Zeitschrift für Medizinethnologie
Journal of Medical Anthropology

Curare

Curare 42 (2019) 3+4

Ästhetiken des Heilens. Arbeit mit den Sinnen im therapeutischen Kontext

Aesthetics of Healing. Working with the Senses in Therapeutic Contexts

Impressum | Imprint

CURARE. ZEITSCHRIFT FÜR MEDIZINETHNOLOGIE 42 (2019) 3+4
Herausgegeben von der Arbeitsgemeinschaft Ethnologie und Medizin (AGEM)
ISSN 0344-8622 ISBN 978-3-86135-848-0

CURARE. JOURNAL OF MEDICAL ANTHROPOLOGY 42 (2019) 3+4
Edited by the Association for Anthropology and Medicine (AGEM)
ISSN 0344-8622 ISBN 978-3-86135-848-0

Herausgeber im Auftrag der AGEM e. V.
Editor-in-Chief on behalf of AGEM e. V.
Ehler Voss (V.i.S.d.P.), ehler.voss@uni-bremen.de
www.agem.de, curare@agem.de

Redaktion | **Editorial Board**
Janina Kehr (U Bern), Helmar Kurz (U Münster), Mirko Uhlig (U Mainz), Ehler Voss (U Bremen)

Postadresse | **Postal Address**
Redaktion *Curare*, Postfach 10 04 04 , D-57004 Siegen

Wissenschaftlicher Beirat | **Scientific Advisory Board**
Karl Baier (U Wien), Josep M. Comelles (URV Tarragona), Claus Deimel (Hamburg), Alice Desclaux (U Montpellier), Katarina Greifeld (Frankfurt), Antonio Guerci (U Genova), Mihály Hoppál (Budapest), Sushrut Jadhav (UC London), Michi Knecht (U Bemen), Ruth Kutalek (MU Wien), Danuta Penkala-Gawęcka (U Poznań), Giovanni Pizza (U Perugia), Bernd Rieken (SFU Wien), William Sax (U Heidelberg), Hannes Stubbe (U Köln)

Ehrenbeirat | **Honorary Board**
Hans-Jochen Diesfeld, Horst H. Figge, Dieter H. Frießem, Wolfgang G. Jilek

Begründet von | **Founding Editors**
Beatrix Pfleiderer (†), Gerhard Rudnitzki, Wulf Schiefenhövel, Ekkehard Schröder (Editor of Curare 2001–2017)

Verlag und Vertrieb | **Publishing House**
VWB – Verlag für Wissenschaft und Bildung, Amand Aglaster,
Postfach 11 03 68, D-10833 Berlin, Germany
Tel. +49-[0]30-251 04 15, Fax: +49-[0]30-251 11 36,
www.vwb-verlag.com, info@vwb-verlag.com

Bezug | **Subscription**
Der Bezug der *Curare* ist im Mitgliedsbeitrag der Arbeitsgemeinschaft Ethnologie und Medizin (AGEM) enthalten. Einzelne Ausgaben können über den Buchhandel oder direkt über den Verlag bezogen werden.
Subscription to *Curare* is included in the membership fee of the Association for Anthropology and Medicine (AGEM). Single copies can be purchased from booksellers or directly from the publisher.

Layout und Typografie | **Layout and Typography**
Nicolai Schmitt, nicolai.schmitt@mailbox.org

Umschlaggestaltung | **Cover Design**
Troppo Design, www.troppodesign.de

Schriften | **Fonts**
Source Serif & Source Sans (Paul D. Hunt).

Begutachtungsverfahren | **Peer Review Policy**
Alle eingesandten Forschungsartikel werden nach einer positiven Evaluation durch die Redaktion einer Begutachtung im Doppelblindverfahren unterzogen. Jeder begutachtete Artikel enthält am Ende eine Information über das Datum des Eingangs und der Annahme des Manuskripts.
After a positive evaluation by the editorial board, all submitted research manuscripts will be reviewed in a double-blind procedure. Each peer-reviewed article contains information at the end about the date of receipt and acceptance of the manuscript.

Umschlagbild | **Cover Picture**
Fotografische Vorlage des Gemäldes „Hoffnung“ (2009; Acryl auf Leinwand, 100 x 70 cm) der Berliner Anthropologin und Künstlerin Inga Scharf da Silva innerhalb ihres Zyklus „Die Suche“ (2009–2010; siehe *Prolog* in dieser Ausgabe).
Photographic template for the painting “Hope” (2009; acrylic on canvas, 100 x 70 cm) of Berlin’s anthropologist and artist Inga Scharf da Silva as part of her cycle “The Search” (2009–2010; see the *Prologue* in this issue).

curare

ZEITSCHRIFT FÜR MEDIZINETHNOLOGIE
JOURNAL OF MEDICAL ANTHROPOLOGY

hg. von der Arbeitsgemeinschaft Ethnologie und Medizin (AGEM)
ed. by the Association for Anthropology and Medicine (AGEM)

VOL. 42 (2019) 3+4

Editorial

This issue presents the results of the 32nd conference of the Association for Anthropology and Medicine (AGEM), which took place from May 24 to 26, 2019 at the University of Münster under the title "Aesthetics of Healing: Working with the Senses in Therapeutic Contexts." The thematic focus was on the sensory formation and perception of therapeutic measures as well as the aesthetic communication of these experiences as an interaction of all actors involved in the healing process. The conference was international, interdisciplinary, and intersectoral, which the contributions to this issue reflect with their different perspectives, approaches, and topics. We would like to take this opportunity to thank the Department of Social Anthropology and the International Office of the University of Münster for their cooperation and support.

The contribution in the forum of this issue was written independently of the conference, but supplements the thematic focus by focusing on the fuzziness of the boundaries between art, religion, and medicine as a classical topic of medical anthropology. Through biographical interviews, the contribution reflects on the lives of Horst and Donata, a German-Italian couple from Cologne, who were thrown off track by the incursion of the invisible and intangible when Donata began painting pictures at the behest of the dead. The text offers insight into the resulting struggle for sovereignty through an ongoing process of individual and social negotiation of normality in different cultures. The paper highlights the precarious status of the boundaries between illness and mediumism, worldview and healing, and suggests reading the text as an art-historical commentary on the reprinted images.

Janina Kehr, Helmar Kurz, Mirko Uhlig,
Ehler Voss

THEMATIC FOCUS
SCHWERPUNKT

Aesthetics of Healing

Working with the Senses in Therapeutic Contexts

EDITED BY
HELMAR KURZ

Eigen-Sinnig *With my own Senses*

Prologue

INGA SCHARF DA SILVA

Stille und Wissen suchend stoße ich im Grimm-Zentrum, der Hauptbibliothek der Humboldt Universität zu Berlin, auf eine Beschriftung von sich dicht in den Regalen drängenden Büchern, die unter der Klassifikation „LB 50000ff Sklaverei, Leibeigenschaft, Hörigkeit" zusammengefasst sind. Diese Verschlagwortung erweckt in mir sofort eine gedankliche Reaktion auf meine gerade fertiggeschriebene Dissertation über postkoloniale Erinnerungspraxis in der sakralen Globalisierung, in der ich im Sinne eines situierten Wissens (cf. Haraway 1988) und der Transparenz meiner Forschung auch auf meine Vorfahr*innen als Bäuerinnen und Bauern vom Land sowie meine Position als sinnesbehinderte Forscherin eingegangen bin. Der Aspekt der Ahn*innen war für diese Forschung von Bedeutung, da die von mir beforschte brasilianische Religion *Umbanda* in Folge des transatlantischen Handels mit versklavten Menschen entstanden ist, in der die Kulturen und die Religionen von verschiedenen afrikanischen Völkern eine wesentliche Rolle spielte (cf. Scharf da Silva 2021).

In der *Umbanda* wird Trance als Annäherung an das Heilige praktiziert. Indem das Ich-Bewusstsein ausgeschaltet wird und abwesend wird, ist der Mensch offen für andere Formen der Wahrnehmung. Diese Markierung einer Fremdbestimmung und des Verlusts an Kontrolle über den eigenen Körper zeigt sich auf eine jeweils sehr eigene und auch unterschiedliche Art und Weise in der Situiertheit von versklavten und als „anders" betitelten Menschen wie auch in der losgelösten und sozusagen befreiten Situation der religiösen Trance. Dieser Verlust der eigenen Identität wird als Gegensatz zur westlichen Vorstellung vom autonomen Menschen angesehen. Indem die Sklav*innen von ihren Geistern in Besitz genommen und durch Trance physisch besetzt wurden und eine „dramatische Verschiebung des alltäglichen Bewusstseins" (Johnson 2014: 3) erlebten, wurden sie von den Sklavenhaltern als unkontrollierbar wahrgenommen (*ibid.* 1ff.), weil sie ihrer eigenen Seele Ausdruck verliehen.

Meine Vorfahr*innen werden nicht als „Sklav*innen" oder „Leibeigene" bezeichnet und dennoch war es damals selbstverständlich, dass der Grundbesitzer die jungen Mädchen der ansässigen Ländereien vergewaltigte und sie derweilen davon schwanger wurden und also Kinder großzogen, die unter Gewalt und Ohnmacht gezeugt wurden. Wer dies nicht hinnahm und Ende des 19. Jahrhunderts als 16-Jährige davor aus der Altmark über die Elbe nach Berlin floh, war meine Urgroßmutter Hermine. Und scheinbar hat sie mir etwas mit auf den Weg gegeben, was in der kleinen Untertitelung der Bibliotheksbücher erkannt wurde, indem der Begriff der „Hörigkeit" neben dem der „Sklaverei" steht, da ich meine andere Wahrnehmung der Welt als mir zugeschriebene „Schwerhörigkeit" als bare Münze nehme und sie wertend umdrehe, als „Schwere Hörigkeit" (cf. Scharf da Silva 2016). Natürlich erkenne ich, dass es sich eigentlich um falsches Deutsch handelt, denn es müsste wohl „schwerhörend" statt „schwerhörig" heißen, aber ich finde es äußerst sympathisch, dass mir so frei weg ein eigenes Denken angedacht wird. Und das nur, weil ich nicht immer konform antworte und mir in der dialogischen Begegnung manchmal einfach etwas Eigenes zusammenreime, was ich nicht gut gehört habe. Darüber hinaus frage ich mich, wie meine eigene spirituelle Verortung innerhalb einer afrodiasporischen Religion und meine damit zusammenhängende Auseinandersetzung mit Sklaverei hiermit in Verbindung steht.

Mein Gemälde „Hoffnung" von 2009 (Acryl auf Leinwand, 100 x 70 cm) erzählt von dieser Widerständigkeit und Eigensinnigkeit gegen eine marginalisierte Position in der Gesellschaft (sei es im Fall meiner Urgroßmutter als armes Bauernmädchen oder in meinem Fall als hörbehinderte Frau), die aus meiner über Krankheiten manifestierten Krise entstanden ist. Diese Krise, obgleich tatsäch-

lich körperlich und bedrohlich, handelte von der Unsichtbarkeit des Wunsches nach Verkörperung der eigenen geistigen Welt (von lediglich erzählter und nicht repräsentierender Geschichte und von Wahrnehmungen) und dem Erstarrtsein in einem durchaus auch angepassten hörenden und hörigen Leben.

Mir sind auf den schwarz-weiß gemalten Bildern des Zyklus „Die Suche" (2009/2010) in Umbra gebrannt, Preußischblau und Weiß nicht nur mein Gehör reduziert, wie ich es mein Leben lang durch meine Behinderung gewohnt bin, sondern auch sinnbildlich meine Augenkraft durch das schwarze, umbundene Tuch um den Kopf genommen worden. Diese mich selbst darstellende Frau auf der Leinwand breitet mir aus der Vergangenheit heraus ihre Arme aus und streckt mir ihre geöffneten Hände hoffnungsvoll entgegen. Rottöne schimmern durch die kontrastierte Oberfläche ihrer schwarzen Kleidung hindurch und drehen zarte Kreise im Hintergrund.

Um eine lebensbedrohliche Krankheit in der liminalen Grenzsituation von Leben und Tod mit Chemotherapie und Operationen zu bewältigen, ging mein Blick nach innen. Doch sind es die suchenden, empfangenden, aktiven und vermittelnden Arme, die die Begrenzungen der vorgegebenen Leinwand und den vorgefertigten sozialen Rahmen des Individuums intuitiv wegzudrängen scheinen, die vom Ort des Rückzugs meiner Krankheiten wieder in die Welt zurückfanden.

Genau diese ambivalenten Momente der Beklommenheit und des Wunsches nach Bewegung waren der Ausgangspunkt für mich, eine Bildsprache zu finden, indem ich mich in meinem Atelier filmen und in Sequenzen fotografieren ließ. Meine Methodik zielte also weniger auf eine repräsentierende Wirklichkeit hin, in der die Betrachter*innen ein Ergebnis konsumieren, als vielmehr auf eine dialogische, bildliche und transformative Darstellung über den eigenen Körper, die performativer Forschung eigen ist (cf. Ploder & Stadlbauer 2013). Dieser Prozess des Ein- und Auswickelns mit und aus Tüchern und Bändern fühlte sich für mich albern und lückenhaft an, so gar nicht beweglich, aber es war der Anfang davon, aus der Stille und Versteinerung der eigenen Präsenz zu Bildern zu finden. Erst während des Malens konnte ich mich innerlich lösen und durch die Weichheit der sinnlich dicken Farbe auf der Leinwand zu einer gefühlten Reflexion finden.

Malen ist für mich ähnlich wie in Trance zu fallen. In diesen Momenten des Kontrollverlustes zeigt sich die Durchlässigkeit des eigenen Selbst und die Möglichkeit, sich von Befangenheit, Stereotypisierung und Begrenztheit zu distanzieren und einen neuen Handlungsspielraum zu finden, indem die eigenen Sinne entgrenzt werden. Diesen Prozess des inneren Loslassens bezeichnete der italienische Ethnologe Ernesto de Martino für die Trance-Erfahrung in seinen Forschungen im apulischen Tarantismus in Süditalien als eine „Krise der Präsenz" (cf. de Martino 2016). De Martino erkannt den Zusammenhang von Tranceerfahrungen und Individuation schon in den späten 1960er Jahren und „verstand die von ihm beobachteten Rituale als Weg, um durch die Partizipation an liminalen Zuständen Handlungsmacht zu gewinnen" (van Loyen 2016: 10). Indem ich mein Ichbewusstsein und meine Sterblichkeit vergesse, komme ich im Prozess des Malens zurück zu mir selber, zur eigenen Gesundheit und Lebendigkeit. Als schwer Hörige mit meinen eigenen Sinnen. *Eigensinnig.*

Searching for silence and knowledge in the Grimm Center, the main library of the Humboldt University in Berlin, I came across a caption of densely packed books that are grouped under the classification "LB 50000ff Slavery, serfdom, bondage." This indexing instantly awakened a mental reaction to my recently completed dissertation on postcolonial memory-practice in sacred globalization, in which I counted on my ancestor's identity as rural farmers and my own position as a handicapped researcher of the senses to produce a situated knowledge (cf. Haraway 1988) and ensure the transparency of my research. The ancestral aspect was critical for this research because the Brazilian Umbanda *religion (which I have been researching and practicing for years) emerged as a result of a transatlantic slave trade in which the cultures and religions of various African peoples played an essential role (cf. Scharf da Silva 2021).*

In the Umbanda *tradition, trance is practiced as an approach to the sacred. By eliminating ego-consciousness and becoming absent, the human being is open to other forms of perception. The marking of a foreign attribution and the loss of control over one's*

*own body manifests in a very particular and variant way in the situation of enslaved and "different" people as well as in the unbound, liberated situation of religious trance. Such a loss of identity is opposed to the Western idea of the autonomous person. By being possessed by their spirits and physically occupied through trance and experiencing a "dramatic displacement of the everyday consciousness" (Johnson 2014: 3), the enslaved were perceived as uncontrollable by the slaveholders (*ibid. *1f) because they gave free expression to their own souls.*

My ancestors are not referred to as "slaves" or "serfs;" however, as history documented, landowners commonly raped the young girls of their resident lands, who sometimes became pregnant and raised children procreated under violence and powerlessness. At the end of the 19th century, my great-grandmother Hermine did not accept this fate, but rather fled the Altmark to Berlin via the river Elbe as a 16-year old girl.

