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Belief, Healing and Meaning:

Examples from Two Complementary Healing Systems in a Western Canadian City

by

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ABSTRACT

This is a study of the role of belief in healing. The purpose is to learn more about how people's beliefs influence their experiences of illness and to explore the nature of the relationship between the beliefs emphasized by individuals and the meanings they attach to their illness experience. With these objectives, I conducted participant observation and interviews in two health care communities, one a Spiritualist church and the other a clinic for complementary medicine. Comparisons are made between these, and a model of etiological beliefs, from proximate to ultimate, is formulated. Examples are given of people and institutions moving from the conventional to the unconventional in health care. I found that the study's participants mould their views according to their experiences and construct eclectic but useful, in that they are viewed as helpful, belief systems. The creation of meaning in lives, stories, and therapies is also considered.

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Everyone included here has contributed significantly to this study, but any errors are mine alone.

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CHAPTER ONE

INTRODUCTION

> Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place.
> Susan Sontag, *Illness as Metaphor*

This is a qualitative study of the relationship between healing and belief. Its purpose is to explore this relationship in two settings, one religious and one ethnomedical. In charting a course through the "webs of significance" (Geertz 1973: 5) within and between the domains of belief, religion, and medicine, I employed meaning as my navigator and stories as my map.

Throughout this journey, I was not looking to discern mechanism. A preoccupation with "what is actually going on here" (Turner 1994: 86), all too often obscures the subtleties that potentiate healing. At the same time, I do not wish to exaggerate the tension between materialism and meaning, for they in many ways comprise the warp and weft of one fabric. Sayer (1992: 265) comments that

> [w]hile it is quite likely that some aspects of reality are two-sided and can reasonably be described in terms of dualisms, it is scarcely credible that complex networks of arguments or historical change could be resolved into neatly aligned sets of dualisms.

However accurate this is, a dichotomy is nevertheless often created for heuristic purposes: "When we consider the *artistry* of folk medical traditions as well as their *science*, the metaphors of meaning become as significant for maintenance of those health systems as scientific proofs of their efficacy" (Baldwin 1992: 192, emphasis added). This is not to position myself as unreceptive to the "science" (i.e. effectiveness

independent from belief and meaning) of the healing modalities described herein, but only to clarify that evaluation of efficacy is not my intention, nor is it to judge the "validity" of the beliefs adhered to by the participants. Rather, it is to examine the ties that bind together a person's beliefs and her life experiences, especially those of illness and healing. We will find that much of this has to do with why a therapy works; that beliefs and experiences are intricately bound up with efficacy. I do not reject the urging of Young and Goulet (1994) to take seriously the stories of one's informants. But at the same time, I believe that taking seriously should imply more than considering their conceptions of reality as "serious alternatives to Western conceptions of reality" (ibid.). It is also about willingness to see one's own views of reality as equally symbolic and metaphorical as one's informants views of reality.

Background

At the age of twelve, I injured my jaw in two separate falls that were the unfortunate result of my propensity for performing youthful but reckless stunts. Two years later, my jaw joint crackled and popped whenever I opened my mouth. The novelty of this wore off, though, when my head, neck, and jaw began to ache persistently. My dentist sent me to an orthodontist, who fitted my lower teeth with a splint to be worn twenty-four hours a day. Combined with early morning physiotherapy that hurt more than it helped, this "bite splint" was my treatment plan. I also underwent a painful diagnostic test that showed my dysfunctional joint on a television screen. This resulted in talk among my doctors about surgery to "repair" the defective tissue. Such possibilities sent me straight to the library, where I learned about people with my condition, called TMJ (temporomandibular jaw joint dysfunction), who had opted for surgery but sorely

regretted that they had. I declined the oral surgeon's proposal for a mechanical solution and decided instead to manage my stress and learn to cope with a malfunctioning jaw. I was 15 years old.

Those experiences are the seeds of this study. I encountered first hand the strengths and limitations of biomedicine which triggered my interest in alternate healing modalities. I wondered why, if doctors were supposed to be the "experts," no one could explain to me what caused my TMJ (the previous trauma seems a probable cause and is my explanation, but the doctors were not as sure and there are many with this condition that lack a similar history). Also, if everyone knew that my symptoms were exacerbated by stress, why did my treatment plan implicitly ignore stress management and coping techniques? Finally, I thought, why was a procedure as invasive as surgery recommended? It made no sense to me that my doctors claimed to be able to fix something although they did not even know what was, or even how it became, broken in the first place.

And so I empathize with the people who tell their stories in the following pages. They provide a vivid glimpse into contemporary views on illness and healing in North American society today and their contributions here are therefore extremely valuable.

Research was carried out over four months, from July to October 1998, at two field sites and within the homes of interview participants. One of the sites was an Alternative Medicine Clinic, the other a Spiritualist Church. Both are located within a large western Canadian city. The methods used in the study are elaborated in Chapter two.

Description of Field Sites

I chose my field sites with several things in mind. I wanted to remain in the realm of complementary medicine, if for no other reason than that its use is an important yet understudied social trend. Additionally, as a student of anthropology, I found myself attracted to that which is outside of my ordinary cultural experience. I also wanted to incorporate what I conceptualized as different "types" of formal belief systems. The "natural communities" (Geertz 1983: 156) of a clinic and a church fit these criteria.

The Alternative Medicine Clinic, which I also refer to as "the clinic," is a multidisciplinary centre for both research and practice. Established in 1993, its staff are comprised of professionals from various backgrounds. There are registered nurses, nutritionists, licensed acupuncturists, physicians, and a dentist. The atmosphere at the clinic is at once clinical and compassionate. It is technological and professional yet familiar and comfortable. The waiting room is quiet and open, stocked with a reverse osmosis water cooler, herbal teas and health magazines to read. The clinic also provides weekly healthful recipes created for those on special diets. These can be found, along with photocopies of articles and literature about the various treatments available, at the reception desk. Adjacent to the reception area are the treatment rooms. Within these are housed several diagnostic and treatment machines, including an ionized oxygen delivery system, the computers used for the biological terrain assessment, and the biophoton therapy machine. Ionized oxygen is said by the clinic to improve respiration, circulation, and blood problems. The biological terrain assessment is a diagnostic tool that tests a person's bodily fluids (blood, saliva, and urine), the results of which are interpreted by a

physician. Biophoton therapy is a type of light therapy used to "correct pathological electromagnetic waves" (pamphlet produced by the Alternative Medicine Clinic). More treatment rooms line the corridor; there are ten in total. Each is equipped with some or all of: an examining table, chair, stool, sink, mirror, acupuncture and cupping paraphernalia, an entrainment machine, and the machines mentioned above. There are also several offices, a conference room, and a charting area. The clinic walls are lined with charts depicting both Western anatomy and Eastern qi (vital energy) meridians and acupuncture points.

Contrasting with the clinic's bustling downtown location, the Church of Spiritualism is found in a quiet residential neighborhood. A child of the Spiritualist movement, it traces its roots to an 1848 incident in Hydesville, New York. On March 31 of that year, a phenomenon that came to be popularly known as the "Rochester Rappings," began. That night, a family by the name of Fox was awakened by the sound of knocking. This persisted, and people arrived to witness it. It was soon realized that the noises were only heard when the Fox sisters, Maggie and Kate, were present. Years later, each separately confessed (and then retracted their confessions) to producing the sound effects by cracking the joints in their toes (Brandon 1984). From then on, and as the Fox sisters' fame grew, Spiritualism spread across the western United States and east across the Atlantic to Great Britain, where it was enormously popular during the last half of the nineteenth century (Oppenheim 1985: 11).

The particular Church of Spiritualism studied here was born out of a newspaper advertisement placed during World War One by a medium looking for others "interested in psychic work" (Collett 1975: 3). Growing steadily over the next years, the church

acquired its own building through teas, socials, and psychic circle fund-raisers. Ministers ordained by the Spiritualist National Union in Toronto led the congregation, and a children's Sunday school was provided. In 1972, the church moved into its present location.

The building's home-like appearance easily blends in with its surroundings. The main floor consists of a room with chairs that hold about sixty people. Most services are attended by twenty to thirty people, with slightly more women than men. There is a raised platform at the front of the room with a podium and several chairs on it. Fresh flowers are brought in and the windows are opened on warm days. Someone is usually at the door before the Sunday evening service to greet arrivals. The welcoming atmosphere is extended after the service as well, when light refreshments are served, healings take place, and people mingle and chat.

One interesting aspect of the church is its familiar, casual mood. The very plain interior counters normative expectations for what the inside of a church should look like. There are very few religious icons; this void seems a deliberate attempt to desacralize and demystify Spiritualism in this highly secular society. Demystification can also be seen in the process of initiation into healing and mediumship roles, which is quite indiscriminate (cf. Finkler 1985). All church-goers are encouraged to develop their clairvoyant and healing potentials. The power of the rituals at the church seems to depend less on "how the practice of secrecy moves every form of absolute truth out of reach" (Barth 1987: 7), and more on the ritual's easy accessibility and simple truth.

Organization

Chapter two is a discussion of the methodology of the study. Following that, the thesis is organized around three major themes: progression, beliefs, and meaning. Each chapter incorporates stories, descriptions, observations, and analysis.

We begin with the progression theme in chapter three by looking intensively at institutional change and individual choice. The theme of the chapter is "progressions" because we are dealing with the reconciliation of the unconventional and the conventional for purposes of overall progress and growth. This process is seen to occur in both systems and people. The chapter is therefore about the incorporation of alternative beliefs, including varied epistemologies and paradigms, into the mainstream. We see that this is done for practical reasons such as legitimating and explaining experiences like dealing with a controversial illness.

Chapter four is a discussion of the nature and types of belief as they relate to healing, especially in the realm of coping. It describes the formal belief systems at the Alternative Medicine Clinic and the Spiritualist Church, and explores the dynamic malleability of these and other beliefs as they occur over a person's lifetime. The notion that beliefs can be chosen and shaped according to individual needs is considered through an examination of life history material and several single substantive beliefs.

Chapter five continues with the subject of belief, but also takes a close look at similarities and differences between the church and clinic, and its members. Points of comparison were selected according to my original research questions as well as their importance to members of the Church of Spiritualism and the Alternative Medicine

Clinic's clientele. They parallel the common ethnomedical categories of affliction, or what things are considered to be in need of healing; etiology, which is what is believed to cause disease and illness; and treatments, those activities that are thought to help and heal afflictions.

Chapter six builds on the previous three chapters' treatment of beliefs and change by bringing the meaningfulness of these to the forefront. It explores ways in which meaning is created in experience and narrative by analyzing the use of symbols, images, and metaphors used in therapy, conceptualization, and the telling of stories.

The thesis is concluded in Chapter seven, where the themes of progressions, belief, and meaning in healing are reviewed. Implications for further research are also considered.

CHAPTER TWO

METHODS

> Ethnography, biography, history, psychotherapy – these are the appropriate research methods to create knowledge about the personal world of suffering. These methods enable us to grasp, behind the simple sounds of bodily pain and psychiatric symptoms, the complex inner language of hurt, desperation, and moral pain (and also triumph) of living an illness.
> Arthur Kleinman, *The Illness Narratives*

The discussion of methodology is divided into four sections: purpose, data collection, analysis, and representation. Each section describes the methods used and provides a theoretical rationale for my methodological choices.

Purpose

The purpose of this study is to learn more about how people's beliefs influence their experience of illness, how an illness experience influences belief, and where, how and when those beliefs become integrated into a belief system that is unique to that individual. My aim is to explore the nature of the relationship between the beliefs that are emphasized by an individual and the meanings attached to the illness experience. Objectives include: a) to consider how beliefs change and are, as forms of knowledge, transmitted; b) to explore the interactions between several different healing modalities in North American society, including the dominant biomedical tradition; c) to compare the attitudes and beliefs held by people at the two field sites; and d) to examine how meaning is generated in lives and stories.

Data Collection

Data on the role of belief in healing were collected at each site, described above, using a combination of participant observation and interviews. This combination strikes a balance between the socio-cultural and the personal, as it allows for the investigation of both institutional and individual knowledge and belief. The methods used are also an attempt to reach those ideal goals of observing "both order and meaning simultaneously" (Bruner 1993: 24) and reconciling the synchronic with the historical (Sayer 1992: 260)

Participant observation is the central method of cultural anthropology. The foremost goals of employing it in this study were to gain experiential knowledge, engage in casual conversation at my field sites, and to make observations. I especially wanted to experience the therapies and healing processes at my field sites, and I therefore welcomed any opportunities for healings or treatments. I received two full treatment sessions at the Alternative Medicine Clinic, observed demonstrations of medical technology and techniques, and witnessed two actual treatments of clients. At the church, I had healings performed by three different practitioners, participated in two, and observed many more. I spent several days at the clinic talking to the staff and some of the patients. It was very difficult, though, to conduct traditional participant observation at this site due to ethical concerns of patient confidentiality and consent. At the clinic I took detailed notes and tape recorded my own observations and impressions about conversations, treatments, and mood. This material was transcribed and expanded later the same day in my office. In addition to this, I practiced meditations, visualizations, and diet recommendations made to me during my own treatments.

At the church, I attended the Sunday evening service and Wednesday evening healing and message services every week, and "hung around" before and after all of the services to talk to people and observe healings. I participated in all of the service's activities (prayer, meditation, singing). Again, I took detailed notes before, during, and after the services, and also sometimes tape recorded my impressions and observations. I also tape recorded clairvoyant messages, but only the ones that were intended for me. I found it helpful to read each group's popular literature, which included any books, magazines, and articles that were recommended or mentioned to me in conversations at the church, clinic, or interviewees' homes.

There were several limitations in using participant observation in this study. As mentioned above, ethical concerns precluded extensive contact with the clients at the clinic. It was nearly impossible to observe treatments because of the mechanisms in place to protect patient privacy, although I was able to arrange observation of two treatments. On the other hand, participant observation at the church was very fruitful. Another limitation to using this method here is related to conducting fieldwork within my own society, a topic to which I will return below. Traditional participant observation sees the researcher collecting data constantly in their day-to-day life, by simply living in another cultural milieu. In essence, I am still participant observer in my own society, however reflexive positioning can not be as powerful simply because I have lived here all of my life. Emiko Ohnuki-Tierney (1984) describes a similar problem in her role as a "native anthropologist" in Kobe, Japan. According to her, "[n]ative anthropologists . . . share a problem with their informants: We take our own customs and behavior for granted, and so patterns and structures become difficult to perceive" (ibid.: 16). On the

other hand, native anthropologists gain the advantages of fitting in more easily and having detailed, first hand knowledge of their subjects' quotidian lives (ibid.: 18).

Despite the above limitations, it is nonetheless necessary to employ participant observation to get a fuller and clearer picture of the phenomena and people under study. One needs to see and experience what people do in addition to hearing what they say. In order to hear what they say, I conducted interviews.

My goal was to locate two or three people from each site who were willing, and well enough, to grant me a life history interview of six or eight hours over several appointments. Anthropologists Watson and Watson-Franke (1985: 2) define life history as "any retrospective account by the individual of his life in whole or in part, in written or oral form, *that has been elicited or prompted by another person.*" My objectives in using this technique were to: a) elicit stories using "grand tour" descriptive questions (Spradley 1979: 86-88); b) gather data to contribute to the construction of a typology and range of folk beliefs and categories relating to diagnosis, etiology and treatment; and c) explore what illness means to the informant. It was anticipated that the life history interviews would vary in length, depending on the amount of time the participant was willing to contribute. I therefore built several basics into the interview guide, hoping at least to cover each participant's beliefs surrounding healing, religion, spirituality, philosophy, the cause of their own illness and illness in general, and what meanings (if any) they hold for their own illness and illness in general. I felt that these topics could be covered even with limited time, but that the results would lack richness and stories. Consequently, I did not want to rely too heavily on this type of interview, because the goal was to conduct a lengthy and detailed open-ended life history interview. The

flexibility built into the interview turned out to be unnecessary because all of the participants, with the exception of the practitioners, gave full length life histories.

In creating the structure and content of the questions, I incorporated many of Spradley's (1979) recommendations for ethnographic interviews. Spradley's treatment of domains and structural questions was especially useful in the formulation of questions regarding types of beliefs and kinds of explanations for illness and wellness (etiological beliefs and beliefs about treatments). In addition to the above topics about beliefs, interviews also probed for stories about life experiences, family background (childhood, marriages, parents and siblings), lifestyle, socioeconomic status, and education. All of the interviews were semi-structured and based on an interview guide (Appendix A) for purposes of comparability (Bernard 1994: 209).

In addition to the life history interviews, I created a separate question set for interviewing practitioners at my field sites. My goal was to interview at least one practitioner at each site, using a more focussed, direct, and briefer interview, although still only semi-structured (Appendix B). The objectives of this second type of interview were to understand the formal beliefs and knowledge that underlie the healing practices at my field sites, and also to elicit if and how the practitioners impart such beliefs to patients and clients.

Participants for the interviews were selected through casual contact at the church and through an intermediary at the clinic. Over several weeks, one of the nurses at the clinic described the study to clients who met the requirements of having the time and wellness to participate in the life history interviews. She then compiled a list of ten names and phone numbers of those who expressed interest in participating. I phoned

those on the list and explained the project in more detail, answered questions, and asked if they would be willing to participate. This alleviated the pressure on the client of a person in a perceived position of power (the nurse at the clinic) asking them to participate in the study. It also allowed them to think about it for several days and come up with questions they wanted to ask, in addition to providing me with the opportunity to explain the process in detail to them. A couple of people declined to participate for various reasons, and some asked if they could get back to me with their decision. A few agreed to be interviewed, and we immediately set up appointments for the first meeting.

The process at the church was very different. I approached people directly, told them about the study, and asked if they would be interested in participating in the life history interviews. A potential participant was identified as anyone who sought healing at regular services or special healing services. My interviews therefore consisted of two practitioners from the clinic, two practitioners from the church, and four life history illness narratives, all from the clinic. Appendix C contains short profiles of each of the participants. Interestingly, there was some cross-over in types of interviews. The interviews of two of the practitioners, one from each of the church and clinic, evolved into lengthy life and illness narratives.

As much as possible, the interviews were conducted at the homes of participants. This was to get a better view of each person within their own setting, and for reasons of comfort to the participant. Two of the practitioner interviews were held at the clinic, and one was at a coffee shop. Each session ranged from one hour to six hours and averaged approximately three hours. The number of sessions for each interview ranged from one to six. At the beginning of each interview, I again explained my purpose and answered

any questions. Then I had each person sign an informed consent form guaranteeing confidentiality and anonymity (Appendix D). At the same time, I asked for permission to tape record the interview, and demonstrated how to turn the tape recorder off. The recorder was set within easy reach of the participant, providing them with control over the recording. This was an attempt to lessen anxiety about being tape recorded, and was used several times by interview participants during some difficult interchanges. Each interview, with the exception of one very poor recording, was transcribed verbatim and in full, resulting in a total of 54 hours of interview, or 350 transcribed pages. I also took notes during the interviews to supplement the recordings with my commentary and observations. This is the bulk of my data.

The strengths of life history interviews are many. Life history information can shed light on how people experience and attribute meaning to illness. This is a valuable contribution to both anthropology and medicine where doctors rarely have the time to build a strongly integrated and truly historical medical record with their patients. Life history interviews, although long and sometimes indirect, are inherently quite satisfying to the researcher (at least to this researcher) as well as the participant. They are more rewarding to use than directed and topically focused interviews, because they allow the researcher to get to know the person they are interviewing, establish a (hopefully) trusting relationship, and see many more facets and complexities in the subject matter. Life history is satisfying to the participant because it allows them to express what they believe is important, tell stories to illustrate their points, and in the case of illness, integrate their experience and infuse it with meaning. Telling a story can be very therapeutic (Farmer and Kleinman 1998[1989]: 340). Many times women would stop and cry, having

realized something about what their illness stood for or its roots in particular experiences. In narrating their lives, they were considering their illness experience as a whole and could therefore see patterns and connections. Studying the formal belief systems at the church and clinic through participant observation and practitioner interviews is complemented by the life histories, as people are communicating in their stories "not faith in what one has been told to believe, but faith in one's own experiences, whether of feeling, fact, reason, or vision" (Campbell 1968: 84). Taking life histories is an opportunity to grapple with change, and the narrative can reveal how beliefs can both determine and be created by changing life situations.

