpersonal domain of the psyche." (Grof 2012: 150)

Furthermore, Grof noted that these systems tend to be associated with certain aspects of the birth process, which he then summarized as *Basic Perinatal Matrices* (see Figure 2).

Fig. 2. Basic Perinatal Matrices
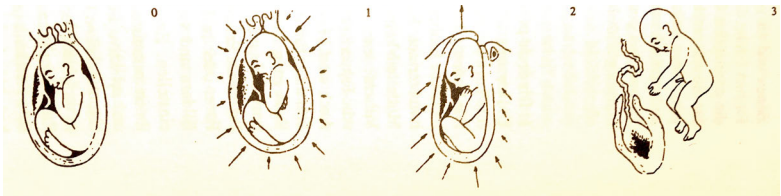
Source: Grof 1994: 31.

As such, they also provide the pattern for different forms of transpersonal experience. Grof distinguishes four different *Basic Perinatal Matrices*, as shown in Fig. 2. These are listed below in a simplified and shortened table according to Grof (see Table 1).

Table 1.

Matrix I: Unity with maternal organism	Matrix II: First stage of the birth process when the uterus contracts, but the cervix is not yet open	Matrix III: Struggle to be born after the uterine cervix dilates	Matrix IV: Separation from the mother
Related memories from life after birth			
Happy memories of infancy or childhood, attention from the mother, romances, swimming in the sea	Situations that were associated with danger to life, accidents, injuries, surgeries, severe psychological trauma	Fights, adventures, intoxicating experiences, victim of seduction or rape	Escape from dangerous situations, overcoming difficult obstacles by own efforts
Related phenomena from LSD sessions			
Undisturbed intra-uterine life: Oceanic ecstasy, oneness with the cosmos, paradise visions *Disturbances of the intra-uterine life:* Feeling of being devoured, disgust, visions of demons and evil metaphysical forces	Devouring maelstrom, violent physical and mental suffering, feeling of an unbearable hopeless situation, hell vision, feelings of futility and absurdity of human existence	Intensification of suffering to cosmic dimensions, simultaneous sensation of pleasure and pain, sado-masochistic orgies, participation in bloody battles, experiences of death and rebirth, religious blood sacrifice motifs, intense body reactions	Sudden release of a strong pressure, visions of gigantic halls, radiant light and beautiful colours, feelings of rebirth and salvation, intensification of sensory impressions

Source: Table by Stephanie Gripentrog based on Grof (1994: 30–31).

This sketch suggests that experiences made in extraordinary states of consciousness are not chaotic but follow very specific patterns and can come from all three different levels of consciousness. Thus, experiences from the recent or distant past, as well as experiences around birth and in the last resort, also from areas that Grof calls "transpersonal," are possible. Through a strong and qualitatively similar emotional quality or physical sensation, these very diverse contents are linked together, and it is through this mechanism that the transitions from one content of experience to the next can be explained. In addition, the respective experiences can be assigned to the four *Basic Perinatal Matrices*, which structure the experience thematically. But how does the access work? And what are the reasons for particular experiences and their timing? For this too, Grof has an explanation that is particularly relevant therapeutically. He writes:

"The techniques that can directly activate the unconscious seem to reinforce selectively the most relevant emotional material and facilitate its emergence into consciousness. They thus provide a kind of inner radar that scans the system and detects the material with the strongest charge and emotional significance." (1988: 4)

This means that it is not the therapist who decides which topic to work on, but rather that the topic with the "strongest emotional charge" will naturally come to the surface. As such, it can then work as a door to deeper levels of consciousness. Grof explains this structure by means of a clinical example:

"A person suffering from psychogenic asthma might discover in serial breathwork sessions a powerful COEX system underlying this disorder. The biographical part of this constellation might consist of a memory of near drowning at the age of seven, memories of being repeatedly strangled by an older brother between the ages of three and four, and a memory of severe choking during whooping cough or diphtheria at the age of two. The perinatal contribution to this COEX could be, for example, suffocation experienced during birth because of strangulation by the umbilical cord twisted around the neck. A typical transpersonal root of this breathing disorder would be an experience of being hanged or strangled in what seems to be a previous lifetime." (Grof 2012: 150)

In repeating an experience under the controlled conditions of a psychedelic session, Grof believes that the negative impact of the experience can be

discharged and thereby neutralized. The therapeutic use of this mechanism will be discussed in more detail below.