*Apparently my great-grandmother endowed me with a certain defiance of spirit. The adjacency of "bondage" (*Hörigkeit*) and "slavery" in the small subtiteling of the library books strongly resonated in me, as I interpret my deafness rather literally as a state of* schwere Hörigkeit *(*Schwerhörigkeit *is most directly translated as "heavy bondage" or "uneasy obedience"). Of course, I realize that this terminology is not linguistically correct; deafness should be termed "hard of hearing" (*schwerhörend*) rather than "hard of being obedient" (*schwerhörig*); however, I like to be described in terms of free and own thinking. The reason is that I do not always respond to the world's "realities" in a compliant way, and sometimes try to devise my own perceptions and conteptualizations in dialogical encounters that I have not heard well. I often wonder how my own spiritual involvement within an Afrodiasporic religion and my related reflection on slavery are connected to this quality.*

*My painting "Hope" from 2009 (acrylic on canvas, 100 x 70 cm) speaks of resistance and obstinacy (*Eigensinnigkeit*) against marginalization, be it of my great-grandmother as a poor peasant girl or in my own case as a hearing-impaired woman which has manifested itself as a crisis.* Eigensinnigkeit*, the German word for "willfulness," can be literally translated as "with its own senses." Though in fact highly physical and threatening, this crisis emerged from the invisibility of my desire to embody my own spiritual world (from merely narrated and unrepresentative history and of perceptions) and of my struggle against being petrified in a perfectly well adapted listening (*hörend*) and obedient (*hörig*) life.*

In my cycle "The Search" (2009/2010), the cloth around my eyes and the use of umber, Prussian blue, and white convey that in addition to my reduced hearing ability, to which I have adapted all my life, I have also symbolically lost my eyesight. The woman on the canvas opens her arms out of the past and reaches out to me with outstretched hands in hope. Red tones shimmer through the contrasting surface of her black clothes, swirling in the background tender circles.

As I struggled to overcome a life-threatening illness treated with chemotherapy and surgery, my gaze went inwards. However, the seeking, receiving, active, and mediating arms seem to intuitively push away the limitations of the given canvas and the prefabricated social frame of the individual, who is returning to the world from the place of retreat in the liminal realm at the border between life and death.

It was precisely these ambivalent moments of unease and desire for movement that were the starting point for me to find a visual language by filming myself and taking photos in sequences in my studio. Thus, my methodology was not so much aimed at a representational reality in which the observers consume a result, but rather at a dialogical, figurative, and transformative portrayal through my own body, which is a trait of performative research (cf. Ploder & Stadlbauer 2013). The process of wrapping and unwinding with and out of cloths and ribbons felt silly and incomplete to me, so not at all mobile, but it was the beginning of finding images out of the silence and solidification of my own presence. It was only during painting that I was able to detach myself and to find a perceived reflection through the softness of the sensually thick paint on the canvas.

To me, painting is like falling into a trance. This moment of loss of control reveals the permeability of one's own self and the possibility to distance oneself from bias (the German word Befangenheit*, bias, can be literally translated into "being caught"), stereotyping and limitations and find a new space for agency by unlimiting one's own senses. In his ethnological research on Apulian Tarantism in southern Italy, Ernesto de Martino described this process of release in the trance experience as a "crisis of presence" (cf. de Martino 2016). De Martino recognized the connection*

between trance and individuation in the late 1960s and "understood the rituals he observed as a way to gain agency through participation in liminal states" (van Loyen 2016: 10). By forgetting my own being and mortality in the process of painting, I return to myself, to my own health and liveliness as a person who is "schwer hörig" (in the German sense both hard of hearing and of being obedient) and with my own senses. Eigensinnig.

References

de Martino, Ernesto 2016(1962). Land der Gewissenspein. In Ulrich van Loyen (ed) *Der besessene Süden. Ernesto de Martino und das andere Europa*. Wien: Tumult: 238–254.

Haraway, Donna 1988. Situated Knowledge: The Science Question in Feminism and the Privilege of Partial Perspective. *Feminist Studies* 14, 3: 575–599.

Johnson, Paul Christopher (ed) 2014. *Spirited Things: The Work of 'Possession' in Afro-Atlantic Religions*. Chicago: University of Chicago Press.

Ploder, Andrea & Johanna Stadtlbauer 2013. Autoethnographie und Volkskunde? Zur Relevanz wissenschaftlicher Selbsterzählungen für die volkskundlich-kulturanthropologische Forschungspraxis. *Österreichische Zeitschrift für Volkskunde* 116, 3+4: 373–404.

Scharf da Silva, Inga 2016. Über die schwere Hörigkeit. In Uta Klein (ed). *Inklusive Hochschule: Neue Perspektiven für Praxis und Forschung*. Weinheim: Beltz: 236–243.

Scharf da Silva, Inga 2021. Trauma als Wissensarchiv: Postkoloniale Erinnerungspraxis in der sakralen Globalisierung am Beispiel der zeitgenössischen Umbanda im deutschsprachigen Europa. *In press*.

van Loyen, Ulrich 2016. Die Abenteuer der Geister: Ernesto de Martino und die Anthropologie des besessenen Südens. In *ibid.* (ed): *Der besessene Süden: Ernesto de Martino und das andere Europa*. Wien: Tumult: 7–19.

INGA SCHARF DA SILVA Dr. phil. is a cultural anthropologist and a visual artist. She studied ethnology and history of art at the Free University of Berlin (FUB), painting at the Berlin University of the Arts (UdK) and in Brazil at the University of Bahia (UFBA), the University of São Paulo (USP) and the University of Pernambuco (UFPE). Currently she is preparing for her postdoctoral research in the field of new religious movements and anthropology of the future. She has completed her doctoral thesis in September 2020 at the Humboldt University of Berlin, where she has been working as a research assistant since 2014 at the Institute of European Ethnology and has been funded by PROMI of the University of Cologne. In addition to ethnological field research on Umbanda and Afro-Brazilian mythology in Brazil and in German-speaking Europe, she is interested in sacral globalization, archive, contemporary spirituality, anthropology of the senses, material religion, migration, memory practices and autoetnographic research. As an artist with a studio in the Sigmaringer1art studio house (since 2008) of the Professional Association of Visual Artists (BBK) in Berlin she has focussed on painting, installation and artistic research, embracing figuative and ethnographic themes.

Atelierhaus Sigmaringer1art:
http://www.sigmaringer1art.de/portfolio/inga-scharf-da-silva,
Berufsverband Bildender Künstler BBK

Atelier 389, Aterlierhaus Sigmaringer1art, Sigmaringer Straße 1, 10713 Berlin
e-mail: inga.scharf@hu-berlin.de

WWU
MÜNSTER

Institut für Ethnologie

Aesthetics of Healing: Working with the Senses in Therapeutic Contexts

© Inga Scharf da Silva, „Hoffnung“, 2009

32nd Annual Conference of the Association for Anthropology and Medicine (AGEM) in Cooperation with the Institute of Ethnology of the University of Münster

May 24-26, 2019 in Münster / Germany

Further Information: www.agem.de, www.uni-muenster.de/Ethnologie

wissen.leben AGEM Arbeitsgemeinschaft Ethnologie und Medizin

INTERNATIONAL OFFICE

Sensory Approaches in Health, Care and Medical Anthropology

Introduction to the Thematic Focus on the Aesthetics of Healing: Working with the Senses in Therapeutic Contexts

HELMAR KURZ

> "The contemporary practice of health, despite all scientific process, presents itself as a fragmented overspecialization. Besides that, it often lacks the individual support regarding resources of self-knowledge, wisdom, and (self-)love, which would be the basis of health-seeking behavior in the sense of permanent efficacy." (MOREIRA 2013: 23, English translation by HELMAR KURZ)

Brazilian Spiritist medical doctor MOREIRA addresses contested realms of healing at the intersection of *scientific* and *spiritual* knowledge, postulating *holistic* approaches towards health, care, and well-being. He also acknowledges the *positionality* of "patients" as humans being *diagnosed* according to biomedical and/or psychiatric categories and *exposed* to treatment rather than actively participating in their own healing experience. For over a decade, I have explored and investigated related Brazilian Spiritist practices in (mental) health/care, exploring practices of *healing cooperation*, *translocal relations*, and, moreover, performative, sensory, and aesthetic aspects of health and healing (cf. KURZ 2015, 2017, 2018a/b, 2019a). It has never been my aim to propagate or evaluate "alternative" approaches to healing in terms of their efficacy but, instead, to facilitate comprehension, communication, and appreciation towards alternate explanatory models as aligned to certain socio-cultural frames, dynamics, and negotiations. However, I am also interested in *efficacy* as related to *experience*. I therefore, as a medical anthropologist, deem it crucial to integrate conceptual models of *performance*, *embodiment*, *aesthetics*, and *sensory anthropology* into my investigation of healing practices. Accordingly, with this *Curare* special issue, I seek exchange of and contest with authors affiliated with different scientific disciplines and therapeutic approaches to explore what a conceptualization and discussion of the *aesthetics of healing* might implicate on a theoretical and practical level.

The Context

Medical anthropologists increasingly explore the social production of therapeutic spaces (cf. DILGER 2013; ZANINI *et al.* 2013; KRAUSE *et al.* 2014) and related impacts of sensory experience in therapeutic settings (cf. NICHTER 2008). Similarly, religious scientists have addressed *religious experience* as *aesthetic engagement* (cf. MÜNSTER 2001; SCHMIDT 2016a; WILKE & TRAUT 2015). From this perspective, we continue to explore how *healing* addresses illness and affliction by "working with the senses" and creates *diversified spaces of care*. Related processes of *hybridization* and *diversification* have been addressed with practice-oriented methods in reference to LATOUR's (2010) *Science and Technology Studies*, focusing on how health-related knowledge is produced in multiple networked practices instead of assuming that any given (socio-cultural) knowledge would automatically result in systemically based defined interventions (cf. MOL 2003, 2008). Therapy, therefore, is understood in terms of mutually linked interactions (cf. KRAUSE *et al.* 2012: 20).

Such a perspective considers bodily experience and practice as crucial factors of health and healing, and accordingly, fancies a debate on *embodiment* and *habitus* as conceptional tools (cf. BOURDIEU 1991; CSORDAS 1993), giving also space to divergent and contested cosmologies on *body*, *mind*, and *spirit/soul* as opposed or complementary to the Cartesian dichotomy of mind and body and related explanatory models and diagnostic systems (cf. COLEMAN & WHITE 2010; CSORDAS 1990, 1999, 2002; FEDELE & BLANES 2011; KIRMAYER 2003; VOSS 2011; NARAINDAS *et al.* 2014). The tripartite model of a *mindful body* (cf. SCHEPER-

Hughes & Lock 1987) as grounded in *phenomenological body* experience, *social body* interpretation, and *political body* control here serves as another influential analytical tool by framing subjective experience, intersubjective practice, and external factors such as social control, body politics, or structural violence.

Theoretical concepts of *embodiment* and the *mindful body* extrapolate the dichotomy of body and mind within "Western" cosmologies and scientific approaches as grounded in a fundamental distinction between rationality and emotion, or, in other words, cognitive and sensory perception. Current research in the cultural and social sciences transcend this dichotomy with an extended focus on social and cultural foundations of aesthetics and sensory experience. Accordingly, an increasingly influential *anthropology of the senses* produces innovative approaches, concepts, and tools: they imply the idea of the human sensorium as socially and culturally produced and constructed (cf. Classen 2005; Hsu 2008). Other approaches focus on the medial quality of the senses (cf. Pink 2009; Stoller 1989). Howes (2005), for example, regards the senses as media that produce and represent socio-cultural meaning to, *e.g.*, medical or spiritual phenomena. The focus is on social implications and intersubjective interaction as foundations of sensuality *and* sociality in so far as social experience is construed by sensory perception and attachment (cf. Chau 2008; Hsu 2012; Vannini *et al.* 2012). Nichter (2008), in a further step, explores "the senses in medical anthropology" in terms of transformative experiences of healing and health-seeking behavior in diversified therapeutic markets (cf. Desjarlais 1992; Halliburton 2009), and addresses sensory modalities and their perception (cf. Hinton & Hinton 2002). This also includes questioning clinical and cosmological constructions of *normal* and *anormal* sensory experience (cf. McCarthy-Jones 2012; Luhrmann 2012).

Place-Making is another aspect in terms of the production of therapeutic environments. Spaces shape bodies and bodies create spaces by movement, experience, and interaction (cf. Casey 2001). Rodaway (1994) develops the concept of *sensuous geographies* as an integrative perspective on physical, socio-cultural, and aesthetic dimensions of human experience and its framing/structuring in certain environments and spaces. Howes (2005: 7) refers to spatial factors of sensory experience and/or embodied knowledge as *emplacement* (cf. Ingold 2000; Pink 2009), that is, a complex network of sensory experiences and interactions, or, in other words, specific *body-mind-environments*.

The intersection of "religion" and "medicine" (cf. Basu *et al.* 2017) is of special interest here, too. Religious-spiritual approaches toward health implicate continuous and long-term processes of learning and cultivating (self)perception in terms of shifting attention to sensory-bodily experiences and expressions (cf. Espirito-Santo 2015; Seligman 2014). Related explanatory models, idioms of distress, and coping strategies are not only negotiated on a cognitive-rational level but also in corporeal-sensory terms (cf. Schmidt 2016).

Having these aspects in mind, I intend to (re-) introduce the concept of *aesthetics of healing* as a methodological tool to be implemented in the investigation of body-mind-environments in therapeutic spaces. To my knowledge, Kapferer (1983) first came up with this term when he extended Turner's (1968) performative model on the importance of aesthetics within healing rituals, perceiving the performative power of symbols offside structural frames and shaping the experience of people involved. Performance studies stress the idea of symbolic conflict management where social relations are (re-)established, and interpret healing rituals as transformative acts adjusting experience, emotion, identity, meaning and practice. Participants develop agency to overcome psycho-social problems and/or to (re-) shape social structures (cf. Turner 1968: 20; Kapferer 1983: 175; Laderman & Roseman 1996; Sax 2004: 302). Roseman (1988) stresses the use of patterned sounds, movements, colors, shapes, and odors as therapeutic techniques and has criticized that medical anthropology remains curiously inattentive to the "aesthetics of healing rituals" which would actually bridge the conceptual gap between "structural" and "experiential" approaches in anthropology.