In addition to the strengths, there are also limitations to relying heavily on interview material. In her study of reproduction in North America, Emily Martin (1987: 9) comments that "doing a study based on interviews meant that I gave up the rich, multilayered texture of life that I would have experienced by living in a community or with a family" but goes on to say that

> doing fieldwork through interviews was far less abstract than I feared. Although I felt I was doing fieldwork only episodically, . . . , the episodes could be very intense. All of us doing interviews often felt swept away by them – either exhilarated or cast down – and the emotional effects lingered, as if we had had the most profound events of someone else's life shoehorned onto our own.

This was very much how I felt conducting interviews. I felt sickened by the hardships people face, yet elated and inspired by the strength and tenacity shown.

Another difficulty with life history interviews has to do with point of view. The person being interviewed is in a certain space at the time of the interview. Their current situation impacts what they attend to in telling their story. Included in the interviewee's positioning, and how that influences what she chooses to relate, is the interviewer's

presence. It is recognized that what was said may have been different had someone other than a young, white, married woman (me) conducted the interview. In other words, each story would be different if it was told to someone else or at a different time or place, as the storyteller "may not remember or choose to emphasize the things that were once important" (Watson and Watson-Franke 1985: 3).

I found it challenging to exercise participant observation at the clinic and relatively easy to locate interviewees, but the converse occurred at the church. People were more inclined to just sit and chat casually at the church rather than schedule an appointment for the life history interview, while participant observation was readily accepted and even welcomed. Half hour to hour long informal interviews were therefore common at the church, but this resulted in a bias in the interviews because I had much more rich life history information for the clinic clients than I had for church members. It was fascinating to note how different beliefs and values were reflected in people's reaction to me in this regard. For example, one woman at the church declined being interviewed because she believed it would interfere with her "healing path."

Using both participant observation and interviews allowed me to strive for a balance between the "macro" (often represented by a society but in this case as the subcultures of church and clinic) with the "micro" (the individual) as well as the descriptive with the historical and the formalized and shared with the dynamic and unique.

Analysis

The objectives of analysis were to organize my data toward achieving the objectives set out in the section on purpose. I endeavored to determine what things people believe, what their experiences are, what they do for health maintenance or promotion, their self-image, and how they bring meaning to their experiences. I also wanted these items to be somewhat comparable. To do this, I indexed all of my transcribed material for statements and stories indicative of: types of beliefs (for example, etiological beliefs and beliefs about how a treatment works), self-image and self-perception, childhood experiences, references to family, physical symptoms, emotional and mental symptoms, things considered to constitute evidence, health seeking, treatments undergone, occupation and work, and use of metaphoric or symbolic language and meaning. The index was a helpful tool in locating material for comparison across individuals and field sites. It also helped to uncover patterns of meaning and similarities and differences in experiences, values, and beliefs. I similarly indexed my field notes.

My goal in analysis was to stay as close to what people said and did as possible. I greatly tried to limit any etic analytical overlay, striving for synthesis in my identification of categories rather than imposing preconceptions and external categories upon the data. Analysis is like panning for gold in that, with patience and gentle handling of the data, vibrant patterns seem to emerge out of the material without being forced.

The data are, of course, in no way appropriate for quantitative analysis. I employed instead comparative, symbolic, and interpretive analytical frameworks. I have also drawn on Jackson's (1989) radical empiricism, which conceptualizes a "world whose

horizons are open, the quotidian world in which we live, adjusting our needs to the needs of others, testing our ideas against the exigencies of life" (ibid.: 1). Jackson's view is that people tend to be pragmatic in their application and engagement of belief (ibid.: 117), a theme that surfaced at both field sites and in all of the interviews.

Although we sometimes have a tendency to create false but elegant boundaries around objects intended for comparison (Coombe 1991: 113; Stephenson 1993: 61; Tilley 1997: 44; Mace and Pagel 1994), the comparative method is still useful in many ways. It is understood that our "objects" of study shift and change unceasingly and yet, in its striving toward general theories of humanity, anthropology ultimately requires a comparative perspective. As well, juxtaposition is inherently valuable as a highlighting tool. Used reflexively, it often reveals that our taken-for-granted generalizations are actually single cases belonging only to the society, or portion thereof, in which we dwell. For example, comparing ethnomedicines that are, from the point of view of one segment of society, unconventional, with each other and with the "conventional," has proven how presumptuous we can be about our own culture. I, for one, had no idea how sharply contrasting are the ontologies of people who are living their lives in the apparently same culture and society as myself. There is more magic and spirituality here than appear on the surface. Comparison of ethnomedical belief systems is one pathway to this realization.

My analysis is in several ways symbolic. In my pursuit to understand the many meanings that surround illness, healing, and belief, I have treated the symbol as a type of evidence that supports beliefs and therefore, makes events and experiences deeply meaningful. My perspective, with Kleinman (1988: 8), is that illness is polysemic and

that to some degree, "symptom and context can be interpreted as symbol and text" (ibid.: 42). In addition to considering the meanings illness holds for people, symbolic analysis can shed light upon how, as well as being meaningful, certain events and experiences become spiritually, mentally, and physically therapeutic. Incorporating a symbolic schema, my intention is to engage "an assumption of the body as simultaneously a physical and symbolic artifact, as both naturally and culturally produced, and as securely anchored in a particular historical moment" (Scheper-Hughes and Lock 1998 [1987]: 208).

From a perspective that emphasizes the interwoven character between physical and symbolic, I have listened to stories of physical ailing and attempted to flesh out the symbolic and the meaningful. I also paid close attention to how my interviewees interpret their own experiences. Then I did the same with my own healing encounters at my field sites. In other words, what I mean by interpretation is that I take as an anchoring point Geertz's (1973: 89) conception of culture as being "an historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms by means of which men communicate, perpetuate, and develop their knowledge about and attitudes toward life." My goal in interpreting illness narratives and the symbolism underlying various healing practices follows Marcus and Fischer's (1986: 26) view of interpretive anthropology. According to them interpretive anthropology should present "accounts of other worlds from the inside, and reflect about the epistemological groundings of such accounts."

Representation

My rendering of belief and healing is arrived at through an amalgamation of narrative, description and analysis. It is anticipated that this recipe will produce a balanced and satisfying flavour for the reader. Again, I was seeking to unite order and meaning (Bruner 1993: 24), this time via multiple viewpoints and voices (Shokeid 1997). I have therefore combined descriptions with commentary and narratives with analysis. I endorse Watson and Watson-Franke's (1985: 2) argument that

> where interest in the individual's narrative is *primary*, the life history has often not been interpreted at all, the investigator simply allowing it to 'speak for itself' (see Lewis 1961). This is not enough. The life history requires additional interpretive elucidation.

This acknowledged, I have nevertheless presented lengthy quotations from my interview transcripts. The purpose of these is to provide the reader with an unmediated view of the interview participants by endowing them with "active voices" (Bruner 1993: 5). It is also to allow the reader to establish a relationship with the participants; to get to know them on their own terms as one would characters in a book. Presenting the participants much in their own words is especially valuable when dealing with personal stories of illness and healing because "illness, as a personal and social reality, and therapeutics directed toward treatment of that reality are inextricably bound to the medium of language and signification" (Good and Delvecchio Good 1981: 175). For purposes of consistency and comparability, I wanted to avoid the typical case study approach, where one person is used to illustrate a single topic or argument. Instead, I have spread individual life stories across the chapters so as to present people in varying contexts and relative to an array of topics. I again employ Jackson's (1989: 4) theoretical standpoint

of intersubjectivity, empathy, and experience in using my own experiences as primary data. This is applied in my descriptions of healings and treatments I encountered at the church and clinic.

A final note on representation: I have used pseudonyms for all interview participants and changed or deleted identifying information. Participants in the study are identified by a first and last name or by initials after a quote and in tables. When each of the interviewees is initially introduced, I provide biographical information and a citation for the interview. I omit these thereafter. Appendix C contains biographical information for each participant. As well, I have lightly edited some of the narrative passages, omitting fillers and adjusting the discursive flow with the goal of making the passage more readable.

Challenges, Biases, and "Unexpecteds"

Two of the most striking disparities in my material are gender and type of illness. Five out of eight of my interviews are with women, all of whom suffer from one or more autoimmune disorders (multiple chemical sensitivities, insulin-dependent diabetes mellitus, arthritis, chronic fatigue syndrome, and fibromyalgia). One of the men also fits into this category. The remaining two men are healthy. Many of the people I spoke with during participant observation also were women, a number of whom had autoimmune disorders. These factors influenced the study in many ways, not the least of which was that I ended up thinking much more about women's health and allocating more of my library and internet research efforts to understanding autoimmunity. It also nourished an interest in exploring further how changing gender relations affect the health of women, especially those who assume an increasingly heavy burden of both professional and

domestic roles. Establishing rapport with the women was generally a faster, stronger, and more intensive process than it was with the men. A feeling of solidarity and trust occurred almost immediately, which was both immensely satisfying and emotionally consuming. Combined with the effects of a female intermediary at the clinic, this affinity may have strengthened the bias toward women, as I felt more comfortable approaching women than men. Despite the captivating rivulets of thought and feeling along which my sampling bias floated me, I would have preferred a more balanced group with more men and a greater variety of ailments.

In terms of sampling, another challenge that, despite my best efforts, resulted in a bias was the relative ease of contracting interviews at the clinic versus the church, and the facility of participant observation at the church versus the clinic. Also, using a facilitator at the clinic, while it helped in avoiding the ethical problem of imploring a "captive audience" to participate in my study, had its drawbacks. The greatest of these was that the control over identifying potential participants was effectively out of my hands and, in fact, contributed to the biases described above.

Where some anthropologists report difficulty conducting a formal interview because of a lack of coded roles to help guide behaviour, I had the opposite problem. The format of a formal yet only semi-structured interview seemed to make people a little uncomfortable at first. It took more time than I had anticipated to explain that I wanted them to tell me what they wanted to, and that I would be merely guiding their stories rather than asking a long list of questions. I would think this is due to the profusion of structured interviews, for example on television talk shows, and survey questionnaires such as market research mailers, that we are bombarded with in this society. My style of

interview therefore did not match the expectation of what an interview "should" be. I tried to solve this problem by continually assuring the interview participants that they were on the right track and that what they were saying was valuable to my research, for this seemed to be a common uncertainty.

One more personal struggle occurred at the church. Over the course of participant observation, I began to feel increasing amounts of pressure to "tap" my own healing potential. Although I viewed this as an excellent learning opportunity as well as a chance to give something back to the church, I was not comfortable assisting with healings without first expressing that my reason for being there in the first place was to conduct research rather than to heal. This met with some puzzlement because it was clear that my *caveat* was irrelevant to the healers – they were not concerned with why I was there, only that I was and should be doing healings myself.

CHAPTER THREE

PROGRESSIONS:

FROM TREATING DISEASE TO HEALING ILLNESS

A sluggish evolution is currently taking place in North American health care. Although it has been criticized for adhering to a philosophy of excessive mechanical reductionism, biomedicine is gradually beginning to explore more fully the connections between mind, body, and spirit. This trend toward a rebalancing of reductionism and holism is also apparent in the behaviour of users of our health care system. More and more are using complementary medicine, which is often perceived as being more holistic than biomedicine (Eisenberg et al. 1993; Eisenberg et al. 1998; Millar 1997; Verhoef, Russell and Love 1994).

This chapter will explore a multilayered shift from the "conventional," meaning that which is common, culturally acceptable, and conforming to social expectations, to the "unconventional" or that which falls outside of broad cultural acceptance. Although I did not conduct fieldwork within a biomedical setting, it is discussed here for several reasons. The first is that without explicating the conventional, one cannot speak of the unconventional. Biomedicine is the dominant health care delivery system in North America; it is the conventional. Omitting it would therefore create a meaningless void into which healing at the Church of Spiritualism and Alternative Medicine Clinic would fall. More importantly, the significance of biomedicine to the people with whom I worked at the church and clinic decrees the clarification of certain issues. Including it here is also meant to mirror the study participants' hopes for an inclusive health care

system that allows equal access to beneficial healing modalities regardless of their designation to the artificial categories of "conventional" or "alternative."

As is reflected in the writing of some physicians and in several new medical fields, discussed below, we are currently seeing in biomedicine more openness towards concepts like holism and interconnectedness, which are usually thought of as characteristics of alternative medicine. But for many individuals, the change is not sufficiently rapid. Part of the delay is attributable to a lag between theory and practice, but some cannot wait idly for the gap to close. Wrestling not only with disease but also with the social and existential difficulties of illness, sick people begin to look for ways to complement and support their use of biomedicine. As a result, relationships between health care institutions and individuals begin to morph, and a "migration" occurs as people who suffer, especially those with chronic and controversial illnesses (Astin 1998; McGregor and Peay 1996: 1318), turn away from the slow-to-change biomedical paradigm to embrace the hope and promise of complementary medicine. We will look at some of the reasons for this migration, emphasizing not only why people become disillusioned with the shortcomings of biomedicine, but also some reasons why they are attracted to other healing modalities.

Growing Pains in Biomedicine

Suzanne Murphy's Spiritualist beliefs shape her view of illness. A member of the Church of Spiritualism and a professional psychic and healer, she suffers from diabetes. I met her at the church where she had come for a healing session. Suzanne believes that attitude can determine both cause and cure. Prior to the Enlightenment period, no doctor would have argued with this statement. But seventeenth century thinkers like Newton

and Descartes greatly impacted scientific theory and method, and thus also the development of modern medicine (Beinfield and Korngold 1991). Isaac Newton emphasized empirical observation, and he expounded the importance of testing ideas in the material world (Bernard 1994: 7). Medicine adopted this emphasis on experimentation, eventually relying on it as the sole method by which to acquire knowledge. Rene Descartes' ideas also powerfully shaped medical thought. He was convinced that the reasoning capacity of the mind was incongruous with and separate from the mechanistic functioning of the body. Combined with a concurrent challenge to religious authority, Descartes' conviction effected an intellectual separation of body, mind, and spirit. The "Cartesian norms of orthodox medicine" (Stambolovic 1996: 601) were stolidly in place. Descartes would have criticized Suzanne Murphy's belief in the power of attitude over the body.

But now, at the close of the twentieth century, some criticize Descartes and his dualistic paradigm. History is like a ballet where the dancers flow together and separate according to the music. Ideas entangle and disentangle, coalesce and then diverge. Any evaluation of ideas must account for context, for a critic would not evaluate a dance without listening to the music. Just as we strive to be aware of and to understand cultural context, so too do we need to consider historical context. It is obvious that the historical context of rationalism and dualism has changed, and yet biomedicine still clings to Cartesian paradigms. Maybe that is why so many are dissatisfied with biomedicine today. The director of the Alternative Medicine Clinic describes this:

> Isaac Newton was a scientist at the time, he talked about cause and effect. So we could look at a bug and it causes pneumonia. We had to limit our paradigm, because in order to do a double-blind [controlled, scientific study in which neither the health care provider nor the patients know who is receiving a placebo], you have to have a linear sort of thing, so we spend all of medicine there, in a linear sort of approach. [Other] scientists do not use Isaac Newton, they use Einstein. So the rest of science has moved on and we are still stuck with Newton (Barry Charanap, September 1998)

Is medicine really "still stuck with Newton?" How would contemporary biomedicine view Suzanne's belief in the importance of attitude today? Although there has been resistance to the idea, more research is being done that shows a direct connection between a person's state of mind and the state of their body. There have been a plethora of books written by disillusioned MD's expressing their discontent with the status quo of rationalism, reductionism, and dualistic paradigms. Some of them even suggest avenues for change (Benson 1996; Chopra 1993; Dossey 1993; Gordon 1996; Hammerschlag 1992; Northrup 1998). The discipline of nursing is even further ahead in incorporating mind-body approaches. According to nursing professor Jean Watson (1995: 64):

> As contemporary scientific agendas such as mind-body medicine, alternative medicine, and healing consciousness emerge, nursing's paradigm of caring and healing relationships can serve as an exemplar for alternative medical practices, as well as a model for exploring complex human science inquiry.

Therapeutic Touch is another example of nursing's influence in establishing credibility for mind-body therapy in conventional medicine. It is a technique that utilizes unconventional paradigms but has nevertheless been highly accepted and integrated into conventional medicine (Kreiger 1987; 1993). Also in support of these changes, research in the field of psychoneuroimmunology has shown that the mind and body are connected via complex interchanges of neuropeptides (Birney 1991). This relatively new discipline

is advancing theories to explain how stress causes immunosuppression and thus illness (Jerry, Jerry, and Bharati 1996: 2). Other examples of scientific and anecdotal evidence for this connection are studies that look at prayer (Byrd 1988, Dossey 1993), spiritual healing (Hamaty 1995), meditation (Astin 1997) and a technique that has been termed "the relaxation response" (Benson 1975). This is not to claim that these views are suddenly being embraced by biomedicine. Again, there are delays, in part due to ignorance and in part to skepticism, between what is theorized, what is shown in the "laboratory," and what is practiced by the care giver.

My interviewees argue that doctors are aware of the mind-body connection, however it seems not to be viewed as diagnostically or therapeutically valuable. More often, it is treated as a mere confound, a variable needing to be controlled. For instance, the family doctors of people at the Alternative Medicine Clinic had consistently given referrals for psychiatric or psychological treatment. But although it acknowledges a mental component to disease, this rarely indicates a holistic perspective. In fact, it was viewed by their patients as yet another example of the doctor's skepticism toward the validity of the patients' physical symptoms. Also, most interview participants indicated that their physicians held negative views towards complementary medicine and were in fact against using complementary therapies (cf. Neher 1994: 859). As Alternative Medicine Clinic physician Jeremy Davies puts it: "What happens a lot of the time in conventional medicine is you get to the point when everyone says, it's just all in your head, it's psychological, it's your marriage, it's this, it's that." We can see that the general practitioners referred to in the study were still adhering to a reductionistic paradigm, though psychological rather than biological. They are also supporting mind-

body dualism rather than holism, as illness is viewed as *either* biological *or* psychological, not as a force of complex interaction between the two.

Similarly, a doctor who is aware of the existence of the placebo effect is not necessarily making practical application of the connection between belief and healing. The success rate of pharmacologically "inert" substances, placebos, is generally accepted to be between 30 and 40 percent, but ranges in research from 10 to 90 percent effectiveness (Kleinman 1988: 245). Despite these findings, allopathic medicine tends to view the placebo effect as nothing more than a hindrance to diagnosis and treatment and "a nuisance variable to be controlled for in clinical trials" (Price 1984: 61). Of course, there are a few dissidents who are convinced of the inherent therapeutic value of the placebo effect (Benson 1996: 243-244). Kleinman (1986: 245) declares that "it is of the utmost importance that physicians achieve the highest possible placebo effect rates." Physicians who ignore the benefits of placebo are said to invoke a double standard:

> If the pharmaceutical industry were to produce a drug which was as reliable, of such wide-ranging applicability, and with a record of efficacy as impressive as that of the placebo effect, it would no doubt be proclaimed a miracle panacaea, and attributed to the wonders of science (Price 1984: 65).

What is the place of the placebo effect in an anthropological study of the relationship between belief and healing? To begin with, symbolic healing has long been considered the domain of anthropologists who study exotic cultures, but Finkler (1985: 168) suggests that what is "symbolic healing" in the language of anthropologists is in essence the placebo effect. Also, there is no reason not to treat biomedicine as another ethnomedicine, along with all of the world's other healing modalities. The placebo is thus a symbolic component of this ethnomedical system, what Moerman (1983: 157)

would argue belongs to the tradition's general medical therapy rather than its specific and pharmacological dimension.

All of these areas of study share a focus on expectation and belief. They are about consciousness affecting the body. This is a concept that is intrinsic to healing practices at both of my field sites. The theories behind mind-body medicine, psychoneuroimmunology, and the placebo effect signify medicine's attempts to translate symbolic healing into their own scientific idiom (Blackburn 1976).

