Introduction

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

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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

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.

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.

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)

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

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 therapeutic 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 consolidate and counteract the entanglements of religion and medicine, depending on the respective social and political contexts. Not all strategies, however, 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 "Innovation 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 conceptualizations 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 influences, 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

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 portraying 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 provided 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 revised (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 contemporary Japanese religions: "Another issue is the attitude shown by some scholars 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 constitute complicity in maintaining patriarchal religious structures." (Kawahashi and Kobayashi 2017: 3) On the other hand, there are various examples of joint authorship 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.

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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).

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