This special issue of *Curare* takes up the thread again by integrating some new perspectives and insights. Sayers (2004) introduces *Visual Arts* as helpful in therapy by establishing connections between "inner and outer experience," which

she deems crucial for psychotherapy. Arantes and Rieger (2014) relate to "sound experience" as socio-cultural practice which would transform human perception and actively used in terms of creating "soundscapes" as "techniques of perception" could help individuals to (re-)connect to themselves and others.[1] In this regard, practices of *mindfulness* and related techniques of *interoception* have been a widely discussed phenomenon, mainly among psychotherapists (cf. Kabat-Zinn 2003; Bohus & Huppertz 2006; Kirmayer 2015). Neuroscientists developed a certain interest in religious practices as technologies of self-transformation, -regulation, and social interaction which would resonate with certain brain activities (cf. McNamara 2009), thus postulating a "neurobiology of religious experience" (D'Aquili & Newberg 1999) which addresses (healing) rituals as "working with the senses." Accordingly, Cave and Norris (2012) investigate how in religious settings "synchronized ritual behavior" shapes bodily awareness and perception by repeated postures and related somatic modes of attention (cf. Csordas 1993). They observe that certain body techniques shape sensory perception and may address spiritual imbalances as gateways to work on the "self."

These interdisciplinary approaches also affect the contemporary discipline of medical anthropology by shifting the focus from political frame and social context back to individual experience. By taking up on the aforementioned performative approach toward spiritual healing practices, Dox (2016: xx), declares that social dynamics and cultural contexts are important for their comprehension, but that we must also explore processes within "selves," their feelings, experiences and needs. Healing practices are not mere representations of social frames, patterns, and moralities, but are to be taken seriously by the participants' own terms and sensed experiences. Dox does not take spirituality (*e.g.*, in dance therapy, yoga, or neo-shamanism) as a symbolic representation but as corporeal engagement with sensation, perception, rational thought, and the material world. She therefore tends to ask what kind of (internal) sense of self is cultivated in spiritual practices and argues for research strategies to turn to the body as a main source of knowledge. Accordingly, Nichter (2008: 163) postulates research strategies focusing modalities of healing practices, asking who addresses which senses in which way, and how healing spaces and experiences are aesthetically and sensually patterned. I also suggest taking into consideration alleged "deviant" perceptional formations as *e.g.*, mediumship and related therapy models which often do not aim at the extinction of perturbing perceptions, but at their transformation in terms of an adjustment of "inner" and "outer" sensory stimuli (cf. Howes 2006). This approach defines "the senses" as resources to receive, process, and react to information from the outside world and the inner organism, both being central to perception and interaction. A major insight has been that certain sensory experiences might be interpreted and evaluated differently among distinct cultures (cf. Beer 2000; Howes 2005; Hsu 2008; Pink 2009), whereby discussion on the predominant effects of collective cultural patterns or individual experience has remained unclear.

The negotiation of different bodies of knowledges and their implementation into practice, as well as related practices of contest have inspired me to organize a conference on the "Aesthetics of Healing" that would likewise address different concepts and models but, moreover, create a space of communication among researchers and practitioners from various disciplines to develop new ideas of how to approach affliction in a way that acknowledges and supports patients' resources, agencies, wishes, and aims.

The Call

On behalf of the *Association for Anthropology and Medicine* ("Arbeitsgemeinschaft Ethnologie und Medizin," AGEM)[2] and in cooperation with the Department of Social and Cultural Anthropology at the University of Muenster/Germany,[3] we developed a CfP for AGEM's 32nd annual conference to take place in Muenster from 24–26 May 2019 with its focus on *The Aesthetics of Healing—Working with the Senses in Therapeutic Contexts* which here, I have slightly adapted due to ongoing dynamics in the field:

The concept of aesthetics covers very distinct aspects and meanings. In public discourse, it relates to ways of human expression including the arts, theater, music, and dance and its appraisal through categories such as "beautiful" or "grace-

ful." Taking into consideration the original meaning of the ancient Greek word *aísthēsis*, the concept relates to sensory perception as delimited from rational-cognitive processes. To discuss "Aesthetics of Healing" thus means to focus sensory aspects of therapy and to integrate them into a theory of the meaning and effectiveness of healing practices. During the *performative turn* of the social and cultural sciences in the 1980s, this idea mainly related to symbolic practices to ritually resolve psycho-social conflicts. Since the 2000s, it also depicts an integration of medical and sensory anthropology: the capacity of the human sensorium to perceive and to react to stimuli from the environment or the proper organism is central to perception and interaction in the therapeutic context. Healing practices can address, intensify, or diminish different sensory functions, and meaning and assessment of the particular senses differ in distinct cultural and social frameworks. Research on the interrelation of culture and the sensorium has produced the insight that humans consist of more than the five senses (seeing, hearing, smelling, tasting, touching) reproduced in public discourse. Bodily sensations such as interoception, pain, empathy or mediumship thus constitute another vital source for the comprehension of health, illness, and healing. The intersection of religious/spiritual and therapeutic practices is of particular interest here. Religious-spiritual healing practices require the acquisition and cultivation of specific perceptional processes, including the shift of sensory attention and bodily expression. Consequently, coping strategies and explanatory models of illness often do not refer to cognitive/rational but to bodily/sensory perceptional forms. Further, contemporary popular healing and health practices like yoga, meditation, and mindfulness training focus on multiple bodily sensations and are increasingly integrated into the psychotherapeutic context. This tendency also unfolds perspectives on mechanisms of the institutionalization and commodification of these practices and related political and economic dynamics.

With a few exceptions, the current interdisciplinary discourse is reduced to the insight that culture, embodiment, and emotion are interrelated without really opening the 'black box' of bodily and sensory processes and dynamics. We thus have little knowledge on how sensuality and sensory manipulation influences health-seeking behavior, therapeutic decision-making, and the establishment of healing cooperation in the context of increasing medical diversity. In a conference in Berlin in September 2018, the CRC "Affective Societies[4]" introduced the theoretical approach of "Affective Arrangements" in therapeutic environments, initiating an interdisciplinary discussion of sensory-emotional factors of (mental) health, well-being, and therapeutic potentials and deficits in the context of current cultural, social, (health-)political, and economic developments (cf. Kurz 2019b). In cooperation with the CRC "Media of Cooperation[5]" at the University in Siegen/Germany, AGEM carried out a series of three interrelated conferences on "Healing Cooperations" (June 2017), "Preparing for Patients" (June 2018), and "Preparing for Physicians" (June 2019). Further developing related approaches, our aim is to now explore the mentioned aspects, questions and problems with the focus on "Aesthetics of Healing." We thus invite you to participate in our discussion on "working with the senses" in the context of health, illness, and healing. We want to investigate how sensory modalities influence therapy as a transformation of self, perception, and experience and how they are embedded in social and hierarchical relations and political and economic dynamics. Our broad spectrum will integrate diverse approaches to sensory experience in the context of health, illness, and healing. The conference will be inter- and transdisciplinary: cultural and social scientists, medical professionals, psychotherapists, physiotherapists, nurses, music and art therapists, practitioners of complementary and alternative medicines, as well as patients and relatives are welcome to contribute with their experience, expertise, and evaluation.

Questions of interest include, but are not limited to: What is the importance of sensory perception in different healing practices? To what extent are sensuality and aesthetics relevant factors for illness experience, health behavior, and therapy decision? How do different therapeutic practices address the particular senses? Which patterns of (self-)perception are generated and cultivated? What is the importance of place, equipment, and substances? Is there a difference between treatment at home and out- or inpatient treatment? How do sensory aspects of therapy contribute to

the diversity of the health sector? Which social, political, and economic dynamics are involved? What is the importance of "Aesthetics of Healing" for the integration, complementarity, or competition of different health and healing practices?

The Conference

To our delight, we received a great deal of international, interdisciplinary and intersectoral feedback from anthropologists and religious scientists, artists and art scientists, health professionals and therapists, and media producers from Austria, Brazil, Canada, Finland, Italy, Germany, Netherlands, and the UK. It has been quite a task to connect and integrate manifold approaches within a broader negotiation, discussion and contest on how to "make sense" of the concept *aesthetics of healing*. Some speakers developed strategies how to interpret healing practices in sensory terms. Others discussed possibilities of how to integrate "aesthetics" into therapy, while others either deconstructed my approach towards the *aesthetics of healing* as primarily focusing sensory perception or made use of it to criticize "traditional" biomedicine and psychiatry. The conference became a fairground of mind-blowing and body-spinning attractions which altogether created a transitional *third space* (cf. Bhabha 1994) of performing, negotiating, and transforming knowledge and experience. A detailed report in German language has been published in the previous issue of *Curare* (Nauber & Kurz 2019), and a few further reflections of participants (Paul Dieppe; Natalie Harriman; Leonardo Menegola) are displayed below. However, I will provide a brief overview to illustrate the vividness and variety of the conference, mentioning also those contributors who, for diverse reasons, do not appear as authors in this volume as, on the other hand, also authors contributed here who did not make it for the conference.

After an introduction by Helene Basu[6] and Helmar Kurz, Anja Lüpken (this volume) and Svea Lindner (this volume) opened the conference with their particular contributions on the realm of *dance*: Anja Lüpken discussed a practice of dance "therapy" in the Münster area, while Svea Lindner introduced her project of *visual anthropology* in terms of filming practices of "trance-dance" in Malawi. With focus on *music*, Leonardo Menegola (see below) vividly illustrated sensory experiences in contemporary music therapy in Italy, whereas Bernd Brabec de Mori, specialized on the intersection of "song" and "health" and/or "wellbeing" in the Amazon (cf. 2015), contested an alleged separation of "cognitive" and "sensory" perception, as well as their philosophical and moral implications. Reading between the lines, this issue has also been addressed by Leonardo Menegola, who displayed examples of persons suffering from dementia recalling memories through playing certain melodies. With focus on *technology & movement*, Felix Freigang addressed so-called "mood-trackers" as digital applications to control states of mental well-being, whereas Shirley Chubb (this volume) introduced digitally supported research approaches and results related to chronic pain, movement, and environment.

As keynote-speaker at the end of the first day, Graham Harvey (this volume) introduced *Indigenous, environmental, and spiritual aspects* of health and healing which would also inform discussions of the second conference day: Johanna Kühn (this volume) explored "alternative healing experiences" in Lebanon, Tessa Bodynek (this volume) in Brazil, and Andrew R. Hatala (this volume) in Belize. Dirck Van Bekkum (this volume) then asked how we could translate experiences of Indigenous healing "there," and their anthropological interpretation, into therapeutic models "here."

Contributing to this question, Paul Dieppe (this volume), Jaana Erkkilä-Hill (cf. 2017) and Tyyne C. Pollmann (cf. 2019) explored different approaches of integrating *art* into therapy or therapeutic spaces. Some of these environments (*psychiatry & hospital*) were further addressed at the end of the second and the beginning of the third day by Sabrina Melo Del Sarto (this volume), Jahangir Khan, and Sjaak van der Geest (cf. 2020). Katharina Sabernig[7] then completed the contest on biomedical and psychiatric practice by introducing models of organs and afflicted body parts she herself handknitted to have patients sensorily understand what is going on within their bodies. The last panel was dedicated to *substances* as shared between Hannah Drayson (this volume) on the bitterness of remedies and Natalie Harriman (this volume) on homeopathy. How-

ever, Hannah Drayson was not able to come, and to her and my surprise, Natalie Harriman suddenly did not just become the last speaker of the conference, apart from my final wrap-up, but moderated a final discussion which reflected all the contested approaches, ideas, and perspectives in such a dedicated, engaging, and secure way, that I just decided to let it go and not "insist" on my role as a final discussant. I was actually very grateful, and it could be a first lesson to be learned from that conference that in a paradigm of the *aesthetics of healing*, we, as researchers and therapists, should not take ourselves too seriously but let it go, see what happens, and facilitate agency. To also share some reflections and comments of other participants on the conference, the next section provides a summary of Natalie Harriman's, Paul Dieppe's and Leonardo Menegola's experiences and interests, before I will properly introduce the contributors in this volume.

The Comments

It's been a thorough path across the multiple fringes of how sensoriality and aesthetics intersect with the field of therapy and care in multiple contexts. These two concepts have been deconstructed indeed in distinct aspects and meanings by different papers. Plural forms of human expression, and multiple ways of socially organising—either at the level of representation or at that of practice—sensory perceptions have been elicited in the ethnographic analysis of the sensory aspects of therapy and of its meaningfulness and effectiveness.

I proposed, with very encouraging feedbacks indeed, a medical anthropological analysis of contemporary "music therapy" practices in Northern Italy, by highlighting the multiple ways in which, through the study of here-and-now, embodied interactions between the therapist and the patient, a thick description of the ethos of care, the epistemology of healing, and the social and political imbrication of music therapy practices can be articulated, by unfolding the implicit models of personhood and disease music therapy representations and practices convey.

Bernd Brabec de Mori argued for a step back into considering the gnoseological and ontological status of the concept "aesthetics" for an anthropology of the auditory. What is at stake there is the judicial, normative nature of aesthetics, considered either as the human experience of fruition of/participation in a sense-centered interaction, or the adoption of an analytical framework (a)critically based on any unquestioned concept of "aesthetics."

Johanna Kühn proposed a virtual journey through the ways in which "alternative healing practices in Beirut, Lebanon" foster journeys of "sensual self-perception" that help people build narratives of self-representation and autobiographical experiences. Letting emerge such a construction apparently seems to be the very role of the "spiritual" healing practices depicted in the paper.

Felix Freigang proposed a paper focusing on a mobile app for "assisted mood-tracking:" a stimulating topic, which opens further questions to the researcher, such as: is "mood" meant to be treated as an achievement, or as a matter of self-management technique? Is emotion a product or a process in contemporary, post-industrial society?

Paul Dieppe brought from England a thorough restitution of a project based on the use of "art to create healing spaces in hospitals." In this work, art is discussed as a mediator to help people express their understanding of their state of health/disease, of their identity as patients within the medical institution, and as protagonists of a program that through qualitative research techniques within a phenomenological framework, and through the organization of a final exhibition, invites all social actors getting in touch with the project to explore around the question: "where does healing come from?" Still, Dieppe's paper stimulates broader questions relating to medical pluralism matters, such as: are the healing practices, and/or the apparatuses provided by current health systems more thinkable of as "sanctuaries of care," or as "supermarkets" (filled with diverse models of knowledge and intervention virtually anyone can resort to, pick from and draw on)?

Also, the work of Jaana Erkkilä-Hill introduced the public space and "setting" issues. The Slow Labs project is a program in Finland aiming at creating what I would call "proto-therapeutic" spaces, where the expressive tools for meaning-making and for socializing personal storytellings are driven by starting from the non-verbal grammar of art and creativity. Erkkilä-Hill's presentation introduced some issues pertaining to the creation of free, empty, available, slow, still-standing spaces, not biased with any expectation on the side of users and bystanders of producing any thing. The Slow Lab configures a participative approach and consequent methodologies in order

to develop and provide caring methods and routines, spaces and activity schedules, that fit individual users' requirements and requests and thus express "inclusive" values. In this framework, one would wonder: what is the social status of vacuum, e.g. silence, as a factor of care?