We can see then that the domains of "conventional" and "alternative" healing overlap and intertwine. But there is also a strong force of opposition between them. The maintenance of this opposition is largely fueled by perceived philosophical disparities and paradigmatic chasms.

Works of Conceptual Architecture: Holism and the Conventional/Alternative Split

One of the most strongly perceived differences between the philosophies of biomedicine and other healing modalities involves the concept of holism. In philosophy, holism is the theory that the whole is greater than the sum of its parts. Its antithesis is reductionism. A portion of theologian Jay McDaniel's (1990) explanation of ecological thinking closely resembles my interviewees' view of holism. He emphasizes that an intrinsic aspect of ecological, or relational, thinking is the notion that "living wholes, are more than the parts of which they are composed" (ibid. 25). I found this to be similar to both patient and practitioner interpretations of holism, where one places high value on taking the self as a whole rather than as its constituent parts of mind, body, and spirit. But as Margaret Lock (1978: 152) points out, the concept of holism is a cultural construct. For example, I found that patients' definitions of holism differed somewhat from those of

practitioners. Patients or clients used the term to signify a mind-body-spirit, or sometimes mind-body-spirit-environment, approach to wellness, in which one element is not given primacy over the others in treatment. Practitioners tended to articulate a more formalized and sophisticated definition of holism, using concepts from physics (especially holographic theory) and Eastern philosophy to colour their descriptions of "holism." They also draw from popular parallels between Eastern traditions such as Buddhism and the "New Science" to validate a holistic perspective (Capra 1991; LeShan 1966; Rubik 1995; cf. Wilber 1985).

A reductionistic perspective, on the other hand, would lead one to view the individual as a collection of parts lacking an overarching entity to connect mind, body, and spirit. Having isolated these three elements, the body is then broken down into smaller and smaller segments. Thus the body is seen to be comprised of systems that are viewed as separate from and irrelevant to each other. Systems are in turn fragmented; organs, tissues, and cells are conceptualized as building blocks or "cogs" in the machine that is a body (McDaniel 1990; McKeown 1978; Murphy 1987). Of course, these divisions are just as culturally determined as are the theories from which they derive.

Although there is often a sharp conceptual split made between conventional and alternative medicine, in practice this boundary is much fuzzier. Conventional biomedicine, despite differences with complementary medicine of epistemology and power (Gursoy 1996: 580), has produced both practitioners and researchers committed to evaluating and even incorporating the best that alternative medicine has to offer. And although this seldom questioned dichotomy places biomedicine at the reductionistic, mechanistic end of the spectrum, it is important to grant that biomedicine sometimes

ventures to the other side of the dichotomy; that it too can be holistic. An effort is being made by some groups in biomedicine to become more open to complementary medicine and holistic paradigms. In 1992, for example, the U.S. National Institutes of Health created the Office of Alternative Medicine, recently renamed the National Center for Complementary and Alternative Medicine. It was mandated to provide a "bridge between alternative and orthodox medical communities" (Jacobs 1995: 40) and to "facilitate the evaluation of alternative medical treatment modalities" (web site of the National Center for Complementary and Alternative Medicine: http://nccam.nih.gov/). Such support for research into the efficacy of alternatives is exciting despite arguments over the validity of scientifically testing therapies not based in science (Dossey 1995; Furnham and Forey 1994; Rubik 1995).

The converse is also true: complementary medicine can be reductionistic. An example of this is the abundance of acupuncture training programs that are springing up all over the U.S. and Canada. Even though acupuncture is considered to be a complementary therapy, the acupuncturists trained through these programs are not necessarily holistic practitioners. Despite possibly holding allegiance to a tradition (Chinese medicine) founded upon the Taoist philosophy of holism (Beinfield and Korngold 1991: 7), an acupuncturist still might apply her technique akin to how a doctor prescribes pharmaceuticals: for symptom relief, which is reductionistic.

But is more than philosophy separating the conventional from the alternative? This is where issues of power and hierarchy make their mark in the American and Canadian health care systems by validating the binary placement of alternative and conventional medicine despite complex overlapping in theory and practice. Biomedicine

is funded and regulated by institutions with great power, such as government, insurance firms, and pharmaceutical companies. The Flexner Report, issued in 1910, was instrumental in guaranteeing biomedicine's elevated status among health care systems. The report "assessed the laboratory and clinical facilities and faculties of all the American medical schools and made definitive judgments about which were and were not acceptable" (Gordon 1996: 182). The Flexner Report thus bestowed allopathic doctors with prestige and privilege over other health care providers like homeopaths, osteopaths, and naturopaths.

If the customary arrangement of conventional and alternative revolves around separation, then the Alternative Medicine Clinic where I did fieldwork exemplifies separation's antithesis: unification. Striving towards an ideal state they term "optimal health," the clinic incorporates and makes full use of healing traditions, paradigms, and techniques that are thought to be beneficial, irrespective of their origins. Gordon's vision of "a more comprehensive, compassionate, and effective model of care . . . that includes both the precision and power of biomedicine and the wisdom of other healing traditions" (1996: 284) is alive at the Alternative Medicine Clinic, and it now requires nurturing to survive.

Raising the Stakes with a Controversial Illness

In five out of eight life history interviews that were conducted, the participant was diagnosed with at least one, sometimes a combination, of several auto-immune diseases. The term "autoimmune disease" refers to a group of more than 80 chronic illnesses in which "the underlying problem is similar – the body's immune system becomes misdirected, attacking the very organs it was designed to protect (web site of the

American Autoimmune Related Diseases Association: www.aarda.org/women.html). The autoimmune disorders encountered in my fieldwork included: rheumatoid arthritis, chronic fatigue immune deficiency syndrome (also called CFIDS, chronic fatigue syndrome, and CFS), fibromyalgia, insulin-dependent diabetes mellitus, and multiple chemical sensitivities. The usual stigma of illness is compounded in autoimmune syndromes. For example:

> On top of feeling physically ill, people with CFIDS have had to face the attitudes of those who don't believe we are sick, who think we are lazy hypochondriacs. This makes you defensive, which makes understanding on both ends more difficult (The Boston Women's Health Book Collective 1998: 600).

These syndromes, of as yet unknown cause, are often difficult for biomedically trained doctors to diagnose and treat, or even to take seriously. The difficulty stems primarily from reliance on scientific epistemology to validate what they know. Such an epistemology hinders their openness to potential causes of and treatments for the disorders. A health care provider with an alternate epistemology, though, might "know" what causes CFIDS or fibromyalgia, and therefore be able to satisfy a sufferer's need for an explanation of their illness. Operating within a validating framework not limited by science, they may also be able to treat the disease and give the patient some relief. An example of the way in which disease or disorder can be explained in different ways and according to different epistemologies comes from my own experience at the Alternative Medicine Clinic. I had made an appointment to be treated for tendonitis in my shoulder. I was feeling tired and irritable, and I attributed this to the pain in my shoulder. The four hour appointment touched on many things, but barely acknowledged the inflammation in

my shoulder! Later on, an inspection of my chart revealed the reason for this: there was another explanation for my symptoms. The top of my chart read:

Traditional Chinese Medicine Program: Initial Assessment

Name: Bonnie Larson

Western Diagnosis: Right Rotator Cuff Tendonitis

Chinese Diagnosis: Deficient Kidney-Liver Yin

No wonder I thought my shoulder had been neglected! I was being treated for something else entirely, although something that was thought to be the root cause of my sore shoulder.

There are ways of viewing the world that allow for many things on many levels to be responsible for creating dis-ease. The absence of such a worldview is often what seems to frustrate both patient and medical doctor when it comes to autoimmune syndromes. What predominates instead is a culturally instilled impulse to locate a single cause for the disorder and then treat it accordingly. The difference between the two is that they follow different methods of validating what they know. My interview participants each had strikingly similar encounters within each epistemological domain. For example, thirty-two year old Andrea Jergens, a client at the Alternative Medicine Clinic who lives with her mother, describes her frustration with her primary care physician's insistence that her symptoms were allergies: "I started off with the family doctor and she started prescribing things like antihistamines which did absolutely nothing. She couldn't even diagnose what I had, she had nothing to offer me" (Andrea Jergens, June 1998). Jeremy Davies agrees with this view: "They tend to try and pigeon-hole people, saying this is your diagnosis, so this is your treatment."

Rosenbaum and Susser, specialists in chronic fatigue syndrome, endorse a causal perspective of "mixed infections, allergies, environmental illness, hormonal aberrations, stress, nutritional imbalances, and auto-immunity" (1992: iii). Nowhere do they suggest that depression causes chronic fatigue (although the reverse is almost certainly true). Unfortunately, this is not reflected in the experiences of Katherine Anderson, a married homemaker in her late thirties attending the Alternative Medicine Clinic, within the medical community.

> Then I went on my next nightmare journey. Yeah, the journey of trying to deal with doctors with an illness that had no rhyme or reason to it. It was a nightmare. First of all my doctor told me that I was nuts and tried to put me on all these anti-depressants. The more I took, the worse I got. I went on trips where I couldn't feel the floor, everything was swimming all around. And I would go back and say I just can't take this stuff. And [her doctor's response was], "Well, you better continue seeing your psychologist" (Katherine Anderson, June-July 1998).

Following a twelve year period of being treated for infertility, Katherine began suffering from fibromyalgia and chronic fatigue. Despite symptoms of generalized pain and sleep disturbance, Katherine's physician treated her for tennis elbow for two years. While Katherine struggled with constant, debilitating pain and fatigue, her doctor struggled with what she perceived as Katherine's non-compliance and depression. Martin (1987: 13) contends that "medical culture [is] a powerful system of socialization which exacts conformity as the price of participation." This seems to apply not only to doctors, to whom Martin is referring, but also to patients. Katherine Anderson would agree: "I didn't conform to their books, I guess. I was out of the norm, I suppose." She describes how her doctor "abandoned" her after reluctantly diagnosing her with fibromyalgia. From Katherine's perspective, her doctor did not believe in fibromyalgia nor did she believe that Katherine had anything other than depression and hypochondria. Katherine

is a medical heretic in the non-conformist sense of the word (Gursoy 1996: 577). Feeling unable to follow her doctor's directions because of her severe drug reactions, she opted to do nothing. Katherine began to feel worse and worse and started putting more and more of her life on hold:

> I left work because I wasn't functioning, and I wasn't functioning at the university either. I couldn't take books off the shelf; I couldn't even walk. I would wake up in the morning and I couldn't even put my feet on the ground. I was desperate. I thought I was dying. And nobody would believe me. Even my husband thought I was putting it all on. And I couldn't come home and say, well doctor so and so says I have such and such. . . . I was so unhappy and I was so sick.

A diagnosis of chronic fatigue syndrome or any other "disease" for which biomedicine does not have clear answers creates a double stigma for the sufferer. Not only do they have to cope with an illness, but they also find themselves occupying an uncertain role within society. Laural Berman, a fifty-seven year old, divorced mother of two, is a patient at the Alternative Medicine Clinic. During our interview, she reflected that she sometimes wished she could have cancer, because then everyone would know why she was ill and what they should do about it.

Itinerant Patients: Legitimation, Explanation, and a Paradigm Shift

My interview participants, though not in themselves a quantitatively valid sample, reflect a strong current of change in health care. In the United States in 1990, 34 percent of the general population used complementary medicine (Eisenberg et al. 1993: 248). As with any migration, a patient's move from using solely conventional medicine to incorporating other healing modalities involves both push and pull factors (Kelner and Wellman 1997: 209). People go to the Alternative Medicine Clinic or to the church for healing, but in doing so, they do not necessarily reject conventional medicine. Far from it

– the health resources people rely on are truly plural. Several people emphasized that they were ignorant and even wary of alternative medicine before they got sick. Rather than a sharp break in attitude, the interviews revealed an oscillation between trusting in conventional medicine and questioning it. And as the questioning increases, a searching grows too; this is seen as a quest for answers and for relief.

Although my research suggests deep dissatisfaction with biomedicine, other research on this is inconclusive (McGregor and Peay 1996: 1318). Dissatisfaction is actually an imprecise description, because what really emerges is an image of someone who is less dissatisfied than profoundly disappointed when the limitations of biomedicine come into sharp and painful focus (cf. Furnham and Smith 1988). The emphasis on patient satisfaction in other studies also belies the migratory nature of people turning to complementary medicine. There is rarely a mention of what *attracts* people to complementary medicine, only what *repels* them away from biomedicine. In order to gain a balanced understanding of this important trend in health care choices, we need to consider motivations from both perspectives.

What, then, pushes people away from a comfortable reliance on conventional medicine and pulls them toward complementary therapies? The interview and observation data suggest that legitimation, explanation, and a change in perception are the main ingredients in a decision to "relocate."

Legitimation

I heard over and over again from people in the interviews that no one, from co-workers and doctors to family and friends, seemed to take their illnesses seriously or seriously enough. Multiple chemical sensitivity patient Andrea Jergens speaks of being

shuffled around in her workplace from toxic environment to toxic environment and being hassled to the point of feeling that she was in danger. Mary Kendrick. a fifty-eight year old accountant and mother of three, said in our interview that she has resigned herself to her husband not knowing "how serious it is." Katherine Anderson and Laural Berman express similar concerns about their spouses. What is common is that they each occupy a sick role that is not legitimated by biomedicine and therefore, by mainstream culture. Their illnesses are chronic, debilitating, of unknown cause or cure, and the end is never in sight. These encumbrances make chronic fatigue immune deficiency syndrome, fibromyalgia, multiple chemical sensitivities, and other puzzling illnesses unacceptable and, in fact, illegitimate to many. Often, people had difficulty legitimating their illness even to themselves, because their validating framework did not allow for such an experience. Surrounded by doubt, impatience, and even occasional hostility in their homes, workplaces, and doctors' offices, these women began to rethink their treatment options. Radio, magazines and newspapers, as well as suggestions from friends, introduced them to complementary healing modalities including homeopathy, naturopathy, traditional Chinese medicine, and chiropractic. What they often found when they decided to explore these modalities was a sympathetic ear, an affirmation that yes, there was something wrong with them and, most importantly, a legitimating framework through which their illness could be interpreted.

The distinction that medical anthropologists make between illness and disease is useful to note here (Eisenberg 1977; Hahn 1995). Illness is a social experience; it refers to "how the sick person and the members of the family or wider social network perceive, live with, and respond to symptoms and disability" (Kleinman 1988: 3) Disease, on the

other hand, is "what the practitioner creates in the recasting of illness in terms of theories of disorder" (ibid.: 5). In reality, the experience of being sick cannot be neatly packaged into these categories, but a shadow of intuitive understanding about this distinction reveals itself in comments about the value of biomedicine in particular realms. I have heard over and over the sentiment that it is good to consider alternatives, but "if I broke my leg skiing, I would want to go to the hospital, not the homeopath." Similarly, McGregor and Peay (1996: 1324) found that even within a community that tends to rely more heavily on alternative medicine than does the general population, an "ominous" symptom, such as chest pain or a lump, would warrant a visit to a conventional practitioner over a complementary one. But this value is felt to be limited when it comes to dealing with illness. Biomedicine is seen to put "an excessive emphasis on narrowly defined medical goals over the existential concerns of [patients]" (Hufford 1995: 57). Skeptical at first, but at the end of her existential rope, Katherine Anderson was pleasantly surprised and profoundly relieved after her first encounter with complementary medicine:

> I was thinking of boiling cauldrons and you know, witchcraft and all. Then the door opened and [the doctor] walked in. And I looked at him, and this feeling like, hope or something came over me. I felt, maybe I'm exaggerating, but I felt like I had just seen God [laughs]. I didn't feel threatened. The boiling cauldrons and the wounded dolls didn't appear. He said, "I've been looking through your records, tell me what your problem is."
> And I said, "Well if I tell you, you promise you won't laugh or anything?"
> He said, "No, why would I do that?"
> So I said, "Well, I've been told I have fibromyalgia."
> He said, "Yes. You must feel very bad." I asked him if he believed me and he said that of course he believed me.

Explanation

The search for an explanation is the second main component in the movement of the people at the Spiritualist Church and Alternative Medicine Clinic toward complementary therapies. Each of them was disappointed with what they perceived as biomedicine's inability to answer their questions about why they had certain symptoms. Jeremy Davies, a physician at the Alternative Medicine Clinic, recalls how his own world of medicine failed him when he became ill.

> I saw all sorts of specialists, immunologists, haematologists, gastroenterologists – and I had bone marrow biopsies, intestinal biopsies, serial bloodwork. Nobody could find anything, but I remember seeing one of my teachers from medical school, and he just looked at me and said, "I don't know what's going on but you definitely aren't well. I can't tell you what's going on but I know you're not well." So at that point, I also worked with my family doctor. We didn't come up with any answers, so I started to explore some other avenues (Jeremy Davies, September 1998).

Illness is an existential dilemma that requires explanations. But explanations are culturally determined – their formulations and acceptability are mediated by cultural idioms. When anthropologist Laurence Marshall Carucci returned to the United States from fieldwork in the Marshall Islands, he was exhibiting symptoms of typhoid fever. His doctors were quick to deduce that his illness was due to the bacteria *Salmonella typhosa* and therefore prescribed antibiotics (Carucci 1993). Marshall Islanders, however, held something quite other than bacteria accountable for Carucci's illness. They explained his symptoms in magical terms; his suffering was due to an incident of love magic. Carucci's American doctors framed his experience in the scientific, biomedical discourse that describes, for them, reality. At the same time, an alternate

discourse in the Marshall islands – magic -- provided another perception of reality through which Carucci's symptoms could be explained.

What is important to note here is that not only do individuals create various realities, but that those realities are informed by cultural idioms, of which there are many. And one need not look to exotic locales for alternatives to the predominant idioms, especially in heterogeneous North America. The selection is vast, and this can be very favourable for people whose experience is not explainable within the predominant discourse. Where some see fickle fragmentation and superficial eclecticism, others behold a wealth of opportunity in different beliefs, idioms, and paradigms.

Paradigm Shift

The third factor that influences an individual's health care choices is a transformed perception of what will help them to get better. A suffering individual begins, sooner or later, to distinguish between treatment and healing, where treatment is seen as symptom or disease management and healing is viewed as a way of coping, in the long run, with an illness. This change parallels what Bohannan (1995: 113) refers to as a "cultural cusp," in which "some event occurs that makes [people] suddenly aware of the changes," and "becomes a cusp in the story, one that people tell, write about, and remember" (ibid.: 113-114). This event is the realization that it will require a lifetime commitment to change in order to achieve wellness. A transformation of worldview often coincides with the cusp.

A treatment is an action taken to counteract a specific symptom, such as a course of antibiotics for an infection or physiotherapy for an injury. This is where the power of allopathic medicine resides. Healing, on the other hand, is thought of somewhat

differently than the biomedical definition – rather than only a restoration of physical integrity, healing is seen as a larger process in which the patient fully participates. While it still includes treatments, healing in this sense can also entail an often drastic shift in lifestyle. Ongoing investments of time, energy, and financial resources are also necessary (an initial assessment at the Alternative Medicine Clinic costs $150, each subsequent visit is $85). Such dedication often calls for a shift in paradigm. According to CFIDS sufferer and clinic client Mary Kendrick, "it's not just nutrition and medication and treatment. It's how you view yourself and the rest of your life. It's how you see yourself in the future and how you get there" (Mary Kendrick June-July 1998). Healing in this sense is a much more inclusive category than it is in medicine, partly because people start to expand their definition of "things that require healing" from the physical outward in concentric circles. Thus they begin to include things like psychological trauma, relationships, and spirituality, until, as Laural Berman phrases it, they are "healing an entire life."

Conclusion

Regardless of the rhetoric of opposition that plagues conventional and unconventional medicine, the two are beginning to converge, sometimes even overlapping, at other times misunderstanding, but always interacting. And people use an endless repertoire of different healing modalities – different kinds of illness experiences position the health care consumer, who looks for legitimation and explanation for their experiences. Conditions such as CFIDS, fibromyalgia, and multiple chemical sensitivities are controversial illnesses that require alternate epistemologies in the quest for legitimation and explanation, not to mention symptom relief. A paradigm shift often

takes place as patients begin to live the differences between treatment and healing. Kakuzo Okakura's resolution concerning relations between East and West is relevant to the progressions in health care today. He argues for unification: "We have developed along different lines, but there is no reason why one should not supplement the other" (Okakura 1964: 5).