In his research with LSD, Grof thus observed that those who had experienced autobiographical content in their psychedelic sessions were increasingly confronted with other complexes at deeper levels, such as mortality, physical pain, emotional agony, aging and, finally, death. The most important element of this process is that on each occasion the images are perceived as extremely realistic and completely comparable to the real process of dying (Grof/Grof: 1980: 25). The relationship to the topic of NDEs becomes clear at this point. Grof expresses this explicitly at the end of his study *Encounter with Death*. He writes:

"Individuals who experience the encounter with death in psychedelic sessions frequently report that it feels extremely authentic and convincing, to the point of being indistinguishable from actual dying. Many descriptions of changes of consciousness in persons facing situations of vital emergency or experiencing clinical death exist in autobiographical accounts, novels, and poetry, but this area has been surprisingly neglected by psychiatrists and psychologists. There are only a few studies in which this interesting field has been systematically explored. We will briefly summarize the work that has been done, illustrate it with subjective accounts of survivors, and relate it to our observations from psychedelic research." (Grof/Halifax 1977: 131)

At this point, it becomes clear how Grof thinks of the relationship between LSD experiences and NDEs: they are caused by the same mechanisms of the human psyche that become active when the normal state is ruptured by something or intentionally changed. This can happen through the use of drugs, as well as in situations of extreme threat to life or through certain techniques, such as the holotropic breathwork that Grof developed with his wife after LSD was banned. This also shows that Grof does not see the drug as *causing* the experience, but as making it *visible* and *accessible*. The possible paths to such experiences are many and in his writings, Grof draws manifold comparisons to induce extraordinary states of consciousness. Later, in their 1980 publication *Beyond Death*, Stanislav Grof and his wife Christina write:

"There are striking parallels between Moody's observations and descriptions from eschatological literature, particularly the Bardo states in the Tibetan *Book of the Dead*. Similar if not identical elements occur in psychedelic sessions when the subjects

experience deep confrontation with death in the context of the death—rebirth process. As we shall see in a later section, there are also correspondences with spontaneously occurring states experienced by some schizophrenic patients." (Grof/Grof 1980: 13)

Here, Grof and Grof compare various aspects directly with each other, describing them as "similar" or "identical:" Moody's research results on NDEs and his descriptions of their eschatological character; Buddhist ways of confrontation with death, as in the context of the *Tibetan Book of the Dead*; and episodes in the experiences of schizophrenics. The images that appear in this context correspond to the cartographies of extraordinary states of consciousness that every human being can potentially experience, as mentioned earlier. At this point, the question of the ontological status of the objects of such experiences becomes of particular interest. In the spirit of James, Grof writes that they are experienced as being on a special level of reality. And, like James, Grof concludes:

"Modern studies of holotropic states [...] have shown that Heaven, Paradise, and Hell are ontologically real; they represent distinct and important states of consciousness that all human beings can under certain circumstances experience during their lifetime. Celestial, paradisean, and infernal visions are a standard part of the experiential spectrum of psychedelic inner journeys, near-death states, mystical experiences, as well as shamanic initiatory crises and other types of 'spiritual emergencies'." (Grof 2012: 157)

Thus, heaven and hell are real, but in the sense of specific states of consciousness, not as external places. However, unlike James, Grof moves one step further. While James, at least in his writings on religious experience, does not go beyond the subjective certainty of others, only observing and describing from the outside (which is all too clearly expressed in his formulation "who apprehend themselves to stand in relation to whatever they may consider the divine" (James 1902: 32)), Grof ascribes priority to consciousness over matter when he says:

"Materialistic science has not been able to produce any convincing evidence that consciousness is a product of the neurophysiological processes in the brain. It has been able to maintain its present position only by ignoring, misinterpreting, and even ridiculing a vast body of observations indicating that consciousness can exist and function

independently of the body and of the physical senses. This evidence comes from parapsychology, anthropology, LSD research, experiential psychotherapy, thanatology, and the study of spontaneously occurring holotropic states of consciousness. All these disciplines have amassed impressive data demonstrating clearly that human consciousness is capable of doing many things that the brain (as understood by mainstream science) could not possibly do and that it is a primary and further irreducible aspect of existence." (Grof 2012: 145–146)

Consciousness itself thus becomes the primary factor of existence. In adopting this proposition, Grof can be aligned with authors of more recent research on NDEs, such as Pim van Lommel (2010) and Eben Alexander, (2012) who also assume the possibility of a body-independent consciousness and consider this to be the only plausible explanation of the NDE phenomenon. But it is not only these three authors who share this approach. Rather, their argumentation is part of a much broader movement within contemporary religiosity, on which I shall elaborate in the next section.