Sjaak Van der Geest's paper introduced the necessity to explore a diametrically opposite fashion of the "aesthetic" in human experience and anthropological methodology, by focusing not on pleasurable pieces of art and expression, creativity, metaphors and narrative—all conveyed through various sensoria and non-verbal mediators—but, on the contrary, on the "unpleasant" as a matter of social construction and negotiation, both in everyday practices of ordinary life as well as illness and care, and in the ritual arena of healing. A "well-known," but highly untracked, fringe of human experience emerges as a terrain suitable for unfolding new opportunities for analysing what constitutes, through the sensory-focused practices of our being in the world as individuals, patients, sick persons. It is clear not by chance at least since Douglas' [2001(1966)] Purity and Danger that what lays beyond the comfort zone of decency, outside the margins of the solar system of moral and (in fact) aesthetic values, shows various practices of shamefulness pave the way for us to mediate our identity and our belonging, to position and negotiate our own selves' personhood and agency in the interaction with the others. (Leonardo Menegola: personal communication 2019-07-04)

I am a doctor with a long-standing interest in healing, and a more recent interest in arts and health, so this was the meeting for me. There are very few academics studying either subject, and a paucity of serious meetings about them. And I was not disappointed by the meeting in Münster, it was wonderful.

The words "aesthetics" and "healing" are both slippery, and difficult to define. This is perhaps because there is a major experiential aspect to both. An added problem is that the words have varying usage in different cultures and languages. So what are "aesthetics" and what is "healing?" There was much useful discussion on both subjects during the two and half days of this meeting, and it was clear that both words were interpreted slightly differently by different attendees.

"Aesthetics," I concluded, was about sensory experiences that can enchant—a beautiful concept provided by one of the speakers, and one that really resonated with me. The definition of the word "healing" was more difficult for me to come to a clear conclusion about, even though I have been researching it for some years. The word can be used as a noun, an adjective or a verb: it is used to describe practices of healing, the healing process, or the outcomes (the healed state). Furthermore, today the word "healing" is used to mean different things by conventional Western medicinal practitioners (who use it to denote wound healing and other repair processes in the body), and the so-called complementary and alternative medicine practitioners (who generally use the word to describe an holistic process that involves achieving integrity of mind, body and soul, leading to wholeness, rather than just the repair of body parts).

During the meeting it also became apparent that there was some confusion between the concepts of "healing," "curing," and "treating," caused in part by linguistic problems in different languages (some languages only have one word for all of these concepts). For me, "treating" someone with a health problem is about using some intervention to try and help—a very general concept that can include both "curing" and "healing." "Curing" is a more restricted concept, it is about trying to find some pathological cause for illness and then eradicating that cause, so that the person is returned to their previous state or to "normality;" "curing" is based in the current biomedical, reductive, materialistic concept of how the world works. In my opinion this approach, which has a stranglehold over medicine, is not enough to describe how illness can and should be treated.

"Healing," I think, is different and more compatible with a spiritual, or metaphysical view of how the world works. Many different ideas were aired about its meaning and its facilitation; beautiful concepts such as:

- *Transformation leading to Well-Being*
- *Sense-Making beyond the "Rational"*
- *Synchronicity and Harmony*
- *Crafting an Improved Self*
- *Co-creation of Wholeness*
- *Stepping into Another Reality*
- *Flourishing*
- *Grace and Love*
- *Spiritual Transformation*
- *Re-Orientation to Greater Meaning*
- *An Emergent Property of the Whole*

Each of these fantastic words or phrases are in my notes from the meeting. The final speaker tried to de-

fine healing for us—a bold undertaking that was, for me, both helpful and successful, but one that I think still requires more work and discussion. During the meeting we heard a lot about different artistic/creative activities that might help facilitate the healing of individuals. They varied from movement and dance, music, visual arts, making things, the natural environment, religious rituals, to medical interventions. We were assailed with a rich mix of different approaches, within varying countries and cultures, all of them aimed at the transformation of people to a better state. The talks on these subjects were both engaging and enlightening.

Many of the presentations were about healing practices in countries within the developing world; excellent anthropological studies of healing in different cultures from those of most of the speakers who live in Westernised rich countries where biomedicine dominates. So, what is the role of healing in such countries? Well, I think it has a crucial role. Biomedicine offers us much in terms of improved health; it is good at many things, such as infectious disease, surgery for bad hips and knees and for cataracts, and many other conditions. But biomedicine finds it difficult to offer much help to people with chronic pain and many other chronic conditions, to those with age-related disorders such as dementia, and the increasing numbers with multi-morbidity (more than one health problem). And even when a cure is achieved for others, many such patients are left with mental suffering and identity issues resulting from their illnesses that require healing. Healing can help all of these people. So, I believe that we must find ways of combining the "art" of healing with the "science" of curing. We must integrate healing and curing to achieve integrity of mind, body and soul. (Paul Dieppe: personal communication 2019-07-04)

I was very nervous in the weeks leading up to the AGEM Healing conference; I had never presented these ideas before, even though they had been forming for the better part of ten years – I guess I never had the courage. I knew they were still ill-formed, but I needed the opinion of others to move forward. So, I had to gather myself and compile something semi-intelligible, worthy of presentation. Healing is a fundamental human experience that, as a practicing homeopath, I have witnessed many times. It filled me with awe and fulfilled something very deep inside, something important about how human beings really operate, how things really work. Watching my patients journey through this process, knowing that I was just a bystander, a reflector at most, brought me to the realisation that I was participating in something not understood or even acknowledged by biomedicine and being the well-trained scientist that I am, I wanted to understand the underlying principles. So, I started reading and thinking. I guess I was also trying to reconcile the apparent opposites in me—the "homeopath" and the "biologist."

Helmar's conference arrived at the almost perfect time: I had decided to return to Europe to live, primarily to continue with this work, and I was ready to get out there and see what others thought. My first encounter in Münster on the first day was with a fellow South African from Rhodes University, working on aspects of our own political and cultural healing process; we laughed about politicians and I knew I'd be ok. That feeling continued and grew—as the talks and the discussion proceeded, I realised that I had lucked out; these people would "get" what I needed to communicate, and I would learn enormous amounts from them. So many of the themes that I had identified over my years of reading came through and it was a joyous and exciting confirmation for me.

Transitional spaces seemed essential for any sort of healing and were discussed by almost all the speakers, but what are they and how are they created? Dirck van Bekkum addressed this at length and believed that what we learned through observing indigenous healing practices should be translated to inform biomedical contexts. It has already been acknowledged in psychotherapeutic circles—Carl Rogers called it 'unconditional positive regard' or love, but it needs to be authentic. Within these transitional spaces, a strange or magical sort of process occurs that was often characterised as creative or imaginative (Anja Lüpken) where the patient frequently relived old trauma (Svea Lindner) or brought memories to mind (Anja Lüpken) which would then bring about a change within or a 'crafting of an improved self' (Joanna Kühn). This is essentially transformation of the self, a common observation among healers, which was first directly mentioned by Leonardo Menegola, a music therapist, who described it as a transformation of personhood. He discussed techniques of transformation as part of a holistic approach, something very difficult to realise as a therapist—how do you conceive of and deal with a whole which you then attempt to influence and heal—but he mentioned noticing small details in the patient

that he used to represent the whole which struck me quite deeply. Homeopaths use small, usually peculiar, individually characteristic details in their patients that can be viewed as analogues to the whole; this is our way into the whole when diagnosing. It also reminded me of the spiritual principle—"as it is above, so below"—the microcosm mirrors the macrocosm… much like holograms.

Tessa Bodynek brought up the idea of the wounded healer: that in order to heal, you need to have been healed, which sparked an interesting discussion on how psychotherapists are expected to undergo their own therapy during their training and certainly resonated with my own experience. I think it might be about the personal experience of trauma allowing you to connect to your patient and also enabling you to create that safe transitional space—the mutual recognition of pain, of our common humanity and the complete acceptance of that and the other which facilitates connection, and this is what many people see as key to healing (Paul Dieppe). Paul also spoke of the stepping into another reality, through the gateways of religion and perhaps art which chimed with Anja's and Svea's work on dance. Andrew Hatala characterised this reality as a shared mythical world between patient and healer who were on a journey together where meaning was generated through the body.

Journeying was a common theme in all of the discussions, and I think it may be a key aspect and differentiator when trying to define healing and it is logically connected to the theme of transformation – a journey through an altered reality in a transitional or liminal space to another way of being, guided by one who has already taken that journey. My question then is why, what for? The answer that seemed to emerge during the discussion was new or greater meaning. Paul's work characterised this as a movement from chaos to order or fragmentation to integration. Perhaps illness is a form of chaos, breakdown, and healing is that search for a new integrated order with a different orientation or meaning?

By the time it came to my turn to speak, I was confident that I was in sympathetic company, but I was nervous—I had decided to stick my neck out and attempt a definition of healing. I think we need something concrete to use as a connector and a differentiator to collectively describe this phenomenon and I think we can find that definition though collaboration, through finding what it is that is shared. We can then use it to begin a challenge to the dominance of Western biomedicine and find a more complete way to treat our patients. Not only does biomedicine largely dismiss ideas of transitional spaces and healing journeys, but its dominance obscures any other perspective, both Western alternative and Indigenous. My brave stab at a definition of healing turned out to be too biased towards homeopathy—understandable—but what I learned from a few days with a group of mainly medical anthropologists, some artists and some medical doctors is that through creating our own transitional space, we could gently, but critically share ideas and knowledge across disciplines and that this was the only way to possibly forge a transformation within medicine which itself may go some way to healing the split between 'science' and 'magic'. I also felt that I'd made some friends on my own journey into healing the split in me. (Natalie Harriman: personal communication 2019-08-05)

The Contest

Divergent approaches toward a conceptualization of the *aesthetics of healing* framed the conference and continue to contest in this volume. The diversity of contributions illustrates the multivocality of perspectives and the challenge of how to grasp it in theoretical and practical terms. This special issue consists of double-blind peer-reviewed articles and other formats such as reflections, a keynote and essays. I want to clarify that this structural categorization does not mirror any evaluation of the contents but rather differentiates (anthropological) research reports, reflections on the topic, and practitioners' accounts. This multiperspectivity constitutes the uniqueness of this project.

Inga Scharf da Silva is an artist and anthropologist with whom I share my interest in Brazilian spiritual healing practices. From my perspective, her painting *Hoffnung* ("hope") in the conference's official poster and program integrates many of the aspects we are discussing here. The cover of this volume has been a template for that painting and she reflects on her experiences and intentions to contribute her work to our thematic discussion (in German and English).

Keynote speaker Graham Harvey explores how *animist* concepts may inform practices and experiences of well-being and healing. Whereas especially in the 19th century, evolutionist anthropologists used this term to denigrate alleged "pre-

modern" systems of knowledge and practices, he illustrates how to apply it as a tool to describe, analyze and interpret health-related models of "selves" in their relation to particular environments. He compares and reflects on ethnographies from around the world, including accounts on North America's *First Nations*.

Although not applying the concept of *animism* to "make sense" of their research data, the first two of the total seven peer-reviewed articles share the perspective of how comparable approaches inform experiences and practices of healing. On an auto-ethnographic base, Cathy Fournier and Robin Oakley discuss the opportunity and its challenges to integrate North American *First Nations* Indigenous healing knowledge and practice with cosmopolitan medicine to facilitate what they identify as a *Two-Eyed Seeing*. Instead of favoring one, and diminishing another approach, their complex discussion on the impact of (post-)colonial negotiations of health postulates and facilitates *healing cooperation* (cf. Incayawar *et al.* 2009; Voss & Schubert 2018) in terms of a therapeutic diversication as opposed to discourses on the supremacy of any therapeutic approach or "medical systems" (cf. Baer *et al.* 2013; Krause *et al.* 2012, 2014).

Andrew R. Hatala and James B. Waldram investigate *Q'eqchi' Maya* aesthetics of healing practices in Belize as unequivocally related to socio-cultural formative processes of cosmovision, relationality, morality, and environmental factors. Whereas both, Fournier and Oakley's, and Hatala and Waldram's contributions address aesthetic qualities regarding "Indigenous healing" in accordance to Harvey's account, they offer quite different views on the "compatibility" or "translatability" of healing practices and their aesthetic modulations (cf. Kirmayer 2015 on the example of *mindfulness*).

Johanna Kühn mediates these alleged opposing perspectives by investigating meditation practices in Lebanon as spaces of bodily and sensory informed negotiations of identity especially among young middle-class women who experience themselves as torn between "cultural tradition" and "cosmopolitan modernity." From this point of view, "healing" does not attempt to fix or (re-)establish social relations (cf. Turner 1968) but to mediate controversial and disruptive experiences by concentrating on oneself and only from there to (re-)engage with a particular environment and dynamics of socio-cultural transformation.

In a different geographical but nonetheless comparable context, Tessa Bodynek explores (Afro-)Brazilian approaches of negotiating "selves" in mediumship practices. Besides providing multiple accounts on sensory aspects in the religion of *Umbanda*, she addresses a realm that has us rethink and adjust our categories and concepts: do we understand healing as "transformative," that is, a way to learn to understand and live with our affliction, or as "restorative" in terms of redistributing a previous state of well-being (cf. Waldram 2013)? Taking this further, her account maintains the discussion on what is *healing* and/or *curing* (cf. Waldram 2000).

Sabrina Melo Del Sarto and Esther Jean Langdon refer to another quite contested Brazilian phenomenon of Spiritist psychiatries (cf. Theissen 2009; Bragdon 2012) which has also been my focus of research. While not neglecting my interpretation of Spiritist practice (cf. Kurz 2017) as aesthetic and comforting engagement with patients, they clarify that it depends on socio-economic capital and resources. Moreover, they illustrate how spiritual practices like the *passe* ("laying-on hands"), which I describe as soothing and supportive, may be also experienced as transgressive and disciplinary practices of control.

Redirecting our gaze to Europe and other forms of "control" in terms of "measuring affliction," Shirley Chubb, Ann Moore, Kambiz Saber-Sheikh, and Neil Bryant introduce their innovative and interdisciplinary research project *Significant Walks* which focuses interoceptive processes related to the experience of pain and environmental stimuli. They investigate the impact of walking on patients with chronic low back pain by combining video documentation with simultaneously gathered biomechanical data and narrative accounts. Their research project thus combines different media and technologies to analyse sensory aspects of affliction and therapy success.

Hannah Drayson discusses the media of taste and language as related to health, illness, and healing. Referring to the human experience of *bitterness*, she illustrates how in many cultures "suffering" is linguistically related to the experience of bitter tastes, and how bitter substances in

many vegetables and herbs support animal and human health and well-being. She thus compliments our perspective on the interconnection of humans, animals, and plants—just that she does not refer to spiritual agencies but to bio-chemical processes.

These research articles are complemented by five more practice-related discussions on the different layers and aspects of the *Aesthetics of Healing* both by therapists and researchers. They apply, develop, question, and reflect on the rather theoretically embedded anthropological accounts in the context of their particular practical engagement, sharing personal experiences, insights, opinions, and ideas.

Dirck van Bekkum reflects on the importance of "transitional spaces" in his and his students' multiple therapeutic approaches. Reflecting anthropological ritual theory, he translates related insights in non-European societies into a therapy models in the European context of supporting, e.g., traumatized soldiers and families with a migratory background.