CHAPTER FOUR

BELIEF, BENEFIT AND CHANGE

Once upon a time, in an age of closely knit social units, human beings lived lives of shared environments, histories, experiences, and beliefs. The postmodern era has changed much of that. Individuals now more than ever actively participate in choosing where they will live, how their lives will unfold, what they will experience, and what they will bring into their personal belief systems. The choices are vast and ever increasing.

An individual's belief system no longer replicates in miniature the formal beliefs of her clan. She is free to devise a new set of morals by extracting from the innumerable dogmas, doctrines, and worldviews accessible to her. It is sometimes thought that this trend does little more than fragment existing traditions, but postmodernism does more than deconstruct; it also reveals new possibilities. As Benko (1997: 8-9) states, "it stands for the liberation of expressive potential, for the free exercise of the creative urge; it favours a profusion of styles, an openness to experimentations that are multiple, disparate, and indifferent to their place in posterity." Postmodern life allows individuals to choose meaningful beliefs that are directly relevant to them. A custom built belief system can be more useful, meaning it is identified as helpful in contending with certain situations, to the individual than one that is shared and dogmatic. But there may be a trade-off. In the previous chapter, we briefly discussed placebos and the physical effects of expectations on health. The question that arises, then, is this: does the availability of a multitude of beliefs decrease the strength of belief in a cohesive tradition such as biomedicine? And if so, does such shaken faith not lessen the symbolic-therapeutic

impact of belief (i.e. the placebo effect) within that tradition, only to further a person's doubts? So we have choice, but are we then compromising the depth and value of tradition? This is a question for further study.

There are many kinds of belief and the arenas in which they play are innumerable. Some beliefs are indeed taken-for-granted, tacit assumptions shared by almost everyone in a given society. Others are derived from a boundless choice of subcultural systems. Still others are not shared at all, in fact, the value of these beliefs is often dependent upon their very privacy. An example of this is when a person's spiritual beliefs are seen as unique, making them feel different and special; somehow blessed and set apart from others. This chapter will focus on individuals' belief systems contextualized by the two subcultural systems that comprise my field communities. The use of the term 'subculture' here parallels Barth's (1987: 1) use of the term 'sub-tradition', however he places sub-tradition in the context of tradition. This analysis moves in the other direction, to place individuals in the context of subculture (or sub-tradition). The people at my field sites have developed their beliefs over time, and many of them have not internalized the full set of formalized beliefs held within the healing environments of the church or clinic. Nevertheless, I have briefly presented these formalized systems because they enrich the contextual landscape and exemplify the sorts of places from which beliefs are collected.

Few empirical studies that incorporate belief as a variable explicate in detail the concepts of belief and belief system. But they do provide a description of the kinds of belief studied. For example, some studies look at the patient's belief in the efficacy of the therapy (Yates et al. 1993); traditional health beliefs (Jenkins et al. 1996); or belief in faith healing (King et al. 1988). All of these can be subsumed under the umbrella of

ethnomedical beliefs, a phrase that denotes "cultural knowledge about illness and its linkages to differential diagnoses and curative actions" (Brown 1998: 108). Having set out in the methodology the types of beliefs that were focussed on in this study, it is hoped that a more thorough discussion of the concept of belief will ground this chapter in a theoretical perspective.

How then does belief relate to health and sickness? There are many possible answers to this query. To begin with, the mind affects the body. Very few would reject this proposition, as one only has to observe a red face of embarrassment or experience the rapid pulse of fear to know the physiological effects of mental processes. It is not much further a cognitive leap to understand that beliefs affect biology. The power of placebos and nocebos, which are placebos that cause negative effects, bears witness to this intricate relationship (Moerman 1983: 156; Hahn 1998). But my purpose here is to extend the discussion of the role of belief in healing beyond its physiological correlates and into the realm of coping and resilience, because for some, these are more relevant to healing than is physical cure.

The purpose of this chapter, then, is not to provide evidence to support the claim that "belief becomes biology" (Cousins 1989: 229). Rather, my intention is to discuss belief: its nature, types, and relationship to the life story and to illness careers. It is also to consider belief as an adaptation, not only in an evolutionary sense but also over the course of a lifetime. Thus it examines how and why beliefs change with experience, especially those that are emotionally forceful (Rosaldo 1996[1989]).

The idea that emotionally forceful events can change one's belief system and worldview is analogous to the "primal" and "proleptic" in the realm of religious

experience (Poewe 1994; Hexham and Poewe 1997). Hexham and Poewe (1997: 59) describe these as follows:

> At the heart of many religious movements, . . ., lie primal experiences – unexpected vivid encounters that are considered to be other than normal. . . . Above all, they not only shock those who experience them but also bring about a change in their attitude toward the material world.

We will see that emotionally forceful, proleptic, and primal experiences of the kind that radically shift one's perspective can include such things as spiritual encounters, dreams, coincidences (often referred to as synchronicities), as well as very difficult experiences such as loss of a loved one and illness.

Formal Beliefs: A Religious and an Ethnomedical System

In this study I treat belief as a form of knowledge. Indeed, it is quite reasonable to assert, as does Black (1973: 511), that "there is no practical difference between 'belief' and 'knowledge'." She goes on to explain that it would be a mistake to "apply cross-culturally" a distinction between belief and knowledge based on evidence, for evidence is a culturally dependent concept (ibid.). William James' (1979 [1896]: 22) contention that "[n]o concrete test of what is true has ever been agreed upon" is timelessly valid. In addition to this, it should be noted that even within a single culture or sub-culture, ideas about what constitutes truth, knowledge and evidence vary. The terms "knowledge" and "belief," "know" and "believe," are therefore interchangeable.

The type of beliefs considered here are propositions, accepted as truths, that inspire commitment in the believer (Borhek and Curtis 1975; Goodenough 1990). When dealing with formal belief systems, we are not merely dealing with particular substantive beliefs, nor even with aggregates of substantive beliefs (Borhek and Curtis 1975: 4).

The relationships between these, that is, their interrelatedness, are of great import. They are what transform collections of beliefs into systems and allow them to transcend and outlast individuals (ibid.: 7). Hence it is important to consider the larger, formal belief system for context and insight into the transmission of cultural beliefs. Barth (1987: 6) argues that:

> it is now anthropological commonplace that the different beliefs and practices found in a culture are closely connected as a system, and that both their description and their meaningful interpretation must proceed with reference to this context and in terms of these connections.

This is true despite variation in individuals' degree of subscription to the system.

The following descriptions of the belief systems at the Church of Spiritualism and the Alternative Medicine Clinic derive from participant observation, literature produced by each institution, and interviews with leaders and health care practitioners at each site. The presentation of these beliefs in this format is not meant to suggest that everyone within each system adheres to each belief. There is great variation in interpretation among the lay persons within each system, as there is (albeit to a lesser extent) between practitioners and "leaders."

The Church of Spiritualism

The belief system at the Church of Spiritualism is, of course, religious. Similar to the Spiritualist temples in Mexico studied by Finkler, the church here also "provides its followers with a clearly defined cosmology, ethics, and liturgical order" (Finkler 1998[1994]: 119). Church of Spiritualism literature contains an inevitable listing of seven principles, upon which most Spiritualists are thought to agree. They are 1) the fatherhood of God; 2) the brotherhood of man; 3) the communion of spirits and the

ministry of angels; 4) the continuous existence of the human soul; 5) personal responsibility; 6) compensation and retribution hereafter for all good and evil deeds done on earth; and 7) eternal progress open to every human soul. Despite their ubiquitousness, there is official recognition of freedom of interpretation of the Seven Principles, a dictum whose application I witnessed almost unfailingly each time I spoke with a member of the congregation.

Spiritualists believe that each individual possesses two bodies: a material and a spiritual. These are said to be linked by a cord that severs at death, allowing the material body to return to the earth while the spiritual body carries the soul to a "better, happier life where we are reunited with our loved ones and friends" (from a pamphlet produced by the church). Spiritualists constantly try to give evidence to support the existence of the spirit realm through mediums. This can be in the form of physical descriptions, how the person in spirit form died, significant memories of the person in spirit, and other "clues" that are meant to enable a message recipient to recognize their spirit guide.

The emphasis in Spiritualist belief is on goodness, helpfulness, and service in daily life. It is believed that these virtues will increase spiritual status and will be compensated for in the afterlife. Conversely, evil done on earth is believed to require repayment but such souls are still eligible to 'advance'; there is no eternal damnation in Spiritualism. The focus on service in Spiritualism sows the ground for healers. Finkler (1998[1994]: 119) points out that Mexican Spiritualism is both a "religious movement and a health care delivery system." The Church of Spiritualism here is also both of these things, although there are some differences in practice – for example the Mexican Spiritualist services consist of a medium in trance delivering a sermon (ibid.). Here, the

sermon or 'lecture' is not done by a medium in trance. In fact, these talks are often characterized by a rather academic tone. The medium's role is to demonstrate clairvoyance by delivering messages to individuals in the congregation during the second half of the service.

The Church of Spiritualism is primarily a religious institution, within which is a healing practice. Beliefs about health, sickness, and healing derive from the seven principles. While healing is extremely important to and integrated with the religious beliefs, it is nonetheless a function secondary to faith. In contrast, the Alternative Medicine Clinic is principally a healing institution. Interestingly, the clinic is a reversal of the church in that it performs a function of spiritual advisory secondary to its primary role as an ethnomedical system.

The Alternative Medicine Clinic

The mandate of the clinic is to "shape the future of health care with a clinical and academic centre dedicated to bridging the gap between ancient healing practices and modern technology" (from a brochure produced by the clinic). The conviction that a combination of old and new will yield an ideal healing modality colours everything about this clinic. The clinic's founder has studied languages, literature, Western medicine, Indian ayurveda, traditional Chinese medicine, and European functional medicine. The eclecticism and diverse knowledge of this quietly convincing man strongly reinforces the clinic's shared belief in the value of integrating disparate healing traditions.

Practitioners at the clinic embrace an ontology of vitalism and holism. A vocabulary of subtle energies and vibrational medicine enables them to articulate how seemingly esoteric technology effects healing. The prevailing attitude is far from anti-

scientific, as some might be inclined to label alternative medicine. It actually operates in an atmosphere of high technology and empiricism, borrowing from that most powerful scientific discourse of physics to validate beliefs. Michael Talbot's *Holographic Universe* (1991) is a good example of commonly prescribed reading at the clinic (other popular reading from the clinic includes Brennan 1987; Capra 1991; Chopra 1989; and Gerber 1988). *The Holographic Universe* proposes a way of thinking about the world that is based on quantum physics' understanding of holograms. For example, one of the characteristics of holograms is that the whole is in every part, a concept that helps to explain certain things about the therapies at the clinic, one of which is acupuncture. Holographic theory can explain why a particular acupuncture point on a patient's ear can, say, affect their heart or liver. It also parallels the traditional Chinese medicine model that "assumes the synchronicity of response throughout the organism, [and therefore] that stimulation of a local site will have global impact. . ." (Beinfield and Korngold 1991: 242). The holographic perspective also supports the idea that the mind is not localized in the brain so beliefs can create powerful changes in the body due to their being stored in *both the mind and the body*. The holistic perspective at the clinic arises also out of the founder's training in psychiatry. When I queried Dr. Charanap about his motivations behind opening the clinic, he replied:

> I think a few things. One is personal interest, because I found in medicine that we tend to wait until somebody gets sick before we look after them. And though we talk about the concept of wellness, we didn't really do wellness. Or understand it for that matter. Secondly, I saw that patients of mine, when we did really good psychotherapeutic work, that they improved physically as well, quite markedly.

The church and clinic are similar in that the belief system of each diverges considerably from that of apparent "mainstream" culture. Whether convinced of the

presence of spirits and a ministry of angels or the unceasing flow of qi's vital energy, each requires a certain faith, regardless of the type of evidence given, that there is more to reality than meets the eye.

Those who attend the church and clinic incorporate many of the above views into their own belief systems, although the practitioners often give a more detailed rationale for any given proposition. Incorporating a particular belief into one's personal system entails a selective process of choosing something that is, or is at least hoped to be, beneficial. Of course, as in any process of diffusion and syncretism, individuals do not always "readily accept innovations" (Borhek and Curtis 1975: 30). They blend them and mould them, and sometimes what results is new. In turn, new beliefs affect the original system. In this way, culture can be expanded from "socially established structures of meaning" (Geertz 1973: 12) to include individuals and the things they deem significant.

In many ways, the Alternative Medicine Clinic closely resembles what Stark and Bainbridge (1985) refer to as "client cults." These are institutions that charge for services such as healing or prophecy, but do not fully engage the clients. That is, clients often retain participation in organized religions and other cults. This is true of many of the clinic's clients. For example, Laural Berman's participation at the clinic in no way interferes with her very Spiritualist beliefs. The reason for this is that client cults offer specific compensators – the promise of a specific and limited reward, such as a cure for an ailment – rather than the more general compensators found in religious systems. But the Alternative Medicine Clinic does offer some general compensators as well. A general compensator will "promise a great array of rewards or rewards of vast scope" (ibid.: 7). The clinic will do this, but only if the client indicates interest in participating in this

aspect of the clinic's services. If they do express such interest, spiritual counseling is incorporated into their treatment plan. Practitioners at the clinic may provide this option because they are aware that "naturalistic systems cannot replace supernaturalistic systems in the hearts of most human beings" (ibid.: 3)

The Benefits of Change: Belief and adaptation

The universality of the human tendency to believe in a higher order and to construct belief systems accordingly is undisputed (Voget 1973: 23). Some would say that this tendency has evolved over time for a reason. It has helped people contend with their sentiency while providing a sense of control in an unpredictable world. According to Frazer (1971[1922]: 57), "from earliest times man has been engaged in a search for general rules whereby to turn the order of natural phenomena to his own advantage . . .". Whether adhering to a world religion, an obscure faith, or to mainstream science, we still pursue this end, looking for relief from hardship and meaning in existence. Benson, a medical doctor, believes that human beings have benefited from being "wired for god." He asserts that:

> whether or not God exists, our genes guarantee that we will bear faith and that our bodies will be soothed by believing in some antithesis to mortality and human frailty. So that we will not be incapacitated by the acknowledgment and dread of death, our brains harbor beliefs in a better, nobler meaning of life (1996: 198).

Pondering the possible genetic advantage of certain human behaviours in terms of reproductive success is a helpful starting point, but it should by no means be seen as conclusive. There are no simple explanations for a subject as complex as belief, but to fairly account for all aspects of biopsychosocial dynamics, the question of biology must be addressed. It is not accurate, though, to say that because belief in a higher order

benefits the species that it is therefore genetic. Cultural transmission alone can account for belief's universality. To claim a genetic adaptation, one must first determine whether belief is susceptible to the forces of natural selection, that is, whether variation existed (Trivers 1985). If it could be established that another group of *homo sapiens sapiens*, aware of its own mortality but without a propensity for faith, had a lower reproductive success than our own, then we would have a basis for a genetic explanation for belief. Without such evidence, the realm of analogy feels more comfortable. In other words, certain characteristics of belief – its universality, variability, vicissitude, and benefits – seem to operate parallel to biological processes rather than being determined by them.

Barry Charanap, the director of the Alternative Medicine Clinic, believes that people who are healthiest "have within their nature mechanisms to support them" during times of hardship and illness. These mechanisms are not static. They change as a result of external factors, influenced by the same pressures as are biology and large scale social movements (for example, environmental pressures) as well as internal factors such as self-assessment and volition.

There are different types of beliefs that play a role in health and illness. Changes and adjustments can be made on any level. It seems probable, though, that macro-systems would require a more forceful experience (or compelling evidence, although we know from Galileo how evidence can be subsumed by dogma) to induce change than would a single substantive belief. Macro-systems of belief, what Goodenough (1963 quoted in Black 1973: 513) refers to as *unifying* beliefs, are those that explain many things because of their generalizability to various domains. These would include a person's religion, ontology, and epistemology; it is the highly integrated nature of these

that renders them resistant to change. A transformation at this level involves a true paradigm shift, which can in itself be healing. James (1979[1896]: 14) would label belief options of this order *momentous*, denoting the high stakes involved in making particular decisions there.

Change does not necessarily mean a rejection of one thing for another. It may instead be an expansion or contraction, an inclusion of beliefs once excluded and vice versa. Jackson (1989: 11) suggests that people will hold a particular belief in "cold storage," calling it to use when necessary. He contends that "a shift from merely entertaining an idea to actually embodying it is usually precipitated by some social or personal crisis that disrupts normal habits and disconcerts normal awareness" (ibid.). Illness is a classic example of such a social and personal crisis. One thing that is important to heed when dealing with changes in belief systems is the way in which people themselves view the change and the belief. What may appear to be, categorically, a unifying belief system (for example astrology) may actually be viewed by an individual as constituting a mere fragment of their own belief system, and its inclusion therein may or may not be considered momentous (Black 1973: 509-10). It is for this reason that I attempt to treat beliefs on the level at which they are conceived by those at the church and clinic, for instance by treating a change in belief as a large scale paradigm shift only if that is how it is seen by them. Because I agree with Jackson's (1989: 111) declaration that "we need to elucidate the place of beliefs in the context of actual existence – how they are experienced and employed. . .," we will look more closely at two examples of how beliefs operate and change in people who are ill.

Katherine Anderson, a patient at the Alternative Medicine Clinic, states that before becoming ill with fibromyalgia, she did not believe in alternative medicine. A middle aged, university educated, married housewife, Katherine had faith in science and her physician. That was what she knew and had no reason to doubt it. But an emotionally forceful experience, her incurable illness, changed that. Her physical symptoms dismissed as psychological by biomedical doctors, she needed to transform her convictions in order to open the door to other healing modalities. She needed options, but she was limited by her belief in a world ordered by scientific principles. A step-by-step progression ensued, whereby her convictions expanded just enough to allow her to go to the Alternative Medicine Clinic. This was prompted by an article in the local newspaper about the clinic that Katherine read at an especially difficult time in her illness. She felt she had been abandoned by her doctors and her husband had recently lost his job. In the article, a patient with fibromyalgia touted the clinic's holistic treatment plan.

Prior to her first appointment at the clinic she felt skeptical. But once there, she encountered another emotionally forceful experience, that of meeting with Dr. Charanap and the synchronicity of seeing her old physiotherapist who had, unbeknownst to her, returned from an acupuncture internship in China and was now employed at the clinic. This second incident convinced her that she was following the right path. Thus assured, Katherine became more and more open to the new ideas presented to her at the clinic. Her outlook shifted such that she was able to add new beliefs to her system and crystallize her discontent with biomedicine to the point that she was able to expunge segments of that belief system.

The process of choosing new beliefs involves not only accepting beneficial ones but also rejecting those that are harmful. The following story illustrates this well, and also shows how volition and self-assessment affect the process of change. Susan Sontag (1990) has shown how negative beliefs, in the form of metaphors, can adversely affect one's health. Similarly, psychologist Taylor (1997: 46) puts forth that

> the role of belief in healing can work both ways – a well-developed worldview is sometimes the best medicine against illness, while at the same time overly rigid habits can become the chronic cause of illnesses that are a long time in the making.

But it is only if one can see this effect that they might change the belief or habit (sometimes beliefs are mental habits). Laural Berman, who has recently started going to the Alternative Medicine Clinic for chronic fatigue syndrome, explains it this way:

> I just feel that the body . . . has such a will to heal, and that if you can just clear away some of these huge blocks that keep it depressed, then it will heal. But it can't surmount the things that you're not looking at or, in a lot of cases, that you're not even aware of (Laural Berman, July 1998).

Laural, a divorced 60 year old retired librarian, believed for a long time that her role as a woman was to take care of and obey men. Her mother had done this with her alcoholic father. She believes that an incident in her early childhood of very violent sexual abuse, during which, she says, "I knew I would die," instilled this belief so strongly that, even after she had blocked out the memory of the abuse, she remained convinced that she must do what everyone else wanted her to do in order to keep her terrible secret. She says:

> I lived this extremely isolated life, I knew what I was supposed to look like, and I began to behave the way everyone wanted me to. I had my mother's continual extreme programming going – she told me everything to say, to think, to do. . . . I ran away from people, always. And as soon as anybody tried to get close, I ran away. Because somebody might find out something, I was just in hiding, always.