5 ON THE THERAPEUTIC RELEVANCE OF NEAR-DEATH EXPERIENCES

As a trained psychoanalyst, Grof's interest in LSD had initially been predominantly therapeutic. He and other researchers in the field hoped that the use of the drug in a therapeutic setting under controlled conditions would provide a cure for schizophrenia and alcoholism. His research with cancer patients and, resulting from it, with depressive patients also demonstrated the drug's high degree of effectiveness in helping people cope with the fact of approaching death:

"According to our observations, those individuals who have experienced death and rebirth in their sessions show specific changes in their perception of themselves and of the world, in their hierarchies of values, general behavior, and overall world-views. Those who prior to these experiences had various forms and degrees of emotional and psychosomatic discomfort usually feel greatly relieved. Depression dissolves, anxiety and tension are reduced, guilt feelings are lifted, and self-image as well as self-acceptance improve considerably. Individuals talk about experiencing themselves as

reborn and purified; a deep sense of being in tune with nature and the universe replaces their previous feelings of alienation." (Grof/Halifax 1977: 210)

On the basis of these findings, later, when LSD was banned, Stanislav and Christina Grof developed the technique of holotropic breathwork as a substitute and introduced it as a new form of therapy. Grof sees in this a modern form of transitional ritual, using the same vocabulary as the French ethnologist Arnold van Gennep: separation—liminality—incorporation,[8] and he ascribes great therapeutic relevance to it. In all cultures, Grof and Grof write in *Beyond Death*, there are certain rituals that have this function:

"However, repeated encounters with annihilation followed by a sense of redefinition have another important function: they prepare the individual for eventual biological death by establishing a deep, almost cellular awareness that periods of destruction are those of transition rather than termination." (1980: 23)

According to Grof, these rituals, for instance therapeutic sessions, prepare people to deal with death. Thus, in such sessions, the area of the sensory barrier is first crossed, followed by experiences of biographical content. After that, one enters the domain in which experiences of death and rebirth are made. Those who engage in holotropic breathing will sooner or later be confronted with this area. In all cases, it is important not only to observe, but to *live through* experiences of problematic content again, including in the physical sense, because that is what causes the therapeutic effect. Ultimately, this also applies to one's own death, which is already a structural part of the cartography of the psyche as a potential experience.

This is why Grof and Halifax say: "It is hard to imagine a more useful way to combine medicine, psychology, and religion than psychedelic therapy with dying individuals." (1977: 24) However, the technique of holotropic breathwork is relevant not only for the sick or those in need of therapy. With the discovery of these structures in human consciousness, Grof claims nothing less than to have found the decisive key to the actual constitution of reality, the understanding of religious history, as well as of mental illnesses and the transformation of psychotherapeutic treatments, which he then

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8 Cp. van Gennep (1909). Grof and Grof refer to van Gennep in *Beyond Death* (1980: 22).

qualifies as "technologies of the sacred". (Grof 2012: 139) Grof's claim is thus all-encompassing, and he sees in his psychology the "psychology of the future" (cp. 2000).

Since 1987, when Grof founded *Grof Transpersonal Training* as a "psycho-spiritual practice," he and his team have been training people in this therapeutic technique. The courses (cp. www.holotropic.com, 04 July, 2018) they teach consist of seven six-day modules, which the trainees have to attend. Each of the modules to be visited has a thematic motto, of which four are compulsory: "The Power Within," "Music and Transcendence," "The Holotropic Paradigm," and "Spiritual Emergency" (Grof 2017: 4). In addition, ten actual experiences with holotropic breathwork during workshops led by certified leaders and another ten individual sessions are mandatory. On the basis of this, the trainees must assist at least four times in the relevant workshops. Whoever has gained two more years of experience with holotropic breathwork and attended the final two-week intensive course receives a certificate. Even then, certain obligations remain to be met regularly to ensure the quality of the work in the long term, on pain of losing one's certificate (Ibid: 6). Grof makes it very clear in the letter accompanying the training application forms that the technology itself is easy to learn, but that as a leader or companion you must have special competences that require longterm learning:

"To be able to effectively facilitate Holotropic sessions for others, we often have to go through a very profound personal transformation that has emotional, psychological, philosophical, and spiritual dimensions. As you train to be Holotropic Breathwork facilitators, we ask you to work toward the capacity to remain unperturbed while providing support for people in all possible forms of non-ordinary states of consciousness, toward the ability to follow them wherever they have to go in their experiences, and toward maintaining trust in the intrinsic healing forces in them." (Ibid: 16)

In addition to the American organization (cp. www.holotropic.com, July 4, 2018), a separate network, the "European Association for Holotropic Breathwork," was founded. The organization's website describes the therapy as a "powerful technique for self-healing and self-exploration allowing for greater self-understanding, expansion of self-identity and access to the roots

of emotional and psychosomatic challenges one might face."[9] The countries in which training is currently available are Australia, Austria, Brazil, the Czech Republic, Germany, Hungary, Ireland, Romania, Russia, Slovenia, Spain, Switzerland, Turkey, Ukraine, and the United Kingdom. Apart from this certified training, the technique of holotropic breathwork is also offered independently. One example is Sylvester Walch (cp. 2012), who was trained by Grof but developed the method further independently of him and has published a lot on the subject.