Natalie Harriman also digs in this goldmine of integrating different perceptions of healing: she blows off the cover of "rationality" that allegedly distinguishes cosmopolitan biomedicine and psychiatry from so-called alternative and complementary medicines (CAM). I read her contribution as a manifest against a certain "hegemonic arrogance" among medical scientists, health professionals, and related public media against "deviant" therapeutic approaches like, e. g., homeopathy. However, this is not the place to contest "what is right or wrong," and accordingly her strength is to not play off different ideologies but to postulate a practice of "gnosis," that is, learning to practice *empathy*, to *connect* with patients, to learn to *understand* their life situation instead of treating them as "organic machines."

Paul Dieppe shares his experiences of participation in an art project in hospitals where patients could communicate their feelings, fears, and hopes. He reports of immense resonance among patients, relatives, and hospital staff members – except from the medical professionals. His compelling account relates to discourses on *placebo* and wonders what it is that heals: remedy, attention, agency, or their integration?

Anja Lüpken dedicates to the *Tamalpa Life/Art Process* as an "expressive arts therapy" integrating body movement, imagination, and expression in dance-like interactions and performances. She addresses interrelated "somatic modes of attention" (cf. Csordas 1993) toward self and others and analyzes the practice according to concepts such as "movement," "metaphor," "movement as metaphor," "imagination," "aesthetics," and "healing." She therefore wraps up our exploration of divergent perspectives on the *Aesthetics of Healing*.

So far, we have hardly addressed related ethnographic methodologies which have been, among others, informed by Sarah Pink (2009), David Howes (2006) and Tim Ingold (2000). Svea Lindner (in German) reflects on her methodology and field data while exploring and filming the *Vimbuza* "healing dance" in Malawi. Her accounts and experiences provide a guidepost on how to implement innovative ethnographic and anthropological techniques to engage with the *Aesthetics of Healing* and related practices of "working with the senses in therapeutic contexts."

A Conclusion?

My introduction and summary only touch some aspects I deem crucial for our ongoing dedication to the *Aesthetics of Healing* and in the accounts of the contributors both of the conference and this volume. However, they are so rich in their contesting and complementing divergent perspectives that I want to invite the dear readers to explore them on their own, from their own perspectives. Comments, discussions, or critiques are very much looked forward to; please do not hesitate to communicate directly with me (email below). Accordingly, I will not provide a synthesis or wrap up, implementing my opinion on them. I will not share a final definition on what *are* the *Aesthetics of Healing* and on *how* we could methodologically integrate this concept in our attempt to grasp sensory aspects of therapeutic practice. Many questions remain and I want to encourage all of you to develop future projects by integrating innovative approaches and technologies to explore an experience that is crucial to all of us: health and healing.

Acknowledgments

Primarily, I want to thank all the participants of the *Aesthetics of Healing* conference and the authors of this special issue of *Curare* who have contributed in so many different ways to realize this project. I want to also thank my colleagues of *AGEM* and the *Department of Social & Cultural Anthropology* at the University of Muenster for their continuous support and cooperation, especially Prof. Dr. Helene Basu as my tutor and coordinator of the research project *Diversification of Mental Health: Therapeutic Spaces of Brazilian Spiritism* funded by the *German Research Foundation* (DFG).[8]

Further, I want to express my gratitude to the *International Office,*[9] "my" students, and the facility managers of ULB at the University of Münster for their manifold support.

Notes

1 I personally associate contemporary *psy-trance* music festivals with that sphere, as some students of mine already did within my seminars. I suggest this field for future research on the *Aesthetics of Health/Well-Being* in terms of further developing Spencer's (1985) accounts on "Society and Dance."
2 http://agem.de/?lang=en
3 https://www.uni-muenster.de/Ethnologie/en/index.html
4 https://www.sfb-affective-societies.de/en/index.html
5 https://www.mediacoop.uni-siegen.de/en/
6 https://www.uni-muenster.de/Ethnologie/en/personal/professor_innen/helenebasu.html
7 https://www.knitted-anatomy.at/
8 https://gepris.dfg.de/gepris/projekt/273588344?language=de&selectedSubTab=2
9 https://www.uni-muenster.de/InternationalOffice/en/index.html

References

Arantes, Lydia M. & Elisa Rieger (eds) 2014. *Ethnographien der Sinne: Wahrnehmung und Methode in empirisch-kulturwissenschaftlichen Forschungen*. Bielefeld: Transcript.

Baer, Hans A.; Merrill Singer & Ida Susser 2013. *Medical Anthropology & the World System: Critical Perspectives*. 3rd edition. Santa Barbara: Praeger.

Basu, Helene; Roland Littlewood & Arne S. Steinforth (eds) 2017. *Spirit & Mind: Mental Health at the Intersection of Religion & Psychiatry*. Berlin: Lit.

Bhabha, Homi K. 1994. *The Location of Culture*. London: Routledge.

Bohus, Martin & Michael Huppertz 2006. Wirkmechanismen achtsamkeitsbasierter Psychotherapie. *Zeitschrift für Psychiatrie, Psychologie und Psychotherapie* 54, 4: 265–276.

Bourdieu, Pierre 1991. *Language & Symbolic Power*. Edited & Introduced by John B. Thompson. Cambridge: Harvard University Press.

Brabec de Mori, Bernd 2015. *Die Lieder der Richtigen Menschen: Musikalische Kulturanthropologie der indigenen Bevölkerung im Ucayali-Tal, Westamazonien*. DVD inkludiert. Innsbruck: Helbling.

Bragdon, Emma (ed) 2012. *Spiritism and Mental Health: Practices from Spiritist Centers and Spiritist Psychiatric Hospitals in Brazil*. London: Singing Dragon.

Casey, Edward 2001. Between Geography & Philosophy: What does it Mean to Be in the Place-World? *Annals of the Association of American Geographers* 91, 4: 683–693.

Cave, David & Rebecca S. Norris 2012. Introduction. In *ibid.* (eds) *Religion and the Body: Modern Science and the Construction of Religious Meaning*. Leiden: Brill: 1–12.

Chau, Adam Y. 2008. The Sensorial Production of the Social. *Ethnos* 73, 4: 485-504.

Classen, Constance (ed) 2005. *The Book of Touch*. Oxford: Berg.

Coleman, Elisabeth B. & Kevin White (eds) 2010. *Medicine, Religion, and the Body*. Leiden: Brill.

Csordas, Thomas J. 1990. Embodiment as a Paradigm for Anthropology. *Ethos* 18, 1: 5–47.

––––– 1993. Somatic Modes of Attention. *Cultural Anthropology* 8, 2: 135–156.

––––– 1999. The Body's Career in Anthropology. In Henrietta L. Moore (ed) *Anthropological Theory Today*. Cambridge: Polity: 172–205.

––––– 2002. *Body, Meaning, Healing*. New York: Palgrave Macmillan.

D'Aquili, Eugene G. & Andrew B. Newberg 1999. *The Mystical Mind: Probing the Biology of Religious Experience.* Minneapolis: Fortress Press.

Desjarlais, Robert R. 1992. *Body & Emotion: The Aesthetics of Illness and Healing in the Nepal Himalayas*. Philadelphia: University of Pennsylvania Press.

Dilger, Hansjörg 2013. Claiming Territory: Medical Mission, Interreligious Revivalism, and the Spatialization of Health Interventions in Urban Tanzania. *Medical Anthropology* 33, 1: 52-67.

Douglas, Mary 2001 (orig. 1966). *Purity & Danger: An Analysis of Concepts of Pollution and Taboo*. New York: Routledge.

Dox, Donnalee 2016. Reckoning with Spirit in the Paradigm of Performance. Ann Arbor: University of Michigan Press.

Erkkilä-Hill, Jaana 2017. Slow Thinking Lab in a Society of Fast Broadband Connections. *Ubiquitous Computing*. Doi: org/10.1145/3123024.3124449.

Espirito Santo, Diana 2015. *Developing the Dead: Mediumship and Selfhood in Cuban Espiritismo*. Gainesville: University of Florida Press.

Fedele, Anna & Ruy L. Blanes (eds) 2011. Encounters of Body & Soul in Contemporary Religious Practices: Anthropological Reflections. New York: Berghahn.

Halliburton, Murphy 2009. *Mudpacks and Prozac: Experiencing Ayurvedic, Biomedical and Religious Healing*. Walnut Creek: Left Coast.

Hinton, Devon & Susan Hinton 2002. Panic Disorder, Somatization, and the New Cross-Cultural Psychiatry: The Seven Bodies of a Medical Anthropology of Panic. *Culture, Medicine & Psychiatry* 26: 55–178.

Howes, David (ed) 2005. *Empire of the Senses: The Sensual Culture Reader*. Oxford: Berg.

––––– (ed) 2006. *The Sixth Sense Reader*. Oxford: Berg

Hsu, Elisabeth 2008. The Senses and the Social: An Introduction. *Ethnos* 73, 4: 433–443.

––––– 2012. Medical Anthropology in Europe: Quo Vadis? *Anthropology & Medicine* 19, 1: 51–61.

Incayawar, Mario; Ronald Wintrob & Lise Bouchard (eds) 2009. *Psychiatrists and Traditional Healers: Unwitting Partners in Global Mental Health*. Chichester: Wiley-Blackwell.

Ingold, Tim 2000. *The Perception of the Environment: Essays in Livelihood, Dwelling and Skill*. London: Routledge.

Kabat-Zinn, Jon 2003. Mindfulness-Based Interventions in Context: Past, Present, and Future. *Clinical Psychology* 10, 2: 144–156.

Kapferer, Bruce 1983. *A Celebration of Demons: Exorcism and the Aesthetics of Healing in Sri Lanka*. Bloomington: Indiana University Press.

Kirmayer, Laurence J. 2003. Reflections on Embodiment. In James M.J. Wilce (ed) *Social and Cultural Lives of Immune Systems*. New York: Routledge: 282–302.

––––– 2015. Mindfulness in Cultural Context. *Transcultural Psychiatry* 52, 4: 447–469.

Krause, Kristine; Gabriele Alex & David Parkin 2012. Medical Knowledge, Therapeutic Practice, and Processes of Diversification. (MMG Working Paper 12–11). Göttingen: Max-Planck Institute for the Study of Religious and Ethnic Diversity.

Krause, Kristine; David Parkin & Gabriele Alex 2014. Turning Therapies: Placing Medical Diversity. *Medical Anthropology* 33, 1: 1–5.

Kurz, Helmar 2015. "Depression is not a Disease. It is a Spiritual Problem:" Performance and Hybridization of Religion and Science within Brazilian Spiritist Healing Practices. *Curare* 38, 3: 173–191.

––––– 2017. Diversification of Mental Health Care: Brazilian Kardecist Psychiatry and the Aesthetics of Healing. *Curare* 40, 3: 195–206.

––––– 2018a. Trans-Cultural and Transnational Transfer of Therapeutic Practice: Healing Cooperation of Spiritism, Biomedicine, and Psychiatry in Brazil and Germany. *Curare* 41, 1+2: 39–53.

––––– 2018b. Affliction and Consolation: Mediumship and Spirit Obsession as Explanatory Models within Brazilian Kardecist Mental Health-Care. In Mônica Nunes & Tiago P. Marques (eds) *Legitimidades da Loucura: Sofrimento, Luta, Criatividade e Pertença*. Salvador: EDUFBA: 129–154.

––––– 2019a. Geist, Heilung und Geistheilung: Spirituelle Obsession und Mediumismus als Erklärungsmodell und Therapieansatz im Schnittfeld religiös-spiritueller und psychiatrischer Heilpraxis: Spiritismus in Brasilien und Deutschland. In Christine E. H. Krebber (ed) *Holistic Medicine IV: The Way to a new Consciousness of Healing*. München: Institut für Ganzheitsmedizin: 205–243.

––––– 2019b. "Affective Arrangements in Mental Health Care Settings." Report on the International Conference organized by the Collaborative Research Center 1171 "Affective Societies," Berlin, September 24-26, 2018. *Curare* 42, 1+2: 119–121.

Laderman, Carol & Marina Roseman (eds) 1996. *The Performance of Healing*. New York: Routledge.

Latour, Bruno 2010. *On the Modern Cult of Factish Gods*. Durham: Duke University Press.

Luhrmann, Tanya M. 2012. When God Talks Back: Understanding the American Evangelical Relationship with God. New York: Knopf.

McCarthy-Jones, Simon 2012. *Hearing Voices: The Histories, Causes and Meanings of Auditory Verbal Hallucinations*. Cambridge: University Press.

McNamara, Patrick 2009. *The Neuroscience of Religious Experience*. New York: Cambridge University Press.

Mol, Annemarie 2003. *The Body Multiple: Ontology in Medical Practice*. Durham: Duke University Press.

–––––2008. *The Logic of Care: Health and the Problem of Patient Choice*. London: Routledge.

Moreira, Andrei 2013. *Cura e Autocura: Uma Visão Médico-Espírita*. Belo Horizonte: AME.

Münster, Daniel 2001. *Religionsästhetik und Anthropologie der Sinne*. München: Akademischer Verlag.

Naraindas, Harish; Johannes Quack & William S. Sax (eds) 2014. *Asymmetrical Conversations: Contestations, Circumventions, and the Blurring of Therapeutic Boundaries*. Oxford: Berghahn.

Nauber, Marion & Helmar Kurz 2019. "Aesthetics of Healing: Working with the Senses in Therapeutic Contexts." Bericht zur 32. jährlichen Fachtagung der Arbeitsgemeinschaft Ethnologie und Medizin (AGEM) e.V. an der Westfälischen Wilhelms-Universität Münster, 24–26. Mai 2019. *Curare* 42, 1+2: 132–138.

Nichter, Mark 1981. Idioms of Distress: Alternatives in the Expression of Psychosocial Distress. A Case Studa from South India. *Culture, Medicine & Psychiatry* 5: 379–408.

––––– 2008. Coming to our Senses: Appreciating the Sensorial in Medical Anthropology. *Transcultural Psychiatry* 45: 163-197.

Pink, Sarah 2009. *Doing Sensory Ethnography*. London: SAGE.

Pollman, Tyyne C. 2019. *visions4people: Artistic Research meets Psychiatry*. Berlin: Jovis.

Rodaway, Paul 1994. *Sensuous Geographies: Body, Sense & Place*. London: Routledge.

Roseman, Marina 1988. The Pragmatics of Aesthetics: The Performance of Healing among Senoi Temiar. *Social Science & Medicine* 27, 8: 811-818.

Sayers, Janet 2004. Healing Aesthetics: Kristeva through Stokes. *Theory & Psychology* 14, 6: 777–795.

Sax, William 2004. Healing Rituals: A Critical Performative Approach. *Anthropology & Medicine* 11, 3: 293–306.

Scheper-Hughes, Nancy & Margaret M. Lock 1987. The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology. *Medical Anthropology Quarterly* 1, 1: 7–41.

Schmidt, Bettina E. 2016. *Spirits and Trance in Brazil: An Anthropology of Religious Experience*. London: Bloomsbury.

Seligman, Rebecca 2014. *Possessing Spirits and Healing Selves: Embodiment and Transformation in an Afro-Brazilian Religion*. New York: Palgrave MacMillan.

Slaby, Jan; Rainer Mühlhoff & Philipp Wüschner 2017. Affective Arrangements. *Emotion Review*. Doi: 10.1177/1754073917722214.

Spencer, Paul (ed) 1985. *Society & the Dance*. New York: Cambridge University Press.

Stoller, Paul 1989. *The Taste of Ethnographic Things: The Senses in Anthropology*. Philadelphia: University of Pennsylvania Press.