Laural was raised a Christian Scientist by her mother:

> [My mother] became a very avid Christian Scientist and, through the trials and tribulations they went through for the next many years, it carried her. And so as far as its influence on me, I was certainly brought up in the Christian Science Sunday school, and never saw the inside of a doctor's office; as you know they heal by prayer and I would say, mind control. I mean, according to the depths of their understanding that we are divine creations and the divine parent is our identity, the body only [manifests] misperceptions in our understanding. . . .And to the extent that we connect with that divine perfection, then to that extent our bodies will manifest that perfection . . . it was what they call radical reliance on the divine healing.

She continues on to give an example of how Christian Science comforted her throughout her tormented childhood:

> I remember vividly, I went to visit some cousins one summer. I knew how to iron, I was probably nine or ten. While I was helping around the house, ironing, I burned my arm quite badly. They were a very medically oriented family, and I don't know if they wanted to take me to the doctor and knew that they mustn't, but I only knew about healing myself. And I just knew that God would take care of me. I remember sitting in the bathtub at another cousin's, just knowing that I was perfect, just knowing and trusting that I was safe and that this was going to be fine. And it healed very beautifully. And would you believe that a few days later I was looking at it and also looked at my hands and realized that the warts that I'd always had were also gone. It was amazing.

When Laural was born, she received x-ray therapy for an enlarged thymus (this occurred shortly before her mother became a Christian Scientist). Later in life, when she was away at college, her parents received a phone call from the hospital where Laural was born. The hospital was obliged to contact the families of babies who had been

treated with x-rays for enlarged thymuses, because they were seeing many cases of resulting thyroid cancer. But because of their strong convictions, Laural's parents did not inform her about that phone call. In her early twenties, Laural was diagnosed with cancer of the thyroid.

Taylor (1997: 60) suggests that when we "[l]et attention turn within, . . . , old habits, intricately built networks of attitudes, and the entire infrastructure of analytic discriminations begin to shift." In the case of Laural Berman, cancer prompted a "turn within" in this sense, and initiated a parting of ways with Christian Science. Against her family's wishes, she underwent conventional treatment for her cancer in the form of surgery and radiation. This resulted in remission of the cancer. But first came the change in her unifying belief system:

> I was at that point receiving Christian Science care, and [the healer] said that if I decided to be worried about it then it was a cause for concern, and if I decided not to be then it wouldn't. And that it was my fear that was causing the problem because it just was what it was and only my fear would make it a difficulty or not. So it puts all the responsibility on the person. And I learned later how unacceptable it was to seek medical attention. . . . And I just felt guilty and bad for having this problem. . . . And the cornerstone of that religion is that God is love, and yet I felt that that love was extremely conditional. And to me, if God is love then it's most definitely an unconditional love and acceptance.

Having assessed what her needs were, she chose to move away from Christian Science. In retrospect, she thinks this was overall a good choice, while at the same time acknowledging that Christian Science taught her things that she still incorporates into her world view. She believes, for example, that dwelling too much on bad fortune might bring it to fruition, that "you just open yourself up to terrible things happening."

Relinquishing some of her faith in Christian Science was a first step, as Laural views it, in changing her belief system for the better. Yet she still had the childhood

sexual abuse incident locked away in the dark recesses of the subconscious, and this, she believes, adversely affected much of her life, including her health. She attributes years of chronic depression, episodes of dissociation, paranoia, and panic attacks to her suppressed memories. She "began to have serious emotional difficulties" (LB) , the treatment of which resulted in addictions to medications and alcohol. She says of this time: "Life seemed absolutely intolerable to me, I simply couldn't bear it a lot of the time." But a change in life circumstances helped. She began a fulfilling job and the resulting feeling of identity and stability prompted her to examine her position more closely:

> Right about that time was when we first began to have real marriage difficulties. That's when it began to break down because now I had an identity, I had a professional identity and I was beginning to get a personal identity, too. I started to explore self-help things. I started going to seminars and read, I was now seeing a psychologist that was very helpful.

The work that she did at this point seems to have prepared her for another engagement with illness later in life. Having explored new possibilities, she was open to the spiritual experiences that carried her through a close encounter with death.

We can see from the above that beliefs change over time, often for practical reasons. There is yet another way to look at practical application of belief. The remainder of this chapter will examine two substantive beliefs. Substantive beliefs are singular beliefs that are often held separate and independent from the major traditions from which they originate. The process of "borrowing" from traditions to create a "recycled," eclectic belief system has been studied previously (Hexham and Poewe 1997; Stark and Bainbridge 1985). Occasionally, rather than being incorporated into a new,

seemingly coherent doctrine, for example a new religion, a singular belief is taken on its own, completely decontextualized from the original tradition and floating without attachment even to new religions. The two beliefs of this kind discussed here occur frequently in both my interview material and conversations at the church and clinic. They are karma and body memory.

The Buddhist conception of karma is that of a law under which "all deeds and thoughts, according to one's intentions, will have set consequences" (Ludwig 1993: 128). This belief remains essentially unchanged, though decontextualized, as a substantive belief. Karma is a helpful way to frame experience and give it meaning, and it also, for good or bad, can serve to alleviate guilt and responsibility. Thinking in terms of karmic law has aided more than one person in this study to cope with the feelings of rage that result from various forms of abuse, because it helps to alleviate the need for revenge. For example, Suzanne Murphy knows that karma will exact a heavy penalty on her abusers, which enables her to rest more easily.

The notion of body memory actually originates in learning theory and popular psychology and physics. It holds that all of our experiences and reactions to them are stored in our bodies' cells, unknown to us but manifesting as dysfunction. Most of us assume that our memories are contained within certain parts of our brains, but some are convinced that they are "distributed throughout the brain as a whole" (Talbot 1991: 13). The belief in body memory exacts this notion one step further, to say that memories are not only found in all parts of the brain, but are actually distributed throughout the entire physical body. Holding this to be true gives a person an increased sense of power over their position as it opens up new explanatory paradigms and therapeutic options. For

Laural Berman, discovering that "the body records on a cellular level" was the beginning of her quest to heal the scars of abuse and hence their physical ramifications. For Andrea Jergens, seeing her very complex symptoms as the result of her cells retaining memory of past traumas and experiences satisfied her need for a unifying and "valid" explanation that made sense to her.

There are many examples of beliefs which help people to cope with their circumstances, and of course this sentiment is far from original. Suzanne more fully developed her belief in communion with the spirit realm after her son died. Laural's spiritual beliefs gave her a stronger sense of identity, protection, and belonging.

Conclusion

Jung (1990: 127) observes that "[m]an positively needs general ideas and convictions that will give meaning to his life and enable him to find his place in the universe. He can stand the most incredible hardships when he is convinced that they make sense. . . ." In this chapter, we have considered three types of belief: formal or institutional, personal, and substantive. We have also explored how beliefs change depending upon life's circumstances. These changes can have either positive or negative results. Beliefs are seen to effect both cause and cure of disease in the narratives presented here. Church members and clients at the clinic distill some of their personal and substantive beliefs out of these institutions. Beliefs are malleable, though, and sources for them are numerous. Although we can see how this has benefited the people in this study, one has to wonder whether tradition is being sacrificed for selection; depth of conviction for choice.

CHAPTER FIVE

AFFLICTION, ETIOLOGY, AND TREATMENT:

ETHNOMEDICAL BELIEFS FROM THE CHURCH AND CLINIC

> We carry our personal history in the tissue that our consciousness co-creates. It remains there like data banks until we transform it. But we carry much more than what is simply personal. On some level, we carry everyone and everything – the collective – all there within and around our very cells.
> Christiane Northrup, *Women's Bodies, Women's Wisdom*

When we think of healing, we often assume that we know what things need to be healed. It may be a disease, a wound, or even a broken heart. But do we really understand the range of pains that demand remedy? What is considered to be an affliction, and what prompts someone to make or seek a diagnosis? In the same vein we might ask: what things cause a person to stray from wellness? The answers, strongly influenced by culture and subculture, vary greatly. For example, in Western society we believe that AIDS is the result of a viral infection, yet how does this knowledge contribute to understanding the experience, including the anguish, of an AIDS sufferer? How can we explain why someone who is unlucky enough to be sneezed on by a runny-nosed two year old does not invariably contract a cold of their own a few days later? Folk theories of disease causation are formed around knowledge, experience, and belief. Once we have begun to grasp the scope of differences in diagnostic and etiological beliefs, we can begin to consider the varieties of treatments employed by people with

different belief systems. We will then explore a multitude of therapies that are considered to help and to heal.

When I constructed my interview guidelines, I did not want to presume that only certain categories, such as physical discomfort, would prompt corrective action. Presupposing that only certain types of ailments require healing would have needlessly limited my data and I would not have seen the same range of beliefs about all of the kinds of pain that justify a healing intervention. Similarly, I wanted to put aside my own beliefs and knowledge regarding etiology. Although I found this to be at times very difficult (I often found myself in the medical library, trying to determine what "really" causes a certain illness that I had come across at one of my field sites!), the process showed that etiological beliefs are strongly linked to and intertwined with a person's overall belief system. Listening to people talk about what they think causes illness, I realized that they were not mentioning viruses or other "germs" very often at all. In fact, it seemed that their etiological beliefs only allowed "germs" because they knew they "should" be included, lest this interviewer think they did not pass high school biology. But despite its prominence in my mind, the germ theory of illness causation was conspicuously absent in the narratives. Even for physical symptoms, biomedical explanations were few and rarely seen as a fundamental cause, although we will see a difference between the church and clinic on this point.

Personal and societal belief systems influence, cohere, and help to explain an experience of affliction and the resulting health-seeking behaviour of an individual. This chapter will explore these interwoven factors within the context of the beliefs of the interview participants and those belief systems at the church and clinic, which were

described in detail in chapter four. A comparison will be made between the beliefs of church-goers with those of clinic clients emphasizing three dynamics of illness experience.

The first dynamic deals with the identification of affliction and the making of diagnoses. This is more than labeling disease, for it illustrates what things are seen to require healing, which differs among individuals. Therefore, an affliction is taken to mean any pain, symptom, or experience that is conceptualized as a deviation either from one's normal state of health or wellness or from an ideal state of health or wellness. It is anything the individual feels compelled to seek treatment for or to self-treat, whether or not they actually act on this compulsion. A diagnosis, then, is the label for or the act of labeling any affliction. It is often suggestive of causation and appropriate treatment.

The second dynamic point of comparative analysis is that of etiological belief. These beliefs derive from an individual's paradigmatic structure that deals with causation. An etiological belief is recognized here as anything that was said to cause, create, or predispose one to affliction.

The third dynamic of the illness experience considered here is treatment. Attempting to avoid medicocentrism, a broad definition is used. A treatment is considered to be any activity undertaken anywhere (home, clinic, church, driving in one's car) with the purpose of moving one closer to a perceived normal or ideal state of health.

Affliction and Diagnosis

The first phase of any illness experience is the identification that something is awry, and then hopefully determining what that is. In this section, we will see that the ways in which this is done vary between the Church of Spiritualism and the Alternative Medicine Clinic.

Spiritual Symptoms: A framework for identifying affliction

In the literature on spiritual and complementary healing, the usual categories of illness and healing derive from the concept of holism (Dossey 1995; Grossinger 1995; Hammerschlag 1992; Harpur 1994; Rubik 1995). These categories are mind, body, and spirit. From the perspective of a holistic framework, it was obvious that members of the Church of Spiritualism placed relatively more emphasis on issues of the mind and spirit than on those of the physical body. It was common for people to talk of relationships, mental illness (especially depression), and spiritual struggles in reference to suffering and healing. Physical symptoms were not ignored, but when they were mentioned, they were often "translated" into a mental or spiritual idiom. For example, one woman's throat problems (soreness, difficulty swallowing) were interpreted by a Spiritualist medium as a manifestation of not being able to talk to someone close to her who was suffering from depression. The opening prayer for the healing service often included a supplication requesting that Spirit "heal us on whatever level we need it." Such a blending of the mental, physical, and spiritual counters the common conception, articulated by Kakar (1982: 5) that "[f]or the West, . . ., the connection of health with orders other than that of the body or the mind no longer exists." Equating scientific biomedicine with the health attitudes of the "west" is inaccurate, for in this small church in the belly of a large North

American city, there is in fact very little concern with the bodily and much with the mental and spiritual sides of health. Physical symptoms are often judged as insignificant because it is the emotions and spirit that are afflicted; they are what are seen to require healing.

Accustomed to consolidating different kinds of pain, things for which people at the Spiritualist Church sought healing were not easily divided into convenient slots of mind, body, or spirit. Rather, a more natural distinction, made by both church members and clinic clients, was between indicators of affliction and events giving rise to affliction. Accordingly, afflictions and diagnoses mentioned at both field sites and in the interviews can be sorted into two categories: *symptoms* and *experiences*.

Symptoms, in the sense used here, are particular states of being, seen to be signs of affliction or deviations from health, with which the interview participants were currently coping, or had coped with in the past. Symptoms could be physical, mental, or spiritual and include such things as pain, injury, conditions (such as swelling or rashes), syndromes (combinations of symptoms), mental effects (such as confusion or depression), diseases, disorders, behaviours (like drug dependence), and emotions (including feelings of spiritual hollowness or sadness). Symptoms include formal as well as self-diagnoses. Experiences, on the other hand, include events in one's past that are seen as traumatic and in need of "dealing with" or healing. These are often seen as resulting in symptoms. What all of the symptoms and experiences have in common is that they are considered to be "afflictions," that is, they are things that require healing.

To illustrate the range of perceived afflictions, Tables 5.1 and 5.2 list afflictions in the terms used by members of the Church of Spiritualism. Table 5.1 includes those

afflictions that are considered to be symptoms; Table 5.2 lists those seen as experiences. Of course, some afflictions appear in both categories, because occasionally a symptom such as fatigue or depression becomes an experience in itself that, due to its social impact and stigma, needs to be healed.

anemia, angina, asthma, back pain, blurry vision, cancer, CFIDS, depression, fatigue, foot pain, injury, grief, heart condition, hopelessness, indecisiveness, lack of energy, overeating, poor attitude, pneumonia, renal failure, shoulder pain, sleeplessness, swelling, water retention

Table 5.1 Church members' perceptions of symptomatic afflictions.

accidents, childhood, depression, incest, emotional abuse, failed marriages, feelings of loss, grief, hopelessness, loneliness, mistakes in parenting, physical abuse, previous life experiences (relationships, incest, failed marriages, wrongful death, revenge, and witchcraft), relationships (especially with father, mother, siblings and children, and also friendships and relationships with spirit guides), severe beatings, sexual abuse, suicide, unexpected death

Table 5.2 Church members' perceptions of experiential afflictions.

The Clinic: A secular-spiritual framework for affliction

Afflictions of the spirit or soul are attributed great importance at the church. While this is also true for some of the clients and practitioners at the clinic, the everyday concerns at the clinic are generally more bodily than emotional, and more emotional than spiritual. Despite this difference between the church and clinic, both apply a holistic model to their process of identifying illness. The church's model is holistic because they simply do not distinguish between elements of mind, body, and spirit. The clinic's paradigm is holistic because, although they may separate them out, they nevertheless strive to give credence to all three elements of affliction.

The identification of affliction or the making of a diagnosis at the clinic emphasizes the bodily and physical, but such afflictions are often said to be "submicroscopic" or "subclinical." What is meant by this is that conventional medicine would be unable to detect a problem using laboratory tests. Allergies, sensitivities, imbalances, and incompatibilities are common diagnoses.

Despite the relative import of the physical, clinic clients still include emotional and spiritual symptoms in their schema of affliction. Tables 5.3 and 5.4 show the range of afflictions identified by clinic clients. Again, the first table (Table 5.3) lists afflictions considered to be symptoms and the second (Table 5.4) contains those viewed as experiential.

ache everywhere, alcoholism, allergies, arthritis, blurred vision, brain fog, cancer, candida, cerebral symptoms, CFIDS, choking and biting tongue, clamminess, closed throat, cognitive difficulties (inability to "think sharp"), cracked teeth, dental issues, difficulty articulating, difficulty breathing, difficulty chewing and swallowing, digestive problems, disabled walk, dizziness and disorientation, drug addiction, dysbiosis*, environmental illness, exhaustion, extreme fatigue, fever, flu, food, drug, and chemical sensitivities, fibromyalgia, foggy, spacey, moods, fungal problems, infertility, irritable bowel syndrome, lack of energy, lethargy, malnourishment/malabsorption, mercury sensitivity, mononucleosis, nervous breakdown, "not functioning," overwhelming sleepiness, pain (generalized, under the skin, back, neck, jaw, head, elbow, joints), peptic ulcer, poor coordination, poor memory, reaction to chemicals and carpets, ringing ears, sinus infection, sleeplessness/oversleeping, sore eyes, surgery, swollen eyelids, vocal chord problems, weight loss, whiplash

Table 5.3 Clinic clients' perceptions of symptomatic afflictions.
***a collection of conditions including intestinal parasites, overgrowth of intestinal yeast, a lack of beneficial intestinal flora, and an increase in intestinal permeability (Northrup, 1998: 725).**

alcoholic father, alcoholism, childhood malnutrition, childhood suppression, codependency, death of a child, death of parents, death of siblings, difficult pregnancy, drug addiction, emotional and verbal abuse, fatigue, failed marriage, imbalance, incidents with coworkers, infertility, infertility treatment, isolation as a mother, miscarriage, mentally ill mother, nervous breakdown, not breastfed, poverty, sexual and physical abuse, relationships with doctors, relationships with men, relationships (with mother, father, siblings, extended family, coworkers, and friends), traumatic birth, workplace relationships

Table 5.4 Clinic clients' perceptions of experiential afflictions.

Perceptions of Causation

Etiology is closely linked to ideas of affliction and diagnosis. Sometimes they are one and the same, as for example when alcoholism is seen to be both a disease and a cause of disease; or when a relationship with an abusive parent is in need of healing in itself, but is also viewed as giving rise to other afflictions. Anthropologist George Foster (1998[1976]: 112) points out the centrality of etiological beliefs: "Most diagnoses prove to be statements about causation, and most treatments, responses directed against particular causal agents." Etiological beliefs strongly influence the meanings that are given to the illness experience. They heavily impact the choices that a patient makes and often determine the patient's attitude toward illness in general. An etiological belief can even be viewed as a microcosm of an individual's entire worldview, illuminating that person's perception of reality, view of relationships between things, cosmology, and process of validating and understanding knowledge and experience.

Analyzing the variety of perceptions of disease causation, we can discern that there are levels or types of causation (ibid.: 114). A belief system can predispose one to

place relative importance upon a certain type of causation, both in general and in regard to illness, so that holding a sacred or magical worldview might lead one to rely on sacred and meaningful, abstract explanations. This is in contrast to a scientific paradigm, which would lean more toward mundane, concrete explanations. These types of explanations are situated at opposite ends of a spectrum ranging from proximate to ultimate causes. The important difference between attributing the cause of illness to ultimate rather than immediate factors is a difference in richness of meaning. Ascribing illness to "a learning experience; part of an overall plan," suffuses the experience with meaning to a much greater degree than does a view of illness as a biochemical reaction. Furthermore, profound theories of causation help one to deal with illness as an experience, whereas less meaningful ones explain only disease. A continuum of meaningfulness in etiological beliefs, from proximate to ultimate, is apparent in the data from the church and clinic, so that the "sacred" site (the church) relied more on ultimate explanations, while the relatively more "secular" site (the clinic) placed more emphasis on immediate causation. Further study might reveal whether this relationship between belief system and etiological perception occurs within other healing environments. In addition to this, individuals with a very spiritual belief system, independent of whether they attended the Church of Spiritualism or the Alternative Medicine Clinic, stressed ultimate and meaningful causes more heavily than proximate ones which are also less open to interpretation.