A website associated with the *Grof Transpersonal Training* website states that there are currently five hundred people worldwide who are certified in the technique of holotropic breathwork.[10] It is unclear how accurate this information is—statistical surveys on the actual dissemination of the practice worldwide do not yet exist. However, random samples for Germany show that there are people in the alternative medicine sector[11] who not only offer holotropic breathwork as a form of treatment but also train others in it.

In fact, LSD has itself recently moved back into the focus not only of social and therapeutic interest, but also of scientific interest. This is currently shown by various research projects on LSD and related substances such as psilocybin,[12] which again not only highlight its extraordinary effect on the human brain, (Nutt et al. 2016: 4853–4858) but also its therapeutic relevance. It may therefore be assumed that this research topic is undergoing a renaissance. Organizations such as the *Multidisciplinary Association for Psychedelic Studies* (www.maps.org, May 8, 2018), founded in 1986 as a non-profit organization and based on donations, have supported this renaissance for many years and taken it further. Moreover, events like the *World Psychedelic Forum* in Basle (March 21–24, 2008), the conference *Horizons: Perspectives on Psychedelics* (Oct 6–8, 2017) in New York and the *International Transpersonal Conference 2017* (Sept 28–Oct 1, 2017) in Prague clearly

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9   http://www.holotropic-association.eu/breathwork/what-is-holotropic-breathwork, May 8, 2018.

10 Cp. http://www.grof-holotropic-breathwork.de/verwandt.html, May 8, 2018.

11 A probably incomplete list of therapists in Germany can be found at: https://www.therapeuten.de/therapien/holotropes_atmen.htm#anbieter, May 8, 2018.

12 On the latest research, including the effects of LSD on cancer patients, cp. Griffiths et al. 2016: 1181–1197.

demonstrate the public presence of the topic. What kind of impact these initiatives may have on the future of the rapidly developing branch of palliative care remains to be seen.

Finally, with regard to the therapeutic dimension, there is an overlap between research on LSD and NDEs.[13] Not only do LSD experiences and NDEs show striking similarities phenomenologically, in the field of TP they also seem to have similar psychological consequences for those affected, as repeatedly reported in the form of the loss of fear of death or of a changed view of oneself and the world.[14] In the form of the technique of holotropic breathwork, the experience of dying, death, and rebirth also has a place today on the German therapy and counselling scene, although exact data are currently still lacking. In addition, Grof's early research on terminally ill cancer patients also demonstrates its claim of potential relevance for end-of-life care.

6 TRANSPERESONAL PSYCHOLOGY BETWEEN SCIENCE AND RELIGION

What is special about the question of the relationship between psychology/psychiatry in the case of TP and NDEs is that Transpersonal Psychology seems to play a twofold role. On the one hand, it is a means to establish an allegedly scientific perspective on the topic of NDEs. On the other hand, psychology—in the form of TP, for example—itself becomes entangled with the religious field through certain therapeutic practices and the exploitation of patterns of scientific plausibility to religious ends. This is probably why

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13 Roland Griffiths, who conducted research on the effects of LSD on cancer patients (see above: Griffiths et al. 2016), set up a new project in 2015, collecting data about people who had an NDE or some other non-ordinary experience that fundamentally altered their beliefs or understanding about death and dying, the results of which are not yet published (cp. http://www.drpennysartori.com/NDE%20death%20flyer.pdf, May 08, 2018). In an earlier interview from 2006, Griffiths also pointed out the parallels between his research on psilocybin and NDEs (cp. https://www.hopkinsmedicine.org/Press_releases/2006/GriffithspsilocybinQ, May 08, 2018).

14 Such results have, for instance, been reported in a recent study on NDEs and their relation to spiritual well-being (Khanna/Greyson 2014: 1605–1615).

the inventor of LSD, Albert Hofmann, said in an interview that psychiatrists are the "curative priests" of contemporary society.[15] And Stanislav Grof too speaks of the "re-enchantment" of psychology in one of his recent publications in which he looks back at the last fifty years of consciousness research (cp. 2012). It therefore seems logical to read this case as a typical example of what Wouter Hanegraaff has described as "New Age religiosity" and the "psychologization of religion and sacralization of psychology" (Hanegraaff 1998: 514).