Theissen, Anna J. 2009. *The Location of Madness: Spiritist Psychiatry and the Meaning of Mental Illness in Contemporary Brazil*. Ann Arbor: Proquest.

Turner, Victor W. 1968. *The Forest of Symbols: Aspects of Ndembu Ritual*. Ithaca: Cornell University Press.

van der Geest, Sjaak & Shahaduz Zaman 2020. *"Look under the Sheets!" Fighting with the Senses in Relation to Defecation and Bodily Care in Hospitals and Care Institutions. Medical Humanities. Doi: 10.1136/medhum-2019-011766.*

Vannini, Phillip; Dennis Vaskul & Simon Gottschalk (eds) 2012. *The Senses in Self, Society & Culture*. New York: Routledge.

Voss, Ehler 2011. The Struggle for Souvereignty: The Interpretation of Bodily Experiences in Anthropology and among Mediumistic Healers in Germany. In Ruy Blanes & Anna Fedele (eds) *Encounters of Body and Soul in Contemporary Religious Practices: Anthropological Reflections*. Oxford: Berghahn: 167–178.

Voss, Ehler & Cornelius Schubert (ed) 2018. Healing Cooperations: Heterogenous Collaborations beyond Dyadic Interactions. *Curare* 41(1+2).

Waldram, James B. 2000. The Efficacy of Traditional Medicine: Current Theoretical and Methodological Issues. *Medical Anthropology Quarterly* 14, 4: 603–625.

––––– 2013. Transformative & Restorative Processes: Revisiting the Question of Efficay of Indigenous Healing. *Medical Anthropology* 32, 3: 191–207.

Wilke, Annette & Lucia Traut (ed) 2015. *Religion-Imagination-Ästhetik: Vorstellungs- & Sinneswelten in Religion & Kultur*. Göttingen: Vandenhoeck & Ruprecht.

Zanini, Giulia *et al.* 2013. Transitional Medical Spaces: Opportunities & Restrictions. (MMG Working Paper 13–16). Göttingen: Max-Planck Institute for the Study of Religious and Ethnic Diversity.

HELMAR KURZ M.A. studied Social & Cultural Anthropology, Science of Religion, and Archaeology at the University of Muenster/Germany from 2003 to 2009. Since 2011, he teaches and researches on contemporary topics and challenges in Medical and Religious Anthropology with a specialization on Ritual Theory, Performance, Sensory Ethnography & Anthropology, and Trans/Cultural Psychiatry. He focuses socio-cultural, religious, political-economic, and individual aspects in the experience, perception, interpretation, communication, and negotiation of health, illness and therapy, especially in terms of "spiritual" and "aesthetic" practices and technologies of and with the body/self. From 2015 to 2018, he engaged in the DFG-funded research project "Diversivication of Mental Health—Therapeutic Spaces of Brazilian Spiritism" in cooperation with Prof. Dr. Helene Basu at the Department of Social & Cultural Anthropology in Muenster/Germany, where he currently performs as a lecturer and research fellow to further explore aesthetics, conditions, economies, and policies regarding practices of health and healing.

WWU Münster (University of Muenster), Department of Social & Cultural Anthropology
Studtstr. 21, 48149 Muenster/Germany
e-mail: helmar.kurz@uni-muenster.de

Animist Contributions to Rethinking Wellbeing and Healing[1]

Keynote

GRAHAM HARVEY

Introduction

Animism has been the subject of considerable debate in recent decades. The term was once used almost entirely to denigrate those it purported to label but has now been reassessed, reclaimed, revalued and re-used. Instead of alleging, as some scholars have (*e.g.* TYLOR 1891), that animists are people who mistakenly attribute life, spirit, soul, mind, agency or intentionality to non-human beings, recent conversations have proposed more interesting and more provocative analyses. Elsewhere I have summarised the new use of the term 'animism' as follows:

> "Animists are people who recognise that the world is full of persons, only some of whom are human, and that life is always lived in relationship with others. Animism is lived out in various ways that are all about learning to act respectfully (carefully and constructively) towards and among other persons. Persons are beings, rather than objects, who are animated and social towards others (even if they are not always sociable). Animism may involve learning how to recognise who is a person and what is not—because it is not always obvious and not all animists agree that everything that exists is alive or personal. However, animism is more accurately understood as being concerned with learning how to be a good person in respectful relationships with other persons" (HARVEY 2017a: xvii).

In this essay, I pick up the thread of the last sentence of that summary and trace ways in which animism contributes to rethinking wellbeing and healing by engaging with views of what a "good life" might be. I argue that different notions of health, wellbeing, good living and, therefore, different therapeutic practices arise from particular understandings of what a person is, should be, or might become. I contrast animist relational approaches with the individualising project of Modernity (by which I refer not to an epoch but to a political-cultural project that began in Europe and is now globally dominant, albeit in diverse forms).[2]

Important as it is to understand the people and practices which could be labelled "animistic," recent animism discussions take place in a wider context. For one thing, a significant proportion of people who express preferences for "spirituality" over "religion" refer to or draw on at least aspects of the worldviews or lifeways of Indigenous people (particularly Native Americans, Amazonians and/or Siberians) some of whom might be considered to be animists. They exemplify a trend in which Indigenous knowledges sometimes provide new inspiration or provocation for reflecting on the accepted norms and practices of globalised "Western" culture. This trend is one justification for the practice of anthropology and ethnological disciplines. As HOWARD EILBERG-SCHWARTZ asserted

> "[A]nthropology has insisted that we have a great deal to learn about ourselves from the study of the other [...]. This is the myth that justifies the anthropological enterprise, a myth that says that the study of the other leads to enlightenment" (*ibid.* 1989: 87).

Put more colloquially, learning from others (whoever they and we are) is the only excuse for poking our (scholarly or spiritual) noses into their business. Tensions between respectful learning, critical questioning and appropriation are entangled in this and other considerations of and debates about diverse knowledges and practices.

"Learning from others" is also a necessary corollary of recognising the expertise of our hosts

(Harvey 2003, 2005, 2013, 2017b). Doing so with respect makes a significant difference to both spiritual and scholarly endeavours. The key point is that learning among others ought to open us to the possibility that our current ideas and practices, cultures and norms, could require alteration. If, as Bruno Latour (1993) has declared, "we have never been modern," perhaps we have been animists or, at least, might come to understand the necessity and value of more carefully thinking about such matters. For these reasons, this article brings animist and Modernist notions of personhood and wellbeing into dialogue. This includes an outline of some of the resonances of the *Anishinaabe* term "bimaadiziwin" which could be translated as "good life" or "living well," or both. The dialogue between animist and Modernist ontologies continues by considering a contrast between therapeutic practices that might be called shamanry and (neo-)shamanism. This is possible (and hopefully productive) because the cosmologies and practices of some Indigenous shamans have influenced some Western spiritualities and/or therapies. The article concludes that the relationality of animism and the consumerist individualism of Modernism involve contrasting notions of "good living" and of health practices.

Persons, Individuals and Dividuals

Recent animism debates (and those related to "new materialism" and the "ontological turn") constellate around the question of what it means to be a person and frequently cite Irving Hallowell's *Ojibwa Ontology, Behavior, and World View* (1960). In this and other publications, Hallowell clearly sets out much of what he learnt among his *Anishinaabe* (also *Ojibwa*)[3] hosts near the Berens River in what is now Manitoba, Canada. He argues that

> "While in all cultures 'persons' comprise one of the major classes of objects to which the self [*i.e.* a particular person, not the 'ego in the psychoanalytic sense'] must become oriented, this category of being is by no means limited to human beings. In Western culture, as in others, 'supernatural' beings are recognized as 'persons,' although belonging, at the same time, to an other than human category. But in the social sciences and psychology, 'persons' and human beings are categorically identified. [...] Yet this obviously involves a radical abstraction if, from the standpoint of the people being studied, the concept of 'person' is not, in fact, synonymous with human being but transcends it. [...] The significance of these differences in perspective may be illustrated in the case of the Ojibwa by the manner in which the kinship term 'grandfather' is used. [...] [If] we study Ojibwa social organization in the usual manner [i.e. treating 'persons' as a synonym of 'humans'], we take account of only one set of 'grandfathers.' When we study their religion we discover other 'grandfathers.' But if we adopt a world view perspective no dichotomization appears. In this perspective 'grandfather' is a term applicable to certain 'person objects,' without any distinction between human persons and those of an other-than-human class. Furthermore, both sets of grandfathers can be said to be functionally as well as terminologically equivalent in certain respects. The other-than-human grandfathers are sources of power to human beings through the 'blessings' they bestow, *i.e.*, a sharing of their power which enhances the 'power' of human beings." (Hallowell 1960: 21f)

A number of matters are established here. Humans are not the only kind of persons. Persons are ontologically relational beings. Some persons are closer kin than others. Persons have varying degrees of 'power' (and different *kinds* of power, some of which might be called authority, prestige, dominance, ability or skill). In the fuller discussion, Hallowell also shows that from a Western perspective some of the "other-than-human" class of person might be considered "supernatural" while some might be considered "natural-" However, he clearly explains that these categories do not serve well to translate or convey the sense of *Anishinaabe* knowledge. So, for example, when Hallowell asked Kiiwiich (Alec Keeper), an elder and ritual leader, whether some nearby stones were alive, a discussion ensued (one that has generated considerable discussion about animacy and relationality in recent years). The relevant point for the present is that, as *Kiiwiich* understood and experienced the world, both humans and stones have the potential to act towards other beings – for example, giving and receiving gifts. Such relational engagements, rather than any sense of having a soul (or mind, ego or other kind of interiority), make them "persons." In terms of linguistic categories, stones are "per-

sons" and "other-than-human persons"—just as humans are "persons" and "other-than-stone persons"—but they are neither "natural" nor "supernatural" in any meaningful sense. In life, relational interactions are not best fixed into categories and "personhood" is recognisable as beings give and receive gifts and other concretisations of respect (Bird-David & Naveh 2008; cf. Bird-David 2018).

Beyond noting that there are many kinds of person, most of whom are not human, but all of whom show themselves to be persons when they act relationally with others, Hallowell and *Kiiwiich*'s conversation anticipated other challenges to the terminology of personhood (in the English language at least). In particular, our understanding of what it might mean to be a person can be expanded by considering the notion of *dividual* relationality. The term "dividual" originated with McKim Marriot's (1976) discussion of "diversity without dualism" among Indian Hindus, and with Marilyn Strathern's (1988) contrast between the ambitions of Melanesians and "Westerners" to grow different kinds of person and to assemble communities differently. It is important to note that in their individual/dividual contrast, both Marriot and Strathern were deploying ideal types. They recognised that in lived reality both conceptions of personhood are evident everywhere, existing on a continuum or emerging in tension. Similarly, in this article, "Modernity," "Indigeneity," "animist," "individual," and "dividual" are employed for strategic purposes. Reality is too messy, diverse, changeable and interesting to be pinned down by strict contrasts or enclosed in the tight boxes such labels might suggest. Playing in the space between ideal types and lived realities is, however, valuable in seeking to understand the priorities, obligations, and ambitions that inform and shape cultural lives. The following paragraphs briefly outline some ideas about individuals and dividuals.

As summed up by Bruno Latour's assertion that "We have never been modern" (1993; cf. Latour 2013), the project of Modernity attempts to separate humans from the larger world, for example by persuading us that culture and nature label discrete realities. In terms of what "person" might mean, this Modernism has emphasised individuality and interiority as it encourages each "person" to imagine they have a unique (self-)identity. In the realm of politics and citizenship, the Modernist process of organising Nation States according to Westphalian system principles required the curtailment of trans-national loyalties (*e.g.* loyalties to Roman Catholic or Protestant princes) (Cavanaugh 1995, 2009). Persons-as-citizens were and are expected to demonstrate loyalty as *individual* voters in Nation States, neither constrained nor compelled by other kinds of relationship. Being cousins, chefs, drivers, pet-owners, club-members, bloggers and other kinds of kin is not negated by the requirements of citizenship, but is seen as different, other-than-political ways in which each putatively bounded and discrete self relates to other individuals. In the realm of religion, the interior faith of individual believers was emphasised above participation in rituals. While this began among Protestant Christians, it was soon pursued by Catholic Christians and eventually spread globally as a plank of Modernity's ideology and sociality. Eventually, "spirituality" has become separated from the institutions and communities that are often taken to define "religion." It emphasises intuition and intention. In the realm of therapy, Modernity's "individuation" also entails an inward focus. Sociologically, as Arnar Árnason points out, the Modern assumption is that "social relations exist between points, or roles, in a structure, or at best *between* the people temporarily occupying these positions" (*ibid.* 2012: 68, original emphasis).[4] Some philosophers have followed Descartes in separating mind from matter, and constructed ontologies in which mindful humans privilege rationality over sensuality in their engagements with the "nonhuman" world. In all these ways, a Modern person is an individual, a discrete object or actor even when interacting with others.

Dividual personhood is conceived differently. Persons are not points or positions in a structure but relations. Beings become persons precisely by engaging and interacting with others. Personhood is not a matter of identity but of interacting, doing or performing. A person is recognised in the performance of relationality with and among others. Because some relations are closer than others, kinship and locality-rooted relations are often crucial to the interactions and performances which form and reform Indigenous communities.

The sensual physicality of dividual persons is integral to the ways in which they engage with others. Knowledge is to be gained not just from self-reflection but from trusting the bodily and worldly sensorium and from learning to pay attention to particular experiences with(in) the world-as-community. (For insightful and provocative consideration of ontologies arising from relationality and sensual embodiment cf. Abram 1996, 2010; Viveiros de Castro 1992, 1998, 2004, 2007). If Modernity might interpret the ancient advice "know thyself" as "look inward" or "honour your individuality," in cultures or communities which encourage dividual personhood it might mean "relate to others with respect" or "honour your responsibilities to others."

Animist Wellbeing

This sketch of what it can mean to be a person in Modernist and animist communities inevitably leads to the question of what a healthy person might be. This section considers wellbeing among animistic, relational *Anishinaabeg*. I engage with *Anishinaabe* animism because of the foundational role of Hallowell's publications in "new animism" debate, because I have benefitted from the hospitality of *Anishinaabe* hosts, and particularly because of the clarity of an *Anishinaabe* colleague, Larry Gross, whose work informs this section. Gross's book, *Anishinaabe Ways of Knowing and Being* (2014), is particularly important because it not only celebrates Indigenous cultural resilience but also engages robustly with the traumas that are its context.

Gross demonstrates that the term *bimaadiziwin* encapsulates the moral structure and religious lives of *Anishinaabe* people. He notes that although the word might be translated simply as "life" (requiring a prefix *mino-* to indicate "a good life"), in many contexts *bimaadiziwin* is commonly used to mean "a good life" or "living well." Gross says that this "can basically be described as a long and healthy life" (Gross 2014: 205). It is learnt about in "a lifelong process that includes every part of the culture" (*ibid.* 208) rather than being taught as a body of facts and rules. Observation of the lives of elders and of the larger-than-human community, the telling and hearing of stories, and the repeated casual, conversational and ritual evocation of respect provide some indicators of what it could mean to live well. Of the contexts discussed by Gross in which *bimaadiziwin* is taught and learnt, three can be usefully summarised here: silence in the woods, hunting and fasting.