Sacred Etiology: A Search for Meaning

People at the church appear to rely more heavily on ultimate explanations for afflictions than they do at the clinic. Not only that, but these ultimate causes are seen to play a more direct role in creating illness than those cited by clinic clients, where ultimate causes are seen as indirect – they are more apt to make a person vulnerable or susceptible to illness than to be the direct cause.

The Spiritualists' beliefs about causes of afflictions are often spiritual in nature – concepts such as karma, debt repayment, past life experiences, souls, energies, chakras and the aura sprinkle discussions of the roots of affliction, whether that affliction be symptomatic or experiential in nature. An excerpt from the interview with Spiritualist Suzanne Murphy illustrates this:

> BL: What do you think causes illness?
> SM: Well, karma is one very big thing; it is whatever you need to learn. Whatever you need to get over. This one lady, this is a true story, died in a fire. She was really burnt and she died in hospital, and she went over to the other side. And a voice told her that she had to go back. She [said], "No, I don't want to go back. I know the pain that's there, I see how ugly I am, I do not want to go back to my body. Let me stay." And a young guy about 20 walked up to her and told her she had to go back. And she said, "Why?" And he said, "Because I'm your son." So she went back and sure enough, he was born. He remembers everything. So a lot of it is karma – it's harsh but a lot of it is karma (Suzanne Murphy, June-July 1998).

There are other ideas that inform Spiritualist Church-goers' perceptions of disease causation as well. Notions of disharmony and imbalance are similar to those of the clinic's clients, however the church-goers are referring to a more generalized disharmony and imbalance in the world, rather than that which is limited to the individual. This is

consistent with a belief held by several of the church-goers in a "universal energy" that all things, including people, consist of and play an active role in changing.

Moving slightly away from these ultimate explanations for illness, it was admitted that a person's "attitude" can affect their health. For example, a dismissive attitude toward spirituality can lead to illness, or even a negative attitude toward life in general is seen as creating an atmosphere of negative-energy around the individual that can induce illness. Feelings of loneliness are also seen as creating, or at least hindering the healing of, afflictions.

Two causal agents that lean most heavily to the proximate end of the spectrum are "the inability for my body to produce insulin" (SM) and lifelong physical abuse. Yet even these, although not the abstract concepts of karma and disharmony, are made meaningful through Suzanne Murphy's narrative that reveals an intense, childhood event-related fear of needles and the spirituality that enabled her to cope with the abuse (SM).

Layers of Causation: Meaning and Evidence

While the explanations relied on most heavily at the church were ultimate, the material from the clinic reveals the important role of proximate as well as ultimate explanations. The clinic clients and practitioners often held a view of illness and health that originated in biomedicine. Ultimate explanations were still of great importance, however it appears more necessary to support these with *evidence* than it is at the church. Such evidence often can be found in proximate explanations. This notion of reinforcing ultimate beliefs with proximate evidence is reminiscent of the shamanic practice of Quesalid in Levi-Strauss' *The Sorcerer and His Magic* (1963). Although Quesalid relies on the symbolic power of the healing ritual, as do his peers from other bands in the

region, the use of a proximate explanation for illness, that is, concrete evidence, renders his healing technique more powerful than that of his peers. The proximate cause, then, gives direct, concrete, tangible, and immediate support for the ultimate cause of illness. It may be that the requirement for this type of evidence varies with belief system. For example, biomedicine, while still having to grapple with issues of ultimate importance, requires evidence of an empirical, physical sort to such an extent that the ultimate causes are eventually overlooked entirely. The Alternative Medicine Clinic, while retaining a spiritual dimension, is run by and works with patients who still require somewhat concrete "proof" of the cause of their illness. The church requires less in the way of proximate causes, tipping the scales so that evidence takes a back seat to faith.

Another distinction that can be made between the church and clinic is the way in which ultimate explanations are made meaningful. At the church, they are meaningful because they are sacred. While this sometimes applies at the clinic, expressions of ultimate causation can also be made meaningful by having occurred in the past or over a long period of time. For example, temporal significance is invoked in the belief that mercury in amalgam dental fillings causes digestive problems. The sudden realization of the harmful nature of something that has been retained in one's bodies for a very long time gives rise to powerful emotional reactions and cognitive shifting. Other, related examples include the realization that one has food allergies or sensitivities to environmental chemicals, or that childhood immunizations or antibiotic treatments affect one's health in later years.

At the clinic, there are a great variety of etiological beliefs that range from proximate to ultimate, but most of them can be slotted into three categories: Stress, Self, and Toxins.

The etiological category of stress is divided into physical, emotional, and spiritual stress. All of these types of stress are believed to cause illness; the narratives do not attest to a belief that emotional stress causes only mental illness or that physical stress only causes physical illness. But emotional factors are more commonly viewed as an indirect cause of physical illness, that is to say that emotional stress weakens the immune system, thus decreasing the host's resistance to disease.

Physical stressors include accidents, trauma, injury, physical abuse, bacteria, viruses, fungus/yeast overgrowth, malnutrition, and dysfunctions such as malabsorption and sleep disturbances. These types of etiologies are rarely infused with meaning and are seen as direct causes of not feeling well. They are usually proximate explanations.

Emotional and mental stressors include unresolved conflict, all types of abuse, mental illness, relationships, and one's living environment. Spiritual stress includes factors such as spiritual doubt or confusion, karmic influences, and an unharmonious world.

Self-based etiological beliefs are often seen as choices that one has made and, since they are thought to be a cause of illness, regret. They are things that people did not think about at the time, or think that it was important enough to pay attention to at the expense of other things. The self always came last for most of the women interviewed; it was their lowest priority. Children, husbands, parents, households, and work took precedence. Mary Kendrick explains this:

> I know I have to handle everything. And even though they look like small things, it's everything. And it's too much. . . . I didn't know that two months ago. Because I felt I could still handle all of that. But gradually I realized that I couldn't. And nobody was picking up the slack. It became like, I can't do that. I just want to leave with my clothes and go somewhere by myself. And not have to worry about anybody.

Katherine Anderson talks about not getting enough education "about my body" and also a general lack of awareness of her body. Laural Berman describes how, with three children and a very busy husband, she never rested and never took the time to properly deal with stress.

Toxins could be subsumed under "Stress," but they are cited so frequently and given more meaning than other physical stressors so as to warrant their own category. The idea of being "poisoned" by something is psychologically more powerful than a bacteria or trauma. There is even a conspiratorial or paranoid air to discussions of toxins, as though "Big Brother" was trying to keep them a secret.

Table 5.5 summarizes the etiological beliefs at both the clinic and church and categorizes each belief as self, stress, or toxin. The vertical placement of each belief indicates whether it is a relatively more proximate or ultimate etiological belief. Horizontal arrows denote that the item belongs in more than one category. For example, the belief that a traumatic birth causes illness is considered to span all types of stress -- physical, emotional, and spiritual. Each belief is cited verbatim – the initials of the originator(s) follow each item. It is noted that even though placing each item required subjective interpretation, every attempt was made to use the context in which the belief was stated to place the item as close as possible to where the originator would place it himself.

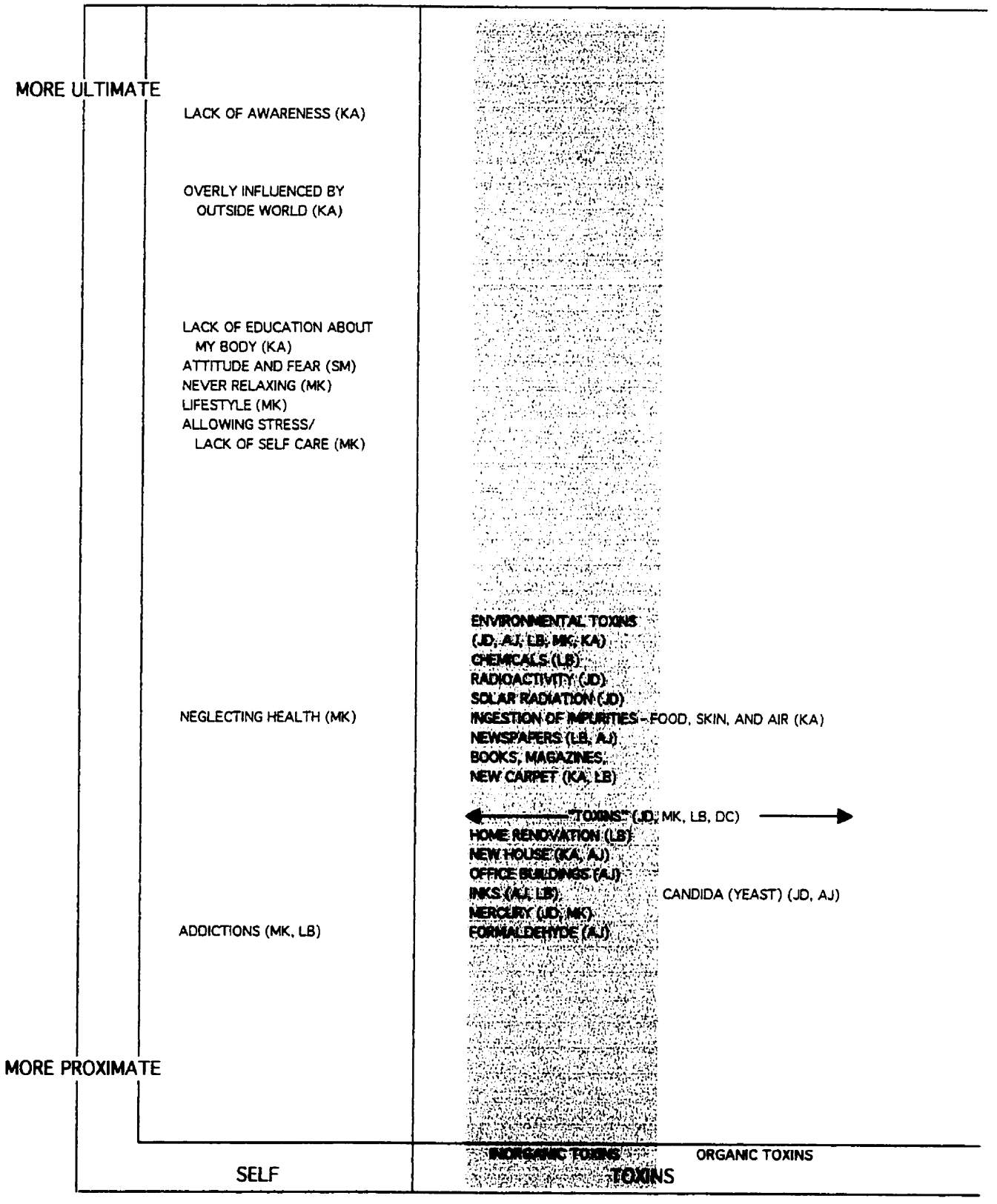
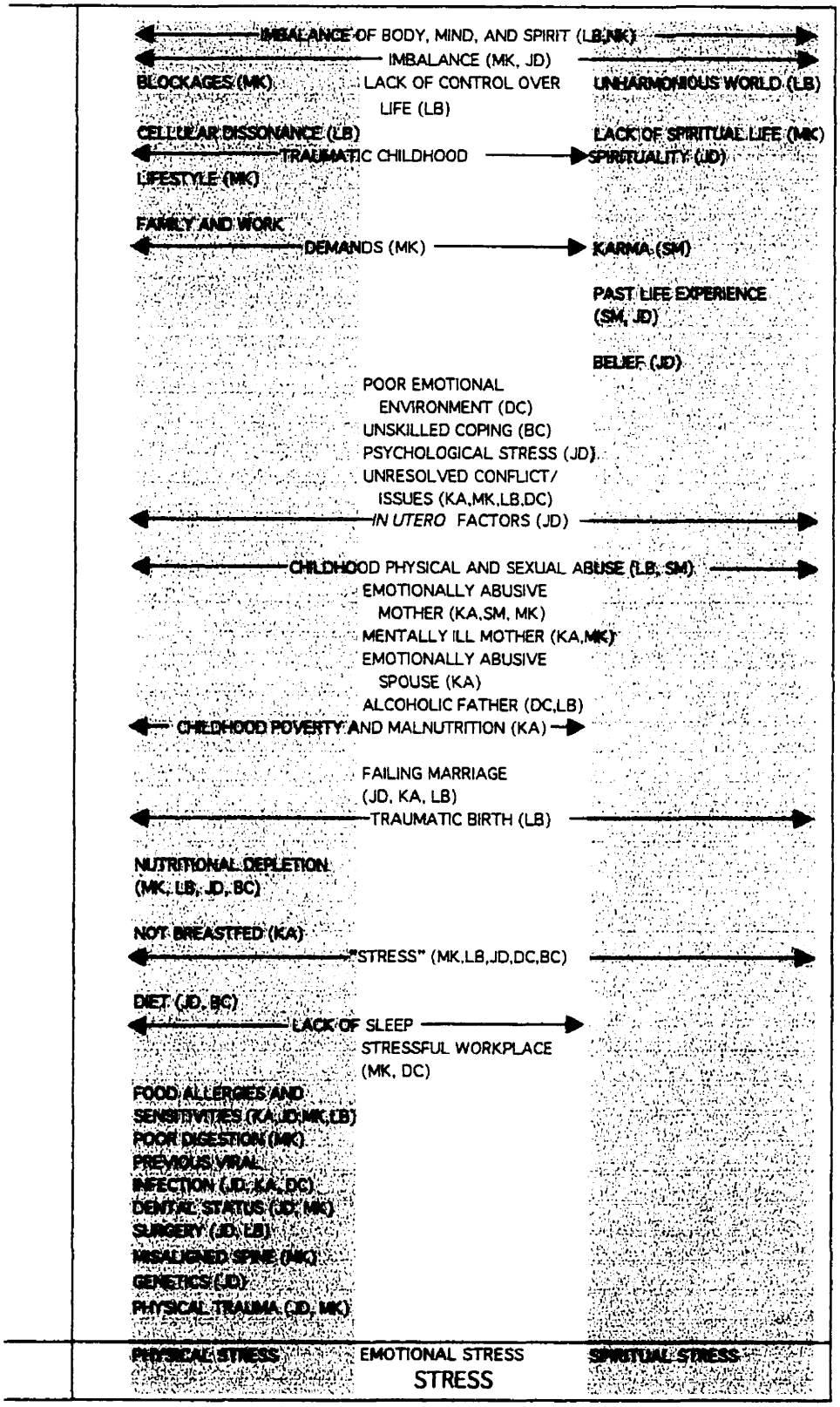


Table 5.5 Etiological Beliefs from the Church of



Spiritualism and the Alternative Medicine Clinic

The rendering of causal beliefs via a continuum of meaningfulness from proximate to ultimate emphasizes the non-equivalent nature of various causal theories, yet still allows us to understand how they coalesce into a system reflective of belief's fickle requirements for supporting evidence. More interviews with health care providers and patients from many different healing environments would help to consolidate this model of perceptions of illness causation.

Practiced Conviction: Healing and Therapy

Concomitant to the process of identifying an affliction and its possible causes, the individual is already attempting to alleviate the physical, emotional, and spiritual discomfort associated with his affliction. In chapter three the difference between treating a symptom and making a lifestyle change was discussed. For all of the people interviewed in this study, therapy, prevention, and lifestyle are transposable at least part of the time. McGuire's (1988: 184) assessment of alternative medicine users is pertinent:

> Alternative healing beliefs and practices are integrated into the routines of most believers' everyday lives so thoroughly that these persons are only occasionally conscious that they are specifically doing healing.

In addition to the lifestyle view of health promotion, each institution has its own way of delivering healing or providing therapy that articulates logically with method of diagnosis and theory of causation.

Spiritualist Therapy: Images and Directed Prayer

I am sitting in a chair across from Leon Bell, a healer at the church. I have arrived early for the healing service; we are alone in the building. No one else arrives, so we begin. Leon begins with a prayer in which he asks Great Spirit to heal us on whatever

level we need healing. We then sit in meditation; he has suggested that I send out special thoughts to anyone I think may be in need of healing. I sit quietly, finding it difficult to regulate my breathing, and think of people in my life who I know are ill or are having difficulty with some other aspect of their lives. I feel nervous and peek at Leon several times to see what he is doing. He is relaxed but erect with his hands resting palms-up in his lap. He breathes deeply and slowly. After about fifteen minutes of the healing meditation, he stands quietly and moves behind me. He places his palms somewhere between ten and fifteen centimetres away from my head, changing the location of his hands every one or two minutes. I can feel something; it is a warm, tingly or fizzy sensation, especially on my cheeks and forehead. I try to keep my eyes closed but I want to see what he is doing. He finishes the healing with his hands on my shoulders for a couple of minutes. Leon tells me that, during the healing, he saw a vivid image of a large white Easter lily. He also says that he envisioned an open plain with a line of light on the horizon due to the sunset. He says these are good images for me. He tells me that he received a very strong burst of energy at my forehead during the healing. Others then enter the church and my healing session is complete. Leon asks me to help him with the next healing. I sit in front of the woman, holding her hands in her lap, and Leon repeats the process of healing that I had received earlier.

The above account describes what Spiritualists at this church refer to as "a healing." Leon explains this as being a form of direct communication with Spirit; he believes that the "other side" has much better knowledge about what a person needs and acts through him to "communicate" this knowledge to the person being healed. He views himself as "a channel for the energy." It is thought that both believers and non-believers

benefit equally from a healing. It is a simple ritual, yet it reflects and reinforces the principles of Spiritualism that were discussed in chapter four.

There are other therapies, in addition to the healing ritual, practiced by those at the church. The most prevalent is the use of imagery, such as the Easter lily mentioned above. Presenting a church-goer with a personalized image is very common during services devoted to healings and the giving of messages from the spirit realm. The healing intention of these images is acknowledged by Leon Bell, who believes that the images "stick" better than words. The therapeutic benefits of imagery and visualization are well known and their cogency as metaphors will be analyzed further in chapter six. Other therapies employed by Spiritualists include the use of power objects such as crystals, mantras and affirmations, meditation, breathing techniques, and movement such as T'ai Chi. It is also implicitly understood that by focussing on healing another, one's self also moves toward wellness.

The foundations of healing in the church are the healing ritual and the use of imagery or "directed prayer" (a term used by a female healer at the church). Quiet, brief, and simple, the ritual is nevertheless inlaid with symbols that reinforce belief in the principles of spiritualism and the benevolence of the spirit realm. One such symbol is the helping hand. Hands are a common motif on the covers of books about healing (see for example Dossey 1993; Harpur 1994; and Krieger 1993). Hands, particularly those folded in prayer, symbolize divine compassion. The Spiritualist Church's healing ritual is based upon a modified version of laying on of hands, which Harpur (1994: 21) found

> made all the difference in how [those being healed] coped with their daily lives. They found it made all the verbal assurances that they were loved by God and in touch with a truly caring community suddenly come alive. The sick said it gave them fresh faith and hope that they were on the road to fuller health.

The symbolic power of touch may not be significantly altered by the lack of physical contact during the ritual. In fact, it seems to reinforce the belief that the healing force is energetic rather than corporeal. It was noted, though, that the healers touched people they were familiar with (for example regular church-goers) more frequently and for longer duration than they did strangers or people new to the church. Leon expressed resignation to the inevitable awkwardness of and doubts surrounding physical touch in this era of political correctness and sensitivity to sexual harassment. Despite this somewhat unfortunate application of societal expectations, it is still the hands that are considered to be the conduits for spirit's healing energy.

One church healer termed the healing ritual "directed prayer," meaning that the healer is actually focussed on praying for the individual seated before him or her. Combined with healing meditations, which occur during both healing and regular services, this form of prayer forms an integral portion of the healing at the church. Participants sit quietly with their hands in their laps and eyes closed, thinking of people they know of who need healing on some level. Sometimes someone whispers the name of the person about whom they are thinking. Significantly, this type of intercessory prayer has been scientifically shown to have therapeutic benefits, even when the patient does not know someone has prayed for them (Byrd 1988). This type of prayer is similar to what sociologist Margaret Poloma (1982: 87) observes in charismatic Christianity. She describes this practice as "private prayer":

> Practicing charismatics may regularly pray for healings for themselves and for others – and believe that they regularly receive results. Witnesses commonly shared include relief of minor headaches, disappearance of lumps or abnormal growths, healing of eye infections, and easing of arthritic pain.