What TP offers from the alternative and complementary medical/therapeutic area in particular, to which Grof can be ascribed, generates an increasing resonance on the customer side. Thus, regardless of how they might be assessed scientifically, they obviously play a role in some parts of society that should not be underestimated.

At any rate, this movement can best be characterized as programmatically transboundary, and as such it may seem more attractive than ever to many people, precisely *because* it claims to be both scientific and religious. Moreover, it stands apart from the institutionally established forms of religion and offers a radically individualized form of access to the beyond which requires no mediator. Grof writes as follows about this with reference to C.G. Jung:

"As he saw it in his later years, the psyche is not a product of the brain and is not contained in the skull; it is the creative and generative principle of the cosmos (*anima mundi*). It permeates all of existence and the individual psyche of each of us is teased out of this unfathomable cosmic matrix. The boundaries between the *anima mundi* and the individual psyche are not absolute; they are permeable and can be transcended in holotropic states." (2012: 154)

Not only does this type of psychology represent a clear rejection of the materialistic paradigm in science, it also claims to open up a path for the connection of the individual psyche with the *anima mundi* and the process of man becoming one with the cosmos.

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15 Cp. http://www.bpv.ch/blog/albert-hofmann-interview/, May 08, 2018.

7 CONCLUSION

The aim of this paper has been to analyze a striking development in the contemporary religious landscape, namely the "religionization" of scientific discourse as manifest in research on Near-Death Experiences in Transpersonal Psychology as a specific, marginal part of psychology and psychiatry. This development has been analyzed by focusing on one of its most important representatives, the psychiatrist Stanislav Grof. Overall, four concluding observations can be made.

First, the distinction between science and religion is once again impugned and re-negotiated in the field of Transpersonal Psychology. As such, these cases are a good example of what Burkhard Gladigow, in his highly quoted text on European religious history, has described as the "vertical transfer" of results of the humanities and natural sciences into the realm of "religion" (1995: 21). In the case of both holotropic breathwork as well as psychological approaches to Near-Death Experiences (NDE), research that claims to be *scientific* becomes productive of religious imaginary.

Secondly, even though TP may be a contested branch of psychology, there have been noticeable changes within "orthodox" psychology in dealing with religion and spirituality as well. This observation helps to further contextualize the case at hand. In Germany, for example, a re-evaluation of topics related to religion and spirituality can be observed in the fields of psychology and psychiatry. This development has already been called "the spiritual turn." "Having been tabooed […] and polemically devalued […], recent publications on religious psychology have registered a remarkable change of direction […]" (Utsch 2002: 68). For example, a survey of more than nine hundred German psychotherapists in 2011 revealed "[…] that spirituality and religiosity seem to be relevant to the majority of psychological psychotherapists in Germany" (Utsch 2002: 69). More than half of them said "[…] that their personal spiritual or religious orientation strongly (8 per cent), fairly (21 per cent) or moderately (27 per cent) affects their psychotherapeutic activity" (Ibid: 69). Thus, quite independently of the special case of TP or of specific client and patient demands, a notable trend to integrate spirituality or religiosity can be observed in the broader fields of psychology, psychiatry, and psychotherapy.

Thirdly, this whole development can be situated in the wider context of research on the "therapeutization of society," (cp. Anhorn/Balzereit 2016;

Maasen et al. 2011). Therapeutization means, according to Anhorn and Balzereit, the diffusion, spreading, and generalization of highly individualized and self-referential methods and techniques of everyday life and problem solving, accelerated under the conditions of the neo-liberal social formation (2016: XVII). This description of the diffusion of therapeutic methods cannot be discussed in detail here. Such a diffusion will, however, not remain without influence on religion. From a theoretical point of view, one aspect seems particularly interesting, namely the *religious productivity* of therapy itself. In this way, therapeutic approaches, same as for instance holotropic breathwork, are at times deliberately designed to induce transpersonal experiences that can be effective in healing. Detached from a definite, clearly identifiable religious tradition, these specific forms of therapy can become an extraordinarily powerful medium for religion. The "re-sacralization" of psychology, the orientation of mainstream psychology and psychotherapy towards religious and spiritual questions, and finally the "therapeutization" of society are therefore important factors in contemporary western religious history.

Finally, the aspect of *somatization* is crucial in current re-configurations of religion(s). In an anthology on the "somatization of the religious" published in 2015, Gritt Klinkhammer and Eva Tolksdorf point out that religion and spirituality have become enormously important in the research-based and application-oriented secular health sector in recent years, alongside an increase in the supply of and demand for religious and spiritualist-oriented therapies in the alternative and complementary medical field, in religious and spiritual communities, and in the esoteric field. Within the current state of research, questions of the effect this development may have had on new understandings of "body", "religion", and "health", on potentially novel ways of religious (self-)organization and communitarization, as well as on formations of religious authenticity and authority remain unanswered (Klinkhammer/Tolksdorf 2015: 3–4).