At the heart of Gross' chapter on "silence and the *Anishinaabe* worldview" is a story about grandparents instructing their grandchildren to be "quiet in the woods because this is the deer's house and we are just visitors" (*ibid.* 2014: 61, citing Northrup 2001: 18). The instruction is given as the family group leave to go into the woods to tap maple trees for the sap from which to make syrup. Arriving in the woods, the children run around, laughing, boisterously competing to collect the most sap. Nonetheless, this is recorded as "a good learning season" because, as Gross comments, the lesson has been imparted and "will eventually find its way into the children's consciousness" (Gross 2014: 62). They will adopt the practice of being silent or quiet in the woods. It will become a life- and personality-shaping habit. They will listen to the larger-than-human community getting on with life. They will become aware of their own presence in that community. They will come to know what sounds, sights and other sensual experiences are communicative, beneficial or threatening. They will appreciate the value of showing respect in the domain of other persons' homes.

Hunting has been and remains a significant part of traditional *Anishinaabe* life. It is framed and shaped by protocols and taboos arising from the understanding that humans and animals have significant relationships—their shared belonging to places composes ecologies of "at home-ness" with kin and generates mutual obligations. This understanding is made stronger by the totemism in which human groups associate together as the relations of specific species (*i.e.* in bear or otter clans—the *Anishinaabe* word *totem* or *dodem* meaning "clan," a larger-than-family interspecies assemblage). Hunting requires specific ways of conducting respect and enacting responsibilities. Gross mentions some of them, including that "one was not to speak ill of animals. Also, dead game animals were to be treated as honoured guests" (*ibid.* 209). Disrespecting prey ani-

mals is, in many animist cultures, one of the main reasons for the employment of shamans (ritualists focused on in the following section). Respecting animals (and other food-persons) and abiding by pragmatic and time-tested hunting practices maintains healthy ecologies, communities, bodies and other relations.

As Gross says, "while ostensibly fasting was traditionally a search to 'know thyself,' more comprehensively speaking, fasting also brought an individual into a lifelong moral compact" with persons able to provide assistance throughout life (*ibid.* 208). Such persons could include songs because these are understood to be "living persons." They can be received during fasts and come to help in healing other people, but "one would also have to work with the song or the [other-than-human] helper who gave one the song [...] [which would] most likely entail following certain modes of behaviour [which] had their moral aspects" (*ibid.*). These behaviours are particularly important because, as Gross sets out in detail, songs are living, animate persons, with "the power to affect other things," who must be fully present along with the singer/healer and the patient for there to be a cure (*ibid.* 105ff). Healers work with songs (or song-persons) to cure patients. As in other relationships, but especially in those of great intimacy or significance, appropriate behavioural etiquette is to be expected.

In all three examples—silence, hunting and fasting—*Anishinaabeg* emphasise sensual, physical practices as ways of creating, maintaining, or restoring relationships between humans and the larger-than-human community. The good life is respectful and entails reciprocity and responsibility. It is rewarded with further opportunities to relate well. But lives in a multi-species world can be fraught with difficulties which sometimes require the intervention of healers and, in animist communities, sometimes of shamans.

Shamanry vs Shamanism

The term "shaman" has become immensely popular far beyond its Siberian homeland. "Shamanism" is now commonly associated with *Altered States of Consciousness* (ASC) to the degree that such states seem to define the phenomena. Workshops and *Do It Yourself* style publications encourage people to undertake "shamanic journeys" to re-connect with their inner selves and the symbolic "power animals" who might aid their individuation. Some such people go on to offer therapeutic support for other Modern individuals, usually in the form of further guided visualisations that fuse Jungian-style therapy with forms of "spirituality" (another term, like "shamanism," of such wide application it can be hard to know if it has any specific meaning). The activities and aesthetics of these practices have been widely debated by scholars in multiple disciplines, generating a large literature alongside that of practitioners (some of which is surveyed in Harvey & Wallis 2016.)

To distinguish "shamanism" (sometimes "neo-shamanism") from the more animistic practices of Indigenous peoples, I propose to use the term "shamanry." This has the added advantages of resisting the systematisation suggested by "-ism" and of emphasising practice over ideology. According to the *Yanomami* leader, diplomat and scholar, Davi Kopenawa, "white people do not become shamans" (Kopenawa & Albert 2013: 375). While some of his reasons for this assertion might be contested by those white people who claim to be practising shamanism[5], his key point is the individualism of white people. He thinks that all the antennas and other listening devices (physical or metaphorical) used by white people "only serve for them to listen to themselves" (*ibid.* 376). For Kopenawa, to be a shaman is to intensify relationships with powerful other-than-human allies (especially those he calls *xapiri* – sometimes translated as "spirits" with evident unease), and with communities who need leadership, knowledge, healing and help.

Kopenawa and other Amazonian shaman/diplomat/educators have profoundly influenced (other) scholars involved in the "ontological turn," and the "material turn" (*e.g.* Viveiros de Castro 2007). Certainly they have enriched the study of what shamans do. It is now a leitmotif of recent "turns" and wider scholarship that Indigenous ontologies and their resultant notions of health and illness are often predicated on the understanding that while relationships compose beings as persons, those same relationships can be problematic. When the world is full of persons (only

some of whom are human), persons necessarily relate to others as predators or prey—needing to eat others and generally wishing not to be eaten (but sometimes willingly self-sacrificing to enable others to survive or thrive). These are fraught relations in which it is frequently necessary to call on others to mediate and resolve difficulties that are understood to have resulted in bad luck or ill-health. In extreme situations, animals might refuse to present themselves to hunters because of some breach of respectful etiquette or some insult to themselves or their close relations. In such situations, shamans are called on.

While their rituals may involve altered states of consciousness (including trance), the more definitive acts of shamans involve altered styles of communication or affective sensual communication (both of which might also abbreviate to ASC). It is, for instance, KOPENAWA's ability to relate well with *xapiri* (allies, helpers or "spirits") that enables him to serve his community as a healer, teacher, and diplomat. Doing so involves significant adjustments of his senses—especially but not only of sight, hearing and place—but also of comfort as the *yākoana* snuff hits him hard and prepares him to see the *xapiri* dancing and to hear them singing. Equally importantly, repeated encounters enable him to remember and increase understanding of the songs and what they teach. He is also adjusted so that he can speak and sing appropriately among his peers, community, and beyond. This shamanry is never a solitary or individual practice—nor one that individuates the shaman—but involves both initiators and initiates within human and larger-than-human communities.

In summary, the practices of shamanry address the interactive personhood that is both required and pressurised by the relationality of animistic worlds. In contrast, the practices of (neo) shamanism address the interiorised selfhood that is both required and pressurised by the separatist project of Modernity. Both Moderns and animists suffer a range of physical, mental, relational, and other stresses and problems which require appropriate forms of therapy. The violent invasion of Amazonia by European extractivists and their diseases have led *Yanomami* and other Indigenous peoples to seek to benefit from Western medicines. Customary practices, however, continue to be vital (important and life-giving). They provide resilience in and aid resistance by endangered communities in endangered forests and other bioregions.

The shamanism of Moderns (in *Latourian* terms) is of a different nature. It certainly cites what anthropologists and others have learnt among Indigenous shamans and their animistic communities. However, it does not resist the project of Modernity but embraces its individualising and interiorising—or its "spirituality." It certainly involves body practices and a sensuality of sound (recorded or live drum or rattle rhythms), sight (or deprivation of sight), and of posture if not always of movement. That is, its most popular expressions involve lying prone on the floor with eyes (or complete heads) covered while some rhythmic noise drives a desired altered state of (inner) consciousness. The therapeutic value of such acts is undoubtedly related to the difficulties of being encouraged to be(come) individuals in a hyperactive consumeristic and acquisitive world. It encourages a self-knowledge that aids individuated beings to deal with the stresses that are erupting in increased mental health problems. This shamanism is certainly a therapy but whether it is a shamanry is doubtful.

Conclusion

There are some things that seem obvious and uncontentious when we ask what "wellbeing" and "ill-health" mean. Someone with a broken bone may seem self-evidently "not well" and in need of healing. But is a boxer or rugby player with a broken nose "not well"? Other matters—such as hearing the voices of deceased relatives or deliberately cutting oneself—seem obvious signs of ill-health to some people but not to others. Some differences in the ways in which wellbeing and ill-health are defined are identifiable as "cultural" with the implication that it might be possible to draw up lists of what diverse cultures consider normal or abnormal, healthy or in need of treatment. Not all such differences are equal in the eyes of even the most liberal observer. Some body modifications and some deliberately induced sensations are more contentious than others. While male circumcision among Jews, Muslims, and Americans may be deemed questionable among some peo-

ple, the cutting of female genitalia is almost universally abhorred and condemned. The fact that both proponents of male and female genital modification *can* claim that these acts perfect or purify human bodies and/or prevent physical or moral wrongs makes relevant debates more difficult. Moreover, such claims point back to the starting point. How do we decide what wellbeing and ill-health are? Underlying that question is the more fundamental difficulty (as we are faced with considerable diversity of opinion and cultural practice) of knowing what a person is meant to be.

The wellbeing and the ill-health of persons moulded by the demands of individualising and consumerist societies are understood and perhaps experienced differently (to varying degrees) with those of societies that require increasing relationality. Both cultural complexes cause stresses as well as providing benefits. The promotion of health and/or resilience is intimately related to the ontologies and ambitions encouraged within particular communities. A larger discussion should take into account the kinds of connections and disconnections people have with the larger-than-human world. Like viruses and other pathogens, Climate Disaster and Mass Extinction[6] affect all persons (human or otherwise), regardless of their acceptance or rejection of such realities. Individualist and dividualist responses and experience might be as different in relation to health concerns and practices as they are in relation to media and other narratives. Being shaped as citizens of Nation States and as consumers (reliant on increasing extractivism) creates different kinds of person—and therefore different kinds of wellbeing and ill-health—from being shaped by the obligations of belonging within larger-than-human communities. Both forms of belonging impact everyone in this era, creating tensions as people try to be good citizens, careful consumers *and* respectful relations. The question raised in this article is how animist knowledges contribute to richer and healthier understandings of "good living."

Notes

1 I am grateful to Helmar Kurz for inviting me to present a keynote lecture at the 32nd annual conference of the Association for Anthropology and Medicine (AGEM), hosted at the University of Münster, Germany.
2 'Modernity' and 'Modernist' are capitalized through this essay in order to highlight, somewhat polemically, their character as a more-or-less deliberate ontology or a cultural-political-colonizing world-making project. Meanwhile, "animism" is not capitalized in order to avoid the suggestion that it is equivalent to the names of specific religions or cultures (e.g. Buddhism) but something more like a style of religion or culture (like 'polytheism').
3 The plural of Anishinaabe is Anishinaabeg. This Indigenous nation (whose traditional territories are in what is now also the northern Midwest of the United States and the central south of Canada) are also known as Ojibwa, Ojibwe, Chippewa and other names.
4 This provides an important corrective to mis-readings of Actor-Network Theory which emphasise those points rather than the interactions.
5 For example, Kopenawa thinks that perfumes and alcohol make white people 'too odorous and too hot', presumably for the liking of 'spirits' (Kopenawa and Albert 2013: 375). Many neoshamans agree that avoidance of alcohol and other stimulants is important. On the other hand, many of them think it is possible to shamanize without resorting to the kind of (DMT carrying) snuffs that Kopenawa insists are necessary for attracting and learning from the *xapiri* beings.
6 Both now such powerful shapers of the world that they require capitalization.

References

Abram, David 1996. *The Spell of the Sensuous: Perception and Language in a More-than-Human World*. New York: Vintage Books.

Abram, David 2010. *Becoming Animal: An Earthly Cosmology*. New York: Pantheon.

Árnason, Arnar 2012. Individuals and Relationships: On the Possibilities and Impossibilities of Presence. In Douglas J. Davies & Chang-Won Park (eds) *Emotion, Identity and Death: Mortality across Disciplines*. Farnham: Ashgate: 59–70.

Bird-David, Nurit 2018. Persons or Relatives? Animistic Scales of Practice and Imagination. In Miguel Astor-Aguilera & Graham Harvey (eds) *Rethinking Personhood: Animism and Materiality*. New York: Routledge: 25–34.

Bird-David, Nurit & Danny Naveh 2008. Relational Epistemology, Immediacy, and Conservation: Or, What Do the Nayaka Try to Conserve? *Journal for the Study of Religion, Nature and Culture* 2, 1: 55–73.

Cavanaugh, William T. 1995. A Fire Strong Enough to Consume the House: 'The Wars of Religion' and the Rise of the State. *Modern Theology* 11, 4: 397–420.

Cavanaugh, William T. 2009. *The Myth of Religious Violence: Secular Ideology and the Roots of Modern Conflict*. Oxford: Oxford University Press.

Eilberg-Schwartz, Howard 1989. Witches of the West: Neopaganism and Goddess Worship as Enlightenment Religions. *Journal of Feminist Studies in Religion* 5, 1: 77–95.

Gross, Lawrence W. 2014. *Anishinaabe Ways of Knowing and Being*. Farnham: Ashgate.

Hallowell, Irving A. 1960. Ojibwa Ontology, Behavior, and World View. In Stanley Diamond (ed) *Culture in History: Essays in Honor of Paul Radin*. New York: Columbia University Press: 19–52.

Harvey, Graham 2003. Guesthood as Ethical Decolonising Research Method. *Numen* 50, 2: 125–46.

Harvey, Graham 2005. Performing and Constructing Research as Guesthood. In Lynne Hume & Jane Mulcock (eds) *Anthropologists in the Field*. New York: Columbia University Press: 168–82.

Harvey, Graham 2013. *Food, Sex and Strangers: Understanding Religion as Everyday Life*. New York: Routledge.

Harvey, Graham 2017a. *Animism: Respecting the Living World*. Second edition. London: Hurst.

Harvey, Graham 2017b. Performing Indigeneity and Performing Guesthood. In Christopher Hartney & Daniel J. Tower (eds) *Religious Categories and the Construction of the Indigenous*. Leiden: Brill: 74–91

Harvey, Graham & Robert Wallis 2016. *Historical Dictionary of Shamanism*. Second, revised edition. Lanham: Rowman & Littlefield.

Kopenawa, Davi & Bruce Albert 2013. *The Falling Sky: Words of a Yanomami Shaman*. Cambridge: Belknap Press of Harvard University.

Latour, Bruno 1993. *We Have Never Been Modern.* New York: Harvester Wheatsheaf.

Latour, Bruno 2013. *An Inquiry into Modes of Existence: An Anthropology of the Moderns.* Cambridge: Harvard University Press.

Marriott, McKim 1976. Hindu Transactions: Diversity without Dualism. In Bruce Kapferer (ed) *Transaction and Meaning: Directions in the Anthropology of Exchange and Symbolic Behavior*. Philadelphia: ISHI: 109–42.

Northrup, Jim 2001. Fond du Lac Follies. *The Circle* (Minneapolis). April issue: 18.

Strathern, Marilyn 1988. *The Gender of the Gift: Problems with Women and Problems with Society in Melanesia.* Berkeley: University of California Press.

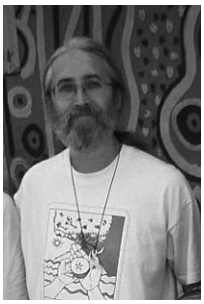
Tylor, Edward B. 1871. *Primitive Culture*. 2 volumes. London: John Murray.