The therapies provided at the church are generalized to all conditions; a healing is thought to be equally efficacious for any ailment. This is not surprising, especially considering that no one I spoke with at the church considered church healing to be the only therapy. Anyone who was suffering and therefore seeking relief looked to conventional medicine and other resources in addition to their trusting in Spiritualist healing.

Therapies at the Alternative Medicine Clinic

The clinic's empirical ontology dictates that certain aspects of the experience of illness are specified more carefully than the "whatever level healing is needed," general view of affliction at the church. The clinic has a heartier appetite for concrete evidence and tends more toward proximate theories of disease causation. Similarly, treatment is more specific and tangible, but it is still holistic in that the clients' bodies are treated as a whole, there is a strong psychiatric and emotional support aspect, and spiritual beliefs are addressed if the client is interested in testing such waters.

When a person goes to the clinic for the first time, they are routed into either the Traditional Chinese Medicine (TCM) Program or the Wellness Program. In either case, the usual recommendation is for a package of ten treatments. The TCM therapies include acupuncture, herbs, cupping, moxibustion, diet therapy, stress management (qi gong and meditation, for example), and entrainment therapy. The foundation of the Wellness Program is a computerized test called Biological Terrain Assessment, which analyzes the

pH, redox potential, and resistivity (mineral content) of bodily fluids. This test is administered at the beginning of and several times throughout the treatment, thus serving as a barometer for improvement. Another therapeutic aspect is dental, for example having mercury amalgam fillings replaced where indicated and undergoing a corresponding detoxification program to clear the materials from the body. The clinic also heavily emphasizes self-care and home-treatment approaches; running the public and personal together in the domain of treatment, an overall shift in lifestyle is often prescribed in addition to inpatient treatments.

One of my treatments at the clinic lasted for three and a half hours. Upon my arrival, I was asked to fill out a very lengthy (twelve pages) and comprehensive questionnaire containing open-ended questions, box-checks, and rating scales on such topics as symptoms, medications and food supplements taken, family history, emotions, libido, relationships, and spiritual orientation. I had requested an acupuncture treatment, so I was streamed into the Traditional Chinese Medicine program. After completing the paperwork, I was led to a treatment room with a heavy wooden door and natural light coming in the windows. I was asked to change into a white hospital gown and have a seat on an examining table piled with cotton blankets and pillows. The next half hour was spent going over the questionnaire with a registered nurse licensed to practice acupuncture, who asked for more details and took notes. She also looked at my skin and tongue, and took my pulse. During this time, she gave me advice on nutrition and suggested food supplements. Once I was lying comfortably on my back with pillows supporting my head and knees, she began the acupuncture treatment. Starting at my feet, she placed needles a few millimetres deep at about 20 to 25 locations, all the way to the

top of my head and including my legs, stomach, ears, face, arms, and shoulders. She turned the needles once they were placed, which produced a localized synesthetic sensation akin to the sound of metal on metal. Some of the needle placements hurt a little, some were not felt at all. The acupuncturist-nurse explained that I had deficient kidney-liver yin and she was treating me with the hope of balancing this deficiency. The acupuncture needles thus placed, the practitioner spoke some more about diet and then left the room. Another woman returned and explained the next portion of my treatment: entrainment. Entrainment therapy is described in a clinic handout as

> a concept which is well understood by the physical sciences. Suppose we take three strings on a guitar. The middle string is tuned to the "C" scale. The string on the right is also tuned to the "C" scale, while the one on the left is tuned to the "D" scale. If we were to pluck the middle "C" string, we would observe that the "C" string on the right will begin to vibrate (oscillate), while the "D" string on the left will remain inert. This is the concept of entrainment in which one oscillating wavelength can cause another to vibrate at the same frequency. . . . We know that brain activity produces electro-magnetic wave forms called brain waves. Studies on subjects who have meditated for long periods of time have shown that these different brain waves are associated with different emotional states and levels of consciousness. For example, the alpha wave is associated with relaxation and is frequently seen in meditation and sleep. If this state is present while awake, the subject describes himself as relaxed and calm. . . . Entrainment will attempt to "tune" these wave lengths back to proper functioning so that various states can be achieved in a harmonious and synchronous way.

Prostrate under the gleam of slim acupuncture needles and covered with a light blanket, I underwent entrainment therapy for about half an hour. Goggles were placed over closed eyes, and earphones conveyed soft story-telling voices, sounds, and music. The goggles flashed white light, perceived behind my closed lids as various colours and patterns. Each earphone spoke different words and stories simultaneously; it was suggested that I not try to listen "consciously" to the stories. Indeed, when I tried to I

found it to be nearly impossible and also quite irritating, as the voices in each ear competed with one another.

When the entrainment session ended, the second practitioner returned and removed the acupuncture needles, swabbing the sites with alcohol as she went. She reviewed the dietary and supplement recommendations that had been made and asked if I had any questions. I rose slowly from the table and dressed. I felt very relaxed, alert, and noticed a significant increase in the range of motion in my chronically tense neck and jaw.

The clinic manages to convey a sense of modernity and technology in tandem with compassion and empathy. This combination appears to be very successful, especially for people raised in our science-oriented society but struggling with a chronic illness poorly understood by science. The experience at the clinic is more secular than that at the church, but the convictions held by both patients and practitioners are no less compelling.

Conclusion

Seeing such a vast range in perceived afflictions and diagnoses, etiological beliefs, and treatments, one begins to question the strict definitions of illness and wellness. Less a dualism and more an ongoing process, people determine that something is wrong based on criteria rooted in their system of belief and experience. They draw on these in response to an affliction, sorting carefully through possible causes and pursuing potential cures. They contort their beliefs if necessary, looking for ways to make the soul-searching experience of illness more meaningful and thus more bearable. In the process, they gain a sense of control over their situation.

The beliefs informing affliction identification and diagnosis, causation, and treatment differ between the church and clinic. They seem to exist on two levels, although each one seeps into the other's domain from time to time. The church's healing can be called sacred and the clinic's secular; and the abstraction and generality characteristic of the church contrasts with the specificity and tangibility of the clinic. But despite these differences, the life stories reflect a similarity: the healing process, no matter what that entails, is not restricted to special times during which the criteria of "sick role" are flawlessly met. People's ideas and awareness influence how they perceive themselves and what, to them, warrants seeking treatment. The interview data suggest that what is thought to require healing is often nothing less than life itself – the process is not defined in time or space but is rather like a perpetual, homeostatic cycle involving the pursuit of health, challenges to that pursuit, and adjustments in response to those challenges. An individual's malleable belief system is an invaluable tool in this process.

CHAPTER SIX

THE CREATION OF MEANING:

THERAPIES, LIVES, AND STORIES

> Illness has meaning; and to understand how it obtains meaning is to understand something fundamental about illness, about care, and perhaps about life generally.
> Arthur Kleinman, *The Illness Narratives*

"Meaning mends," declares Moerman (1983: 165). So it would seem at both the church and the clinic. Much energy is devoted at each venue to generating meaning. The thrust of this chapter is to examine the creation of meaning within the dual domains of experience and narrative. In the first domain, we see how meaning is put to work therapeutically. This involves infusing experience with significance such that it becomes symbolic, and the symbols themselves become therapies. This premise is one with which anthropologists are familiar: "Many societies utilize symbolic means in healing under the presumption that in some manner or other the symbols penetrate to the disorder and effect a cure" (Laughlin 1994: 117). Symbolic therapy can be accomplished in two ways: one involves a reframing of experience to show that it has a higher purpose underlying its sometimes gloomy veneer. The second way is more materialist in that it emphasizes the power of imagery in a physiological sense.

Another aspect of meaning creation examined in this chapter, that of narrative accounts, is largely interpretive on my part. The perspective assumed here diverges from my attempt in the rest of this thesis to maintain emic valuations and representations. I choose this path with some hesitation, but I believe that there are important points to be

made that can be articulated only in terms of a critical perspective. Therefore, my goal in this section is not as focused on representing the experience and thoughts of the participants in this study as it is to offer my own reflections upon listening to people tell their life stories. I do this through a close reading of and listening to their narratives, with an eye towards how meaning is produced in a life and in a story.

This chapter discusses concepts of metaphor, imagery, myth, and symbol. All of these are related to the production of meaning. Metaphors, images and myths can all be considered symbols in the sense that they exhibit multivocality (Turner 1967). Multivocality describes the way in which symbols can represent many things at once. Metaphors of illness are cast in many scopes and scales, including human archetypes, society, nature and the individual. Likewise, symbolic healing can serve to heal much more than the sick person, providing catharsis for the community and reinforcing cosmologies. It is from the vantage point of these concepts that we can observe the healing forces contained within metaphors and images.

Meaningful Paradigms, Significant Therapies: Symbols that frame and restore

While she was working as an industrial mechanic, Andrea Jergens developed a severe sinus infection that worsened over time. A year later she left work, having developed multiple chemical sensitivities due to "poor industrial hygiene" (AJ). A virtual prisoner of her reactions to common substances like inks and perfumes, it is difficult for her to even leave her home to do everyday things. Five years later and a regular client at the Alternative Medicine Clinic, she expresses to me her hope for the existence of some kind of "universal justice system," and says that she tries every day to

come away from the experience of illness "with something" but that it is difficult to maintain a positive outlook when you are suffering.

Reframing an Illness

Believing that there are important reasons for hardship helps people to cope with the mundane and difficult aspects of pain. It is a way of reframing the experience in a more positive light and endowing suffering with a sense of purpose. If it is all thought to happen for a *reason*, the experience becomes, unsurprisingly, more *reasonable*. Such reframing is often expressed in a metaphorical idiom. Four of the most frequently occurring metaphors that were seen in this study were: illness as teacher, illness as journey, disease as warning sign, and life as a scripted play. These I call teleological metaphors, because of their ability to define illness as its purpose rather than by its causes.

Dr. Barry Charanap, the founder of the Alternative Medicine Clinic, views "illness as one of the greatest educators of people." Andrea Jergens says that her illness prompted her to reevaluate all of the decisions that she has made and has also taught her that "there are very few things you need in life -- clean air, clean water, clean food and shelter" (AJ). Learning something from hardship, or hoping to, is a dominant theme. People either reflect on what it has taught them so far or they speculate about what edifying lessons they will see in hindsight, once their pain subsides.

A physician at the Alternative Medicine Clinic, Jeremy Davies' story is thick with metaphors describing the pedagogical function of illness as well as its parallels to a journey: "My personal belief about illness is that it's a journey, a journey that can be an

extreme learning experience. [It] really, really gets you looking inside yourself."

Later in the interview he returns to this idea:

> I would not be where I am today had I not gone through my illness. I would not be doing what I'm doing professionally, I would not be, and I'll use the word 'evolved' as a human being, had I not gone through what I've gone through, as much as it's been a really hard thing, it's funny but I would have to say I would almost go through it again. It was the only way to learn what I have learned. And I hope that, what I would like to take from that is to be able to say to my patients, when they come in with illness, that there is going to be a journey for you, you're going to learn alot about life and yourself and that is going to be tremendously inspiring.

Laural Berman similarly enriches her illness story with spiritual themes suggestive of a pilgrimage. For her, illness and healing are both smaller journeys within the grand odyssey of life. It is quite common for stories to be allegorized as voyages, winding roads from which side trips like illness are inevitable.

Disease as a warning sign is another teleological metaphor commonly brought to bear by people in the study. This way of viewing illness is very often a source of both gratitude and lamentation, because although thankful when it finally hits home, the abundance of warning signs that were simply ignored is grasped only in retrospect. As Mary Kendrick describes it, she was given many warning sign to which she did not attend, until "the wheels just fell off":

> Every so often, especially for us mothers, like when you're raising a family, I have had a few times when I got knocked off my feet, you know with a good pneumonia, or with a cold that I never took care of. Your body shuts you down, like okay you dumb lady, if you're not going to listen, I'm going to force you. And your body shuts you down, you can't get up one morning. And this is really what's happening; we're not smart enough to listen to the signals.

A final example of a metaphor invoked often in the reframing of illness experience is life as a scripted play. Shakespeare's melancholy character Jacques *(As*

You Like It) voiced this notion when he declared that all the world's a stage. This image is often conjured to illustrate the sociological concept of roles. Several people in the study used it in the role-sense, but there was also often a facet of fate added. And despite dismissals of fatalism as a convenient way to absolve someone of their responsibilities, it nevertheless appears to help alleviate the blame reaction and guilt that occur when things go wrong. For example, Laural Berman legitimated many of her life's hardships by explaining that she was "without a script" for most of the "roles" she was playing. For Suzanne Murphy, the life as a script analogy is interwoven with the illness as teacher metaphor. All things, including experiences, relationships and events, are about lessons that one is supposed to learn, regardless of outward appearances. She says, "You know, it's all a big script and [everyone else is] in the play, too" (SM).

In addition to teleological metaphors, there is also a profusion of image-based metaphors which provide useful lenses through which to view experiences. They are useful because they help to make sense of events by coercing order out of seeming disorder. Sometimes image-based metaphors aid in the therapeutic visualizations prescribed at the church and clinic. Metaphors of this type frequently include: destruction/construction, toxicity/clearing or cleansing, a clean slate, military imagery, pollution, sensitivity, incompatibility, and accumulation. In order to understand how these images impact illness and healing, we will examine one of them in some depth.

The Straw that Broke the Camel's Back: A Metaphor of Accumulation.

At the Alternative Medicine Clinic, cases are discussed in terms of their "core issues." Core issues can be digestive, dental, energetic (qi-related), and others. They are viewed as the basic problem from which most of a person's symptoms arise. The core

dysfunction's causes are believed to accumulate over at least one lifetime. In this way, the etiology of core issues is consistent with the belief system of the clinic; there is no one direct cause for disease or dysfunction. Instead, life and its pathogens are thought to leave permanent "scars" on individuals, whose "systems" consequently break down little by little. There are ways to counteract this effect, and ways to prevent one's systems of defense from breaking down. But sometimes the cumulative burden becomes too heavy, and the immune system gives out, swinging the doors wide for the entry of disease-causing entities. Jeremy Davies describes it in this way:

> [Illness is] the cumulative effect of different events or circumstances that occur throughout the lifetime of the individual that basically cause disturbances in cell function and body function. So, when I look at chronic illness, like when someone comes in to me and they're age 45 and they have sort of vague symptoms, or they may have an overt diagnosis, the onset of that triggers something that was to me the straw that broke the camel's back. So they may get a virus that may . . . push them over the edge and all of a sudden they start getting some symptoms but the virus is just sort of the final breaking point in the system.

One of the positive ramifications of looking at disease as a product of accumulation is that, if convinced of it as truth, people begin to understand why a treatment aimed solely at solving the immediate or most recent problem will never be adequate. This metaphor also suggests an almost limitless depth to illness, which is often construed not only in physiological but also mythical terms. In the metaphor of accumulation, the illness becomes symbolic, so thoroughly is it infused with significance. Especially when we consider that healing is not synonymous with cure, it seems that reframing can sometimes be the most important yet difficult step in the healing process.

Symbolic Therapy

Metaphors, in addition to being used to reconceptualize illness, can also serve a more direct healing function. As Barasch (1993: 235) poetically queries: "If images are the 'Spirits' that shuttle between brain and body, might they not carry on their wings the messages of healing?" Symbolic imagery is an integral part of healing at the Spiritualist Church. Enmeshed within every clairvoyant message is an image. Each image is presumed, by the healers at the church, to be in some way healing. Research into how imagery works in healing very often has a materialist base, with researchers attempting to 'translate' the therapeutic mechanism of visualization into a positivist idiom. Physician James Gordon (1996: 125) exemplifies this tendency: "The capacity of imagery to exercise a potent effect on many aspects of our mental and physical functioning may well be related to the close proximity, in the brain, of the areas for imaging to the hypothalamus and the emotional centres."

Practitioners and lay persons at the Church of Spiritualism are not overtly concerned with *how* their use of imagery works. Some of them may not even be consciously aware of the healing intention behind the images presented to them by mediums. But imagery and encouragement to visualize images are pervasive at the church. Anthropologist Michael Kearney (1978: 37) explains the importance of imagery in spiritualist healing: "The essential features of spiritualist therapy are its ability to evoke powerful imagery, especially of body parts and aspects of the spiritual cosmology, and to loosen blocked emotions."

At the Church of Spiritualism, personalized images are relayed by either a healer or a medium and may or may not be accompanied by an interpretation of the image.

Some of the images are expressed as being "given" to the medium or healer specifically by the spirit guide, others are just plainly seen by the medium. For example, contrast: "he [the spirit] is presenting you with a bouquet of roses," with, "I am seeing you on a roller-coaster." Many of the metaphors and images that I heard at the church during both healing and message services, are presented in Table 6.1. Images are listed only once, even though they may have been used several times. When given, the medium's or healer's interpretations accompany the image. Some of the images, when vocalized, express intended purposes, such as "healing blue light." Others seem to be more generally applicable, as in "the colour red for strength."

The Alternative Medicine Clinic also relies on imagery and guided visualization for healing. The clinic puts to use the idea that "there is a magic of metaphoric resonance, which helps make symbolic sense for the cures" (Baldwin 1992: 182). During my initial consultation, for instance, Dr. Charanap suggested a meditation for me to do on my way to work every day. It was to visualize sending out healing energy in the form of light to the people I saw. This, he said, would help me to "centre" (feel calm, balanced and in control) for the day ahead. Meditation in some form is often recommended at the clinic. In addition to this, one of the clinic's main therapies, entrainment, is based on guided imagery.

Many of the people at the clinic and the church are convinced of the healing power of imagery. All of the interviewees meditate on a daily basis. Visualization of healing images is often described as a "direct" connection between mind and body. Suzanne Murphy practices it in one of her healing techniques: "Telepathy is where I visualize you dancing, walking, whatever. I see you whole. That's one of the strongest

healing techniques in the world, visualization. Because that's what your subconscious understands -- pictures, not words."

Image	Interpretation
balancing on a rolling log	trying to do too much
black box that changes to crystals	transformation, lightening of constraints
cakes that won't rise	lost your "air"; feel deflated
comet	huge amount of energy behind you
figure skating	able to do something
flamenco dancer trying to dance	not able to creatively express self
giant ear with little birds flying in	spirit has much to tell the person
glider swing on a old porch	put troubles and worries of this world in perspective
healing white light	uninterpreted
healing blue light	uninterpreted
hot air balloon	need to solidify things
jumping off a cliff	leap of faith
kite	it gets easier as it gets closer
kitten	comfort
large white Easter lily	uninterpreted
little envelope	you will receive important information
lost hearing	speak up for yourself
messy car	chaotic life
metronome	meditative state; let it take care of itself
mountain viewpoint	uninterpreted
open plain with a sunset	you can see your options
question mark over your head	a big decision made up of smaller questions; take one at a time
ray of sunshine through a cloud	things are getting easier
reddish brown bundle of energy, pulsating with golden rays behind it	should focus on this image
roadrunner	things will flow
rolling up your sleeves	the process has begun
ruler placed under the chin	to lighten up
running white water rapids	pace is too fast, but is exciting
spring flowers	a sign of friendship and protection from the spirit
treadmill	daily grind is tiring you; not getting anywhere; need rest
vase with roses	each stem stands for one of the paths you've chosen; all together means everything has blended together beautifully
warm light	presence of Spirit
white tornado	need to focus your energy
wise old owl	think of your spirit guide as such

Table 6.1 Images and their Interpretations from the Church of Spiritualism

The Creation of Meaning in Lives and Stories

Geertz (1973: 5) believes that cultural analysis should be "not an experimental science in search of law but an interpretive one in search of meaning." In an attempt to understand another facet of meaning in illness experiences, I examined my life history interview transcripts as "illness narratives" (Kleinman 1988). What can be gleaned from these stories is the multitude of ways in which people who tell them infuse their lives with meaning in order to a) make sense if the experiences described and b) recount a compelling tale. As Steffen (1997: 106) relates it, "[t]he illness account becomes a narrative of lived experience to the benefit of everybody, and the narrator's experience of pain and suffering loses its meaninglessness and gains value as collective knowledge." There are many ways that this can be accomplished, several of which will be explored here.