The topic of NDEs seems to be a paradigmatic case here, in which dying, even if "only" perceived psychologically, is always a physical event. From the point of view of therapists such as Grof, who deliberately induced such processes, they are always both psychological and physical events at the same time. This method is characterized by the fact that a psychic experience always implies a physical one, and that it is only by involving both that healing becomes possible. As mentioned in the passage from Klinkhammer and

Tolksdorf quoted above, this further implies a specific view of religious authenticity and authority: authenticity is constituted by the individual experience of the clients, and therapists are solely companions of a process that is basically autonomous. Developments such as these change the social configuration of the field. This is why Klinkhammer and Tolksdorf predict that the new processes of somatization in the religious field will re-establish charismatic communitarization, as well as retroactively affect traditional forms of religion(s). This understanding could generate in-depth questions about new processes of religious authorization by means of "the body" and "healing" and new communitarization dynamics in the face of a charismatic healing relationship. The practice of healing is by no means limited to the religious virtuosi, as there is a definite tendency to duplication and individuation. These developments therefore raise questions about changes in the understanding of roles, the relationship between religious clients and healers, and the dynamics of the healing process (ibid: 7–8).

In the case of both holotropic breathwork and NDEs, the individual experience is itself meant to *cause* the healing. These are therefore exactly the tendencies towards duplication and individuation that Klinkhammer and Tolksdorf speak of. What is new here, above all, is the connection with the aspect of healing, which is both physical and psychical at the same time and is put back into the hands of the clients themselves as a process of self-healing. Therapists are solely companions in these processes or temporary teachers in therapeutic techniques, which are never limited to them as "virtuosi".

What kinds of new communities are emerging from these constellations? How are they changing the religious field?[16] What widespread effects are such developments exerting in view of the "therapeutization of society" and the "spiritual turn" in psychology and psychotherapy? Research is just about to start at this point.

BIBLIOGRAPHY

Alexander, Eben (2012): Proof of Heaven: A Neurosurgeon's Journey into the Afterlife, New York: Simon & Schuster.

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16 Related to this is the question of the influence of NDEs on current "spiritual worldviews" (cp. Schlieter 2018: 145–169; Schlieter forthcoming).

Anhorn, Roland; Balzereit, Marcus (eds.) (2016): Handbuch Therapeutisierung und soziale Arbeit, Wiesbaden: Springer Fachmedien.

Bal, Mieke (2009): "Interdisciplinarity: Working with Concepts", in: European Journal of English Studies 13, pp. 11–28.

Blanke, Olaf/Faivre, Nathan/Dieguez, Sebastian (2016): "Leaving Body and Life Behind: Out-Of-Body and Near-Death Experience", in: Steven Laureys/Olivia Gosseries/Giulio Tononi (eds.), The Neurology of Consciousness: Cognitive Neuroscience and Neuropathology, Amsterdam: Academic Press (imprint of Elsevier), pp. 323–347.

Britton, Willoughby B./Bootzin, Richard R. (2004): "Near-Death Experiences and the Temporal Lobe", in: Psychological Science 15/4, pp. 254–258.

Bryant, Clifton D. (ed.) (2003): Handbook of Death and Dying, Vol. 1, Thousand Oaks: Sage Publications.

Corazza, Ornella (2008): Near-Death Experiences: Exploring the Mind-Body Connection, London/New York: Routledge.

Gabbard, Glen O./Twemlow, Stuart W. (1991): "Do 'near-death experiences' occur only near death? Revisited", in: Journal of Near-Death Studies 10/1, pp. 41–47.

Gladigow, Burkhard (1988): "Religionsgeschichte des Gegenstandes – Gegenstände der Religionsgeschichte", in: Hartmut Zinser (ed.), Religionswissenschaft. Eine Einführung, Berlin: D. Reimer Cop., pp. 6–37.

Gladigow, Burkhard (1995): "Europäische Religionsgeschichte", in: Hans Kippenberg/Brigitte Luchesi (eds.), Lokale Religionsgeschichte, Marburg: Diagonal Verlag, pp. 21–42.

Greyson, Bruce (1999): "Defining Near-Death Experiences", in: Mortality 4, pp. 7–19.