Viveiros de Castro, Eduardo B. 1992 [1986]. *From the Enemy's Point of View*. Chicago: University of Chicago Press

Viveiros de Castro, Eduardo B. 1998. Cosmological Deixis and Amerindian Perspectivism. *Journal of the Royal Anthropological Institute* 4: 469-488.

Viveiros de Castro, Eduardo B. 2004. Exchanging Perspectives: The Transformation of Objects into Subjects in Amerindian Ontologies. *Common Knowledge* 10, 3: 463-484.

Viveiros de Castro, Eduardo B. 2007. The Crystal Forest: Notes on the Ontology of Amazonian Spirits. *Inner Asia* 9: 13–33.



GRAHAM HARVEY is professor of religious studies at The Open University. His research largely concerns "the new animism," especially in the rituals and protocols through which Indigenous and other communities engage with the larger-than-human world. These contribute to a focus on material- and lived-religion. His recent teaching related work has involved a focus on foodways and associated "purity" practices. His publications include *Food, Sex and Strangers: Understanding Religion as Everyday Life* (2013), and *Animism: Respecting the Living World* (2nd edition 2017). He is editor of the Equinox series "Religion and the Senses" and the Routledge series "Vitality of Indigenous Religions."

Faculty of Arts and Social Sciences
The Open University, Walton Hall, Milton Keynes, MK7 6AA
e-mail: graham.harvey@open.ac.uk

Creating Space for the "Sacred" in Cancer Care

Integrating Indigenous Medicines into Health Care

CATHY FOURNIER & ROBIN OAKLEY

Abstract *Indigenous First Voice* is utilized to explore the *Two-Eyed Seeing* ("Etuaptmumk") principle to theorize the integration of Indigenous medicines into health care in Canada. Similar to autoethnography, Indigenous First Voice positions the experiences and knowledge of the researcher at the heart of the analysis, while bringing formerly erased, contorted and stigmatized knowledges to the fore. In particular we draw on FOURNIER's account of a recent cancer experience and exploration of her experiences as a *Métis*[1] woman to illustrate tensions that require negotiation in order to avoid being absorbed into a dominant biomedical way of understanding health and wellness. We juxtapose her sensory experiences of using Indigenous healing alongside biomedicine for cancer care and call for a dynamic, multi-eyed seeing framework which more accurately captures the nature of the *Two-Eyed Seeing/Etuaptmumk* principle.

Keywords Cancer, Indigenous, Etuaptmumk,Two-Eyed Seeing, Aboriginal Peoples, Biomedical Dualism, Critical Medical Anthropology, Aesthetics of Healing

Introduction

> "The sound of the drum, the smoke, the smell of burning sage. I feel it beyond the bone, I feel it in my blood, like my blood, is remembering something. I always cry when I hear that drumming not out of sadness, but from a feeling of profound relief."

This excerpt from FOURNIER's auto-ethnographic cancer notes serves as an entry point into our paper exploring the integration of Indigenous knowledges/medicines[2] and healing ceremonies into health care in Canada, while evoking cancer as a trope for colonialism and its aftermath. Drawing on *Indigenous First Voice*, a form of autoethnography, we expand on the concept of *Two-Eyed Seeing*, referred to as the *Etuaptmumk* principle in the *Mi'Kmaw* language, and theorize the integration of Indigenous medicines into health care more broadly. *Two Eyed Seeing/Etuaptmumk* is a guiding principle positing that we learn to see "from one eye with the strengths of Indigenous knowledges and ways of knowing, and from the other eye with the strengths of Western knowledges and ways of knowing, and to us[e] both these eyes together, for the benefit of all" (BARTLETT *et al.* 2012: 335). *Etuaptmumk/Two-Eyed Seeing* is linked to the broader movement of "decolonizing" health care institutions through integrating Indigenous medicines/knowledges and forms of governance, to help foster safer and more inclusive health care access in Canada (cf. BRUNGER & WALL 2016; CHRISJOHN & WASACASE 2009; JAMES 2012; MARTIN-HILL 2003; ROBBINS & DEWAR 2011). Over the past decade, multiple calls proliferated to examine how Indigenous healing differs from biomedicine, and the need to examine how best to incorporate Indigenous medicines/knowledges into biomedical contexts (cf. BENOIT *et al.* 2003; HOLLENBERG & MUZZIN 2010; MANITOWABE & SHAWANDE 2013; ROBINSON *et al.* 2017). This paper is a modest contribution to these calls and more broadly toward overcoming the mind-body dualism of biomedical approaches.

Indigenous*?*

Before embarking on this journey, we need to clarify our use of the term *Indigenous,* a recently proliferating concept that emerged due in part at least, to the surge of *settler-indigenous* studies. In Canada, it is often used to refer broadly to Aboriginal Peoples, a constitutional category referring to: *First Nations* (registered and non-registered Indians), *Métis* and *Inuit* Peoples. Aboriginal Peoples in Canada have been, and continue to be, in a unique position in terms of International Law due to the *Doctrine of Aboriginal Title* applied in Canada, USA, New Zealand and Australia (cf. Oakley 2006). In Canada, colonial and post-colonial practices (Neu 2002) and policies, such as demographically erasing people through the colonial period based on the virulent *Indian Act,* were explicitly designed to assimilate *Aboriginal Peoples* into a *Euro-Settler* norm (Mackey 1997; Smith 2012). The Indian Act is a Canadian federal governing document, with legal implications, that allows the government to control many aspects of Indigenous Peoples lives including who is considered Indigenous in the eyes of the state. It was and remains part of the assimilationist strategy in Canada (Joseph 1991; Palmater 2011), along with forcing people to take up agriculture instead of gathering, hunting and fishing, enforced sedentism (Grygier 1994), banning of essential economic and spiritual practices, (Kelm 1999), conversion to forms of Christianity (Smith 2001), starvation (Daschuk 2013), forced sterilization (Stote 2015), shaming and devaluing language/culture, and erasing womens' and off reserve peoples' right to claim Indigenous status (Cannon 2007). All these processes made people more susceptible to opportunistic infections and co-infections (Kelton 2007). While some have referred to these processes as constituting "ethnocide" (Sider 2014), others name these processes, including infamous "gift" of smallpox (Mann 2009) and scalping proclamations (Paul 2006), genocide. In addition to this was the residential school system, where Indigenous children were removed from their families and forced into Indian residential schools that were meant to aggressively strip them of their culture, languages, Indigenous worldviews and ways of living (MMWIG Report 2019; Smith 2001). A paternalistic serial foster care system (Crichlow 2002), overrepresentation in the penal system (Jackson 1989a; Rudin 2008), intergenerational trauma (Menzies 2008) and resulting suicide epidemics (Wexler & Gone 2016) led to the development of a massive infrastructure governing the health and lives of Indigenous peoples; something that Harlan Lane, in comparing Deaf and indigenous/colonised peoples find themselves subject to "masks of benevolence" (Lane 1999): the perpetuation of infrastructures ultimately designed with assimilation in mind. Much of this surge of information on Indigenous Peoples, has come to public attention in recent years as a result of the UN's Decade of Aboriginal Peoples (1994–2004) and in Canada, the Truth and Reconciliation Commission Report. The *Truth and Reconciliation Commission* (TRC) is a component of the *Indian Residential Schools Settlement Agreement*, which was created with the support of the *Assembly of First Nations* and *Inuit* organizations in which, former residential school students took the federal government and the churches to court (TRC 2015). These cases led to the *Indian Residential Schools Settlement Agreement,* the largest class-action settlement in Canadian history. The agreement sought to begin repairing the harm caused by residential schools. The TRC's mandate was to inform all Canadians about what happened in *Indian Residential Schools* (IRS) in Canada between 1883 and 1996, and to address the ongoing impact of colonization on Indigenous Peoples. Hence, while being aware of the wider implications accompanying the surge of "Indigenous" as generalised terminology that has the potential to obscure the specific focus from Canadian *Aboriginal Peoples* (cf. Oakley 2019, 2021), we do use the term in this paper to refer to "those which have a historical continuity with pre-invasion and precolonial societies that develop on their territories, consider themselves as distinct from other sectors of societies now prevailing in those territories [...] and are determined to preserve and transmit to future generations their ancestral territories" (Valeggia & Snodgrass 2015: 119, citing Martinez Cobo 1981: 10).

Colonization and Medicine

While it is clear that the elements pointed out above created the foundation for assuredly poor health among Canada's Indigenous Peoples, it is

important to note that the specific experience of colonialization under the Indian Act was accompanied by the penetration of Christian missions and biomedicine into Indigenous communities that was instrumental in the expansion of the Euro-Canadian frontier (cf. Kelm 1998; laugrand & Oosten 2014; Robbins & Dewar 2011). Kelm (1999) argues this happened partially through the construction of imperial biomedicine as superior, while Indigenous ceremonies/medicines were reduced mere superstitious quackery and/or witchcraft. In fact, as mentioned earlier, many Indigenous healing ceremonies were banned and even considered a criminal offense between 1885 to 1951 by the state. Colonialism and colonial processes have been articulated as a social determinant of health (cf. Manitowabi & Maar 2018). The legacies of colonization have also left in their wake a significant lack of trust in mainstream biomedicine amongst many Indigenous Peoples in Canada (Vogel 2015). The TRC calls to action such as the integration of Indigenous medicines/ceremonies into health care are seen by the government as one way to rebuild this lost trust with Indigenous Peoples. This is important in this context as the government is providing millions of dollars in funding for numerous initiatives to help integrate Indigenous medicines/healing into biomedical health care settings. While there are questions to be raised about whether the state will continue to support these programs now that the TRC is closed, and the acceptability of the content of the programs by Indigenous Peoples who use them, it can still be stated that some cultural inroads in public health have been initiated through the funds (cf. Allen *et al.* 2020; Cameron *et al.* 2019; Cook *et al.* 2019).

Methodology

Given the context discussed above we want to examine, how can sacred healing spaces, spaces of hope, be created, while dealing with cancer? What are the tensions that require navigation and how can they be theorized using sensory aspects of healing to build on existing understandings? Within these spaces can methodology become an embodied experience as well as an intellectual exercise? We explore the *Two Eyed Seeing/Etuaptmumk* principle and query the need to accentuate/highlight the spaces and tensions *between* "Indigenous" and "Euro-centric" ways of knowing rather than their integration, while drawing on notions of embodied space (cf. Low 2003). We also suggest that in this instance we must move beyond mere physically embodied space to include other aspects of being, such as spiritual, emotional and historical realms, or toward a "*wholisic*" embodiment (cf. Blackstock 2011; Walters *et al.* 2011).

In order to explore our questions, we draw on Fournier's experience of a recent cancer diagnosis while also exploring her awakening identity as a *Métis* woman.[3] Specifically, we juxtapose Fournier's "wholistic embodied" sensory experiences of engaging with Indigenous healing approaches alongside biomedicine for cancer care to help develop *Two Eyed Seeing/Etuaptmumk* towards a more dynamic *Multi-Eyed Seeing* framework, which more accurately captures the intended essence of the *Two-Eyed Seeing/Etuaptmum*k paradigm according to *Elder* Albert Marshall (cf. Bartlett *et al.* 2012). Throughout we draw on the literature that explores the *aesthetics of healing*, as well as theories of embodiment to help develop our argument (cf. Csordas 1990, 1993; Nichter 2008).

We employ an Indigenous and decolonizing approach, (*i.e.* Indigenous First Voice) informed by Indigenous scholars such as Bull (2010), Chilisa (2011), Kovach (2009), Smith (2012), and Wilson (2009). A decolonizing approach entails privileging throughout the research process Indigenous worldviews and knowledges that come from an Indigenous paradigm, and not just an Indigenous perspective (Wilson 2001). An Indigenous paradigm derives from the "fundamental belief that knowledge is relational" (Blastock 2011; Wilson 2001: 176; cf. Josephides & Grønseth 2017). We also draw on Buroway's (1998) extended case method, which encourages a reflexive model of research/science that emphasizes, rather than tries to underplay or obscure, the intersubjectivity between researcher and "subject." Buroway's extended case method purposefully blurs and even tries to erase the bounded spaces of "researcher" and "researched" and is in line with Indigenous methodologies and relationality (cf. Chilisa 2011; Kovach 2009; Smith 2012; Wilson 2008). In this regard we dig deep into our pasts to salvage the

knowledges undermined by the processes of assimilation in Canada through the *Indian Act*.

Denzin *et al.* (2008) define Indigenous decolonizing methodologies as "research by and for Indigenous peoples, using techniques and methods drawn from traditions and knowledges of those peoples" (*ibid.* x). Indigenous methodologies also highlight the role that past and present forms of colonization, imperialism and globalization play in the construction of knowledge, and help illuminate the ways that Euro-centric paradigms tend to carry with them "imperial power" over vulnerable populations (Chilisa 2012: 8). Shawn Wilson (2008), a *Cree* scholar, maintains that Indigenous research needs to be enacted as a form of ceremony in itself, a pathway of learning and healing in its own right (see also Corntassel & T'lakwadzi 2009). While Linda Tuhiwai-Smith (2012), a *Māori* scholar, argues that we deconstruct Western scholarship through carving out spaces for Indigenous peoples to tell their own story in their own way. Indigenous methodologies, including *Indigenous First Voice*, helps honour this goal as it brings to the fore a relational ontological stance to understanding the world; a stance that opens space for Indigenous perspectives and ways of understanding disease and wellness, where the person is considered an inseparable part of a wider social, and natural world; a world where one is also connected to a spirit realm.

In this paper we specifically draw on *Indigenous First Voice* excerpts from Fournier's cancer journal, to frame the research within the personal/subjective realm, an important element of Indigenous and decolonizing approaches to research (Chilisa 2012; Graveline-Frye 1998; Smith 2012). *Indigenous First Voice* also requires that we examine our self-in relation, to all that surrounds us, our experiences, and to view the people, places and things we encounter as interconnected; so intertwined that we cannot possibly separate ourselves or other research "subjects" as objects (cf. Wilson 2001). Knowledge is relational (*ibid.*). In the words of George Sefa-Dei (2013), "ideas develop through relations we have with others" (*ibid.* 29) and not just human others, but the natural world and all of our experiences.

Embodying Methodology

In her book *Lost Selves and Lonely Persons*, Anne Sigfrid Grønseth (2010) highlights the importance of emotion and the body in the research experience; for example, using body language, embodiment, and a felt, or subjective sense of what is happening when gathering data, as well as when engaging with research participants. This perspective purposefully places the "self-in-relation" as one of the center points, of not only the research process, but findings as well: "to recognize the embodiedness of our 'being in the world' is to discover a common ground where self and other are on" (Jackson 1989b, quoted in Grønseth 2010: 10), a place where our interconnection with others, the earth, animals and plants is *felt* rather than just theorized, and where theorization is as much an embodied experience as it is an intellectual exercise.

Csordas (1990), on the other hand, argues for a paradigm of *embodiment* that transcends methodology. In this sense the "body then is not an object to be studied in relation to culture but is to be considered as the subject of culture, or in other words as the existential ground of culture" (*ibid.* 3); our self-in-relation to culture. In keeping with Indigenous perspectives this "subject" of culture must also include our emotional and spiritual bodies; a wholistic embodiment of "self" which does not separate or even see as separate, the body/mind/spirit and emotions. In this study Fournier's body, mind, emotions and spirit are an integral instrument of study, an instrument that explores *through* her experiences from inside out, as well as in relation to the