In many ways, the telling of a life history can be viewed as myth-in-the-making. Some might question whether a life story can be a myth, and I would answer that it can, at the very least, have myth-like qualities. Campbell's (1968: 4) discussion of "creative mythology" is helpful: "the individual has had an experience of his own -- of order, horror, beauty, or even mere exhilaration -- which he seeks to communicate through signs; and if his realization has been of a certain depth and import, his communication will have the value and force of living myth . . .." Such "living myth" is not meant to adhere closely to "historical circumstances but rather significance and validity in the creation of a life story" (Kleinman 1988: 51). The following is an example of the creation of a living "myth."

An Extraordinary Happening

"Extraordinary experiences tend to challenge one's conceptions of reality in the sense that normal ways of classifying perceptual data are no longer adequate and the boundary between the real and the imaginary is blurred" (Young and Goulet 1994: 8).

Laural Berman is both a Spiritualist and Alternative Medicine Clinic client in her late fifties. She is divorced and lives a quiet and comfortable country life. But only nine years ago, she knew she would die. She had been ill for months, and now she was in bed, unable to eat or drink. A few weeks earlier, she had been on an extended business trip with her husband. What transpired in those weeks is indeed mythical.

> It was a blistering hot night, but I was hypothermic. I had on a toque and mitts, but I could not get warm. I was just freezing. I realized that my thermostat was just gone. Everything had shut down, I had not been able to eat. My throat simply didn't work. So we stayed up half the night figuring out how we could get home the fastest way, and we did, we drove straight through. By this time I was just in this little spiritual cocoon, and the thunder and lightning began; it was an outrageous electrical storm, and I was in direct communication, I had never been in such a remarkable close connection with these entities who were now speaking to me. They began explaining things to me like perfect love cast without fear. Suddenly they made me realize that it was this divine love, if I simply opened to it enough, I would not be fearful. And I suddenly realized this and I experienced the most beautiful shower, it was just like being in a glow of love, and it was just a remarkable journey for me. I now think that's when I let go of my body. That's when I think my body had permission to stop.
>
> That night we figured out how to get home quickly, and I phoned the homeopath along the way and told her what my condition was, and she said she would be waiting for me when I got home. It would have been right about this exact week, nine years ago. So for the next weeks, I just deteriorated. By then I

weighed eighty-five pounds. And the thing that alarms me now is that I was so obviously leaving my body, and nobody was doing anything. Sometimes you can almost disappear because everyone thinks that someone else is looking after you. It was impossible to be in the hospital because I was sensitive to all those chemicals. A friend came to my home, which was, I now know, what really saved me. My husband was desperately afraid but he just resorted to drink. I, on the other hand, was blissful because I was in this wonderful connection. I wasn't afraid. So this friend showed up and she said that somebody has to intervene, and she recommended a holistic nurse.

The next night was August 1 and coming up on August 2. And in the wee hours of that night, this spiritual connection woke me up. It was four in the morning. I looked at the clock, and I was just drifting in and out of blissful here and blissful there. It woke me up and said, "You need to make a choice." It wasn't so many words, it was a feeling rather than words, but it was very real. "You need to make a choice," it said. "The vehicle is becoming depleted, and steps need to be taken." The message was: I could leave the body, I had permission, and all my life I had wanted not to be here. So this was, in effect, an answer to a prayer. But if you decide to stay, your life will never be the same. You will never be alone, your life will never be as hard, and doors will begin to open to you. It was a deal I couldn't pass up. I'd never had promises like that. And I believed it, and I suddenly knew that I wanted to live. And so, I sat up in bed, and I was so weak, and I began to pound on the mattresses with my fist: "I choose life! I choose life! I choose life!" That was at four o'clock, and at seven o'clock, this wonderful nurse arrived. That was the turning point, the beginning of the life that I now have.

This compelling narrative of Laural Berman's near-death experience does much more than merely fascinate the listener. It enables her to order her experience in her own mind, and to realize just how symbolic the related events were.

Treatment of time in the narrative shows where the highly meaningful, emotionally charged turning points are. At two separate points (the night they made the decision to go home and the night of the near-death experience), time slows to a virtual halt. This temporal condensation creates an air of surrealism and deep meaning. It demonstrates the significance of the event to the listener, and reinforces it for the teller. It might even reflect how time seemed to be creeping along when the events actually transpired. And immediately after the turning points, time speeds up again. Temporal manipulation is applied again when Laural mentions the approaching nine-year anniversary of the narrated events. This is a device of juxtaposition that places *her now* alongside *her then*; the tension between the two indicates how far she has come and how much she has improved. It adds wonder.

Laural's portrayal of her struggle between two opposing forces is archetypal. The scene is set with the thunderstorm, a symbol in Western culture of power and supernatural forces. In theatre, lightning denotes a bracketing off of reality, whereby the unreal is given license to appear. The spirits are thus empowered to enter. A contest as old as nature ensues. On one side is the lure of death. Laural wants to leave her material body, but her spirits offer her an ultimatum, a "deal" that she cannot reject. She wavers, but she chooses life. The phrase "I choose life" is her vigorous affirmation.

Treatment of time and describing a life or death struggle are two ways in which meaning is created in this illness narrative. There are others. Metaphor is used to evoke parallels between the journey that is a business trip and that which is an illness. Speaking of her illness in terms of "letting go" of her body and disappearing are compelling turns of phrase meant to show her proximity to the borderland between life and death. Her

isolation and "blissful" detachment are emphasized, blissfulness being illustrated persuasively by images of being "showered" in a "glow of love."

Everything in the narrative leads up to the moment of ultimatum between life and death. Hyperbolically, she states that, "all my life, I had wanted not to be here." Now, finally, she was being given the chance to remove herself. Or choose a better life. Then characters representing salvation appear -- not only the ethereal spirits but also the somewhat more corporeal holistic nurse. Interestingly, her husband is *not* represented as a helpful figure at this momentous time. Reflecting upon this, Laural concludes that it was right then that her marriage began to truly crumble, but that it was also the point at which her independence began to soar. She was no longer playing the imposter; she had elected to be in her body, after all.

Conclusion

We have seen in this chapter how important teleological reframing and therapeutic imagery are at both the church and clinic. We have also explored a few ways in which meaning is created in life history and illness narratives. These processes are not unique to illness nor to complementary medicine, but they do serve to increase the power of the beliefs that people subscribe to when they are ill. We can see that the illness experience incorporates much more than searching for the alleviation of physical or mental symptoms. It is also about the erection of a sphere of meaning around the experience through reframing, imagery, and rich narration. Further research could shed light on more ways in which people use the techniques and devices described here in their everyday lives; ways in which the profane is made sacred.

CHAPTER SEVEN

CONCLUSION

It is true that health seeking behaviour is often determined by *what works*. But another very important factor in making such decisions is *what makes sense*. We have seen that these two things are actually closely aligned but vary, depending upon such factors as epistemology, world view, and experience. As these change, often as the result of an emotionally forceful or proleptic experience, so do both private and shared beliefs and, correspondingly, views of illness. We have looked at such changes, deemed "progressions," in both individuals and institutions, and compared the ethnomedical categories of affliction, diagnosis, etiology, and treatment in different healing environments. We see great variety in perceptions about what things are judged to warrant curative steps, what causes illness, and what should be done to treat an illness. These beliefs represent a microcosm of an individual's entire belief structure, mirroring their convictions regarding everything from the causal, cosmological, and ontological to the magical, ethical, and aesthetic. Of course, the beliefs revealed within these categories represent choices among many. A benefit to having so many choices available is an increased likelihood of finding one that suits one's needs. But, this comes with a possible loss of the depth and consistency of values that are stored within established traditions. With illness, the impetus to shift beliefs lies in the search not only for alternate treatments but also for new paradigms that explain and legitimate the illness experience.

Philosophical beliefs at the Alternative Medicine Clinic and Church of Spiritualism parallel one another. Both hold holistic views of illness and treatment. It

was expected, though, that the Church of Spritiualism would place more emphasis on the spiritual aspect of holism than would the modern and highly technological Alternative Medicine Clinic. This was true, but the difference was not as great as was expected. People go to the church with hopes of alleviating a much broader range of complaints than do those who seek healing at the clinic. Perceived affliction at the church, for example, commonly includes such things as distress at having to make a difficult decision or healing a relationship. The afflictions at the clinic, by contrast, more closely resembled those that would be encountered in a biomedical office. They were more physical and as likely to be of natural as supernatural, spiritual, or emotional causation. To dig a little deeper, though, was to uncover a very spiritual foundation for diagnosis and treatment at the Alternative Medicine Clinic. Ultimate causal beliefs are common at both church and clinic. "Core issues," a phrase used at the clinic to describe ultimate causes of illness, seemed to always include emotional and spiritual as well as physical factors. This deeply impacts treatment, because the core issues are attended to very carefully. In addition to the specific compensators (diagnosis and treatment) offered, the clinic actually provides its clients with general compensators (an entire worldview) akin to those usually found in religious systems (Stark and Bainbridge 1985).

In our discussion of the relationship between complementary and conventional medicine, we observed that access to alternate choices is often littered with obstacles. Many societies do not make it easy for their members to inhabit the fringe, and North America is no exception. And although we are in some ways progressing towards more equality among healing modes, there is still an extreme disparity of power between conventional biomedicine and alternate healing modalities. But the effects of this

disparity may be predicated on whether or not the conventional perceives the unconventional as a competitor. Because the clinic offers its services to the same population as does biomedicine, it is therefore viewed as a threat to biomedicine. On the other hand, the healing services offered by the church can more easily be disregarded by biomedicine. I speculate that this may be because the church poses neither an economic nor an epistemological threat to biomedicine's hegemony. As well, church-based healing may be more easily dismissed because it is thought of as belonging to an entirely different domain, that of religion, than scientific biomedicine. But despite the ability of biomedicine to more easily ignore spiritual and religious healing, it remains that North American health care's pecking order is frustrating and even feels discriminatory to those who have found relief in alternatives. These feelings occur, for example, when people must pay out of their pockets for a relatively inexpensive homeopathic remedy from which they obtain relief, but are covered by insurance for an expensive drug with side effects and poor results. The perception is of a system that is not even handed, especially to people coping with chronic ailments.

This is not to say that every therapy should be automatically endowed with a status equal to biomedicine, but to suggest that more research, done from various perspectives, is needed to assess the unique values of each. Ideally, the status of ethnomedicines would be achieved through criteria of what works and what makes sense, rather than being arbitrarily ascribed by those holding power. And while there is value in government regulation in certain circumstances, a health care system more open to various therapies might incline individuals to assess the merits and shortcomings (and sometimes dangers; see Randi 1987) of particular techniques, drugs, surgeries, herbs, and

manipulations (Kaptchuk 1996: 972; Micozzi 1997). This would sharply contrast with the current heavy reliance on economically, as opposed to academically, driven "experts" to decide for us.

Intimately related to whether something makes sense to an individual is its potential for creating meaning. We have seen how the discourses at the Church of Spiritualism and the Alternative Medicine Clinic can metaphorically transform a seemingly pointless and negative experience into something potently meaningful. Personal beliefs thus serve to reframe an illness experience as well as provide therapeutic options. The embodiment of particular beliefs is illustrated in narrative accounts that highlight reliance on belief during times of distress. When all seems lost, people turn to the support of their most cherished beliefs.

While the above may not be an earth shattering revelation, one more surprising outcome of this study was the prevalence of religious frameworks among those most cherished beliefs. Not only did the Alternative Medicine Clinic incorporate more spiritual elements than were expected, but interviews and casual conversations I engaged in throughout the research period suggest that belief in a guiding principle of some type is actually quite common in North American society. The guiding principle was often envisioned as an entity to which we all belong and that connects everything in the universe together. The thoughts, actions, and "energies" of one are thus thought to affect and be affected by everything else. One would think that our secular and science oriented education would smother any magical and supernatural beliefs held by people. Statements such as "things always happen for a reason," and "if you expect it, it will happen," heard often during the study, indicate otherwise.

As with many studies, there are particular circumstances that have made this what it is and not something else. A comprehensive treatment of the roles that beliefs play in healing and medicine could include an almost infinite array of possible subtopics. I have chosen the ones included here because they seem to best approximate the themes that were important to the people within my field communities. But certain things that seemed to simply evolve without my direction, such as the inclusion of a disproportionate number of women and the high incidence of autoimmune disorders, have shaped the outcomes of this study.

Chronic fatigue immune deficiency syndrome, fibromyalgia, and multiple chemical sensitivities are all very real, tangible syndromes with physical causes and painfully physical symptoms. Thankfully, we seem to be moving beyond the tendency to view women who complain of generalized and chronic pain and exhaustion as malingerers and hypochondriacs (Boston Women's Health Book Collective 1998: 600-601; Kleinman 1986: 156). It must be said, though, that the poignancy of framing illnesses such as these in a metaphoric light is as striking as it is frightening. The occurrence of autoimmune disorders is much higher among women than men; a full 75% of cases occur in women (web site of American Autoimmune Related Diseases Association, http://www.aarda.org/women.html). Rosenbaum and Susser (1992: 2) cite that in the United States, "70 percent of CFS patients are educated and affluent Caucasian women in their childbearing years." Why is this? More research needs to be done, in social as well as medical science. Given these demographics, a genetic component to the illness is probable. What other factors might be involved? Many of those diagnosed with autoimmune diseases are trying to take care of elder parents, husbands, and children, run

a household, and pursue a career outside of the home. And although this society is beginning to concede the entitlement of a woman to both family and career, there is also a strong expectation for her to carry the full load of these commitments. These mixed messages produce a "catch-22" for women that must have an impact on their health.

We have said that the roles of belief in healing are many, and that belief's malleable nature can be beneficial. Beliefs can serve as coping mechanisms that help one to acquire, maintain, or regain a healthful attitude in the face of illness. Studies that explore the relationship between optimism and outcome in disease show that people with positive outlooks fare much better than those harbouring negative expectations (Hood et al. 1996; MacDonald 1998; Scheier et al. 1999; Segerstrom et al. 1998). This phenomenon means that beliefs have the potential to heal the mind, the spirit, and the body by mitigating the social experience of illness as well as the pathophysiology of disease. They give a person resiliency in the face of hardship. We can say then that belief is the point of departure in a journey called illness. It determines the route that one is about to embark upon but, because belief changes, can also redirect one's footsteps to a more healing path.

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Appendix A: Interview Guide

The following is a list of questions or topics to be covered in an ethnographic interview. the aim of these questions is not to control the answers that are given, but rather to enable the interview participant to tell their story. Therefore, these questions provide a guideling to facilitate the interviewer and their use will increase comparability across interviews.

1. I want to understand what illness means to you. Since I don't know anything about you, I would like for you to first tell me a little about who you are.
   [Prompts: where you were born, where you grew up, where you went to school and for what, siblings, parents, marriage, children, education, occupation].

2. Now that we have looked at your life story, can you describe how illness has affected your life? I want to leran the story of your experience of your illness(es).

3. Because this is a study of the roles that belief plays in healing, I would like to learn more about your beliefs. What do you consider to be your most important beliefs? Why are your beliefs in ___ important to you? Do these beliefs affect you in your day-to-day life? In what ways?

4. Have your personal beliefs made a difference in your experience of being sick? Do your beliefs in ___ make a difference in your experiences with healing? Can you give an example of the way in which your beliefs have influenced you experiences with illness and healing?

5. What things do you think cause illness? What do you think caused your illness? In your experience, what do you think are the main things that cause or create healing? What do you do for health and healing?

Appendix B: Interview Guide for Practitioners

1. How would you describe your role in the church/clinic? (What are some of the things you do here?)

2. I am interested in understanding where your knowledge comes from. Can you describe the training or education that led you to become a [the role they describe above]?

3. What do you believe are the causes of illness? (Repeat this question later, recapping what was already said).

4. I want to understand if people give special meanings to experiences such as illness. What kinds of things can illness mean to people (if anything), including to yourself?

5. I would like for you to describe two or three "typical" cases and their treatments. You can use single past cases or compile several into one "typical" case.
(Key Points: How was the illness described and presented to the practitioner by the client or patient? How was the diagnosis made, if at all? How was the patient treated? What was thought to cause the illness? What meanings does the illness hold? what was the patient told by the practitioner? Which, if any, of the practitioner's beliefs were imparted to the patient?)

Appendix C: Participant Profiles

Katherine Anderson: A 42 year old upper middle-class sufferer of fibromyalgia, Katherine atttends the alternative medicine clinic on a regular basis. She also maintains her and her second husband's home. Katherine's history includes fibromyalgia, chronic fatigue immune deficiency syndrome, depression, and infertility.

Leon Bell: Leon Bell is a 38 year old healer and medium at the Church of Spiritualism. He organizes and runs the great majority of healing activities at the church. He is married to Constance Bell, a member of the church who also practices some healing. Leon is a stock market analyst who "doesn't' get ill; my struggles aren't physical."

Laural Berman: 60 years old, Laural lives in a beautiful, serene setting. She is a member of the upper middle-class, retired but financially independent. She is divorced and has three sons. Her medical history indicates severe depression, post-partum depression, addictions, cancer, and most recently, an auto-immune complex of arthritis, fibromyalgia, chronic fatigue immune deficiency syndrome, and environmental illness.. She has recently started going to the Alternative Medicine Clinic for therapy.

Barry Charanap: The founder and director of the Alternative Medicine Clinic, Dr. Charanap is a Canadian trained medical doctor. He also practices traditional chinese medicine and Indian ayurveda.

Jeremy Davies: Dr. Davies is a practitioner of functional medicine at the Alternative Medicine Clinic. He is a Canadian trained medical doctor who practiced sports and occupational medicine before arriving at the clinic. Jeremy sees his role at the clinic as a consultant who "explains a different paradigm in htinking about healing and illness." He himself suffers from chronic fatigue immune deficiency syndrome. He is divorced.

Andrea Jergens: A 32 year old former industrial mechanic, Andrea Jergens is unable to work due to her condition of multiple chemical sensitivities, also known as environmental illness. She keeps regular appointments at the Alternative Medicine Clinic. She is unmarried and lives in her childhood home with her mother. She is struggling financially.

Mary Kendrick: Mary is a 58 year old upper-middle class, married mother of three grown sons. Formerly an accountant for a large company, Mary suffers from chronic fatigue immune deficiency syndrome and injuries sustained during several traumatic accidents. Her treatment regimen includes acupuncture, chiropractic, and physical therapy. She attends Alternative Medicine Clinic regularly.

Suzanne Murphy: Suzanne Murphy, 32 years old, is a Spiritualist healer as well as suffering from insulin-dependent diabetes mellitus. Married and divorced, she now has a common-law spouse with whom she lives in a small apartment. They have no children. Suzanne, and sometimes her husband as well, attend the Church of Spiritualism on a regualar basis. She is a professional healer and psychic, subsisting on a very modest income.

Appendix D: Informed Consent Form

Harnessing the Healing Power:
The Role of Belief in Medicine and Healing

Investigator: Bonnie Larson
Funding Agency: University Research Services Granting Agency

This consent form, a copy of which has been given to you, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Please take the time to read this form carefully and to understand any accompanying information.

The purpose of this study is to investigate the role that belief plays in healing. You have been contacted because of your involvement in a complementary or non-traditional form of healing.

Your participation in this study will involve an interview with a length of between two and six hours. During this interview, you will be asked to tell stories about your beliefs as well as your experiences with health and illness. You will also be asked questions about what you think causes illness and what illness and wellness mean to you.

All information gathered from this interview, including any tape recorded information, will be stored in confidential files (either on computer disk or paper) in a secure office. Your name will not be on any of the data gathered nor will your name or other identifying characteristics appear in the written version of the study.

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time. your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. If you have any further questions concerninig matters related to this research, please contact Bonnie Larson at (phone number and email address).

If you have any questions concerning your participation in this project, you may also contact the Office of the Vice-President (Research) (phone number and contact name).

_____ _____
Participant Date

_____ _____
Investigator Date

A copy of this consent form has been given to you to keep for your records and reference.