Griffiths, R.R./Johnson M.W./Carducci M.A./Umbricht A./Richards W.A./Richards B.D./Cosimano M.P./Klinedinst M.A. (2016): "Psilocybin produces substantial and sustained decreases in depression and anxiety in patients with life-threatening cancer: a randomized double-blind trial", in: Journal of Psychopharmacology 30/12, pp. 1181–1197.

Gripentrog, Stephanie (2016): Anormalität und Religion: Zur Entstehung der Psychologie im Kontext der europäischen Religionsgeschichte des 19. und frühen 20. Jahrhunderts, Würzburg: Ergon.

Grof, Stanislav (1975): Realms of the Human Unconscious, New York: Viking Press.

Grof, Stanislav (1980): LSD-Psychotherapy: Exploring the Frontiers of the Hidden Mind, Alameda CA: Hanter House.

Grof, Stanislav (1988): The Adventure of Self-Discovery: Dimensions of Consciousness and New Perspectives in Psychotherapy and Inner Exploration, New York: State University of New York Press.

Grof, Stanislav (1994): Das Abenteuer der Selbstentdeckung: Heilung durch veränderte Bewußtseinszustände. Ein Leitfaden, Reinbek: Rowohlt.

Grof, Stanislav (2000): Psychology of the Future: Lessons from Modern Consciousness Research, New York: State University of New York Press.

Grof, Stanislav (2012): "Revision and Re-Enchantment of Psychology: Legacy of Half a Century of Consciousness Research", in: Journal of Transpersonal Psychology 44/2, pp. 137–163.

Grof, Stanislav (2017): Transpersonal Training. Information Pack. https://www.holotropic.com/wp-content/uploads/2015/10/GTT-Training-information-pack-2017.pdf, July 04, 2018.

Grof, Stanislav/Grof, Christina (1980): Beyond Death: The Gates of Consciousness, London: Thames and Hudson.

Grof, Stanislav/Halifax, Joan (1977): The Human Encounter with Death. With a foreword by Elisabeth Kübler-Ross, New York: Dutton.

Hanegraaff, Wouter (1998): New Age Religion and Western Culture: Esotericism in the Mirror of Secular Thought, New York: State University of New York Press.

Hofmann, Albert (1979): LSD – mein Sorgenkind, Stuttgart: Klett-Cotta.

Irwin, Harvey J. (1985): Flight of Mind: A Psychological Study of the Out-of-Body Experience, Metuchen: Scarecrow Press.

James, William (1902): The Varieties of Religious Experience: A Study in Human Nature, New York.

Khanna, Surbi/Greyson, Bruce (2014): "Near-death experiences and spiritual well-being", in: Journal of Religion and Health 53/6, pp. 1605–15.

Klinkhammer, Gritt/Tolksdorf, Eva (2015): Somatisierung des Religiösen. Empirische Studien zum rezenten religiösen Heilungs- und Therapiemarkt (=Veröffentlichungen des Instituts für Religionswissenschaft und Religionspädagogik 7), Bremen: Universität Bremen.

Knoblauch, Hubert (1999): Berichte aus dem Jenseits: Mythos und Realität der Nahtoderfahrung, Freiburg: Herder.

Krech, Volkhard (2005): "Religiöse Erfahrung und artikulatorische Identitätsbildung in Konversionserzählungen: Wissenschaftsgeschichtliches und Systematisches", in: Magnus Schlette/Matthias Jung (eds.), Anthropologie der Artikulation: Begriffliche Grundlagen und transdisziplinäre Perspektiven, Würzburg: Königshausen & Neumann, pp. 341–370.

Maasen, Sabine/Elberfeld, Jens/Eitler, Pascal/Tändler, Maik (2011): Das beratene Selbst: Zur Genealogie der Therapeutisierung in den "langen" Siebzigern. Bielefeld: Transcript.

Maslow, Abraham H. (1962): "Lessons from the Peak-Experiences", in: Journal of Humanistic Psychology Vol. 2 No. 1, pp. 9–18.

Maslow, Abraham H. (1964): Religions, values and peak experiences, London: Penguin Books.

Maslow, Abraham H. (1968): Toward a Psychology of Being, 2nd ed., New York: Von Nostrand Reinhold.

Moody, Raymond (1975): Life after Life: The Investigation of a Phenomenon: Survival of Bodily Death, Covington, Georgia: Mockingbird Books.

Nutt, David J. et al. (2016): "Neural correlates of the LSD experience revealed by multimodal neuroimaging", in: Proceedings of the National Academy of Sciences of the United States of America 113/17, pp. 4853–58.

Pahnke, Walter (1966): "Psychopharmaka und mystische Erfahrung", in: Zeitschrift für Parapsychologie und Grenzgebiete der Psychologie IX, pp. 85–106.

Pahnke, Walter/Kurland A./Unger S./Savage C./Grof S. (1970): "The experimental use of psychedelic (LSD) psychotherapy", in: JAMA 212, pp. 1856–63.

Richards, William/Richards, William/Grof, Stanislav/Goodman, Louis/Kurland, Albert (1972): "LSD-Assisted Psychotherapy and the Human Encounter with Death", in: Journal of Transpersonal Psychology 4–2, pp. 121–149.

Ring, Kenneth (1980): Life at Death: A Scientific Investigation of the Near-Death Experience, New York: Coward McCann and Geoghegan.

Ring, Kenneth (1992): The Omega Project: Near-Death Experiences, UFO Encounters, and Mind at Large, New York: William Morrow.

Schlieter, Jens (2018): "'Death-x-Pulse': A Hermeneutics for the 'Panoramic Life Review' in Near-Death Experiences", in: Günter Blamberger/Sudhir

Kakar (eds.), Imaginations of Death and the Beyond in India and Europe, Singapore: Springer Verlag, pp. 145–169.

Schlieter, Jens (forthcoming): "What is it like to be dead? Near Death Experiences, Christianity and the Occult", in: Oxford Studies in Western Esotericism, Oxford: Oxford University Press.

Thonnard, Marie/Charland-Verville, Vanessa/Brédart, Serge/Dehon, Hedwige/Ledoux, Didier/Laureys, Steven/Vanhaudenhuyse, Audrey (2013): "Characteristics of near-death experiences memories as compared to real and imagined events memories", in: PLoS One 8/3, pp. 1–5.

Traut, Lucia/Wilke, Annette (eds.) (2015): Religion – Imagination – Ästhetik: Vorstellungs- und Sinneswelten in Religion und Kultur, Göttingen: Vandenhoeck & Ruprecht.

Treitel, Corinna (2004): A Science for the Soul: Occultism and the Genesis of the German Modern, Baltimore: Johns Hopkins University Press.

Utsch, Michael (2002): "Religiosität und Spiritualität in den psychotherapeutischen Schulen", in: Michael Utsch et al. (eds.), Psychotherapie und Spiritualität, Berlin/Heidelberg: EZW, pp. 68–82.

Vaitl, Dieter (2012): Veränderte Bewusstseinszustände: Grundlagen – Techniken – Phänomenologie, Stuttgart: Schattauer.

Van Gennep, Arnold (1909): Les rites des passage, Paris: Émile Nourry.

Van Lommel, Pim/van Wees, Ruud/Meyers, Vincent/Elfferich, Ingrid (2001): "Near-death experience in survivors of cardiac arrest: a prospective study in the Netherlands", in: Lancet 358 (9298), pp. 2039–45.

Van Lommel, Pim (2010): Consciousness Beyond Life: The Science of Near-Death Experience, New York: HarperOne (Harper Collins).

Walach, Harald/Kohls, Niko/Belschner, Wilfried (2005): "Transpersonale Psychologie – Psychologie des Bewusstseins: Chancen und Probleme", in: Psychotherapie, Psychosomatik, Medizinische Psychologie 55, pp. 405–415.

Walch, Sylvester (2012): Dimensionen der menschlichen Seele, 5th ed., Düsseldorf: Patmos.

Wren-Lewis, John (2004): "The Implications of Near-Death Experiences for Understanding Posttraumatic Growth", in: Psychological Inquiry 15/1, pp. 90–92.

Yensen, Richard/Dryer, Donna (1995): "Thirty Years of Psychedelic Research: The Spring Grove Experiment and its Sequels", in: Yearbook of

the European College for the Study of Consciousness (ECBS) 1993–1994, Berlin: Verlag für Wissenschaft und Bildung, pp. 73–101.

LINKS

http://www.holotropic.com, 04 July, 2018.
http://www.holotropic-association.eu/breathwork/what-is-holotropic-breathwork, 04 July, 2018.
http://www.grof-holotropic-breathwork.de/verwandt.html, 04 July, 2018.
https://www.therapeuten.de/therapien/holotropes_atmen.htm#anbieter, 04 July, 2018.
http://bewusstseinserforschung.de, 04 July, 2018.
https://www.dr-reisach-kliniken.de/start.html, 04 July, 2018.
https://www.heiligenfeld.de/Therapiekonzept/therapiekonzept-fach-klinik.html, 04 July, 2018.
http://www.bpv.ch/blog/albert-hofmann-interview/, 04 July, 2018.
http://www.drpennysartori.com/NDE%20death%20flyer.pdf, 04 July, 2018.
https://www.hopkinsmedicine.org/Press_releases/2006/Griffithspsilocy-binQ, 04 July, 2018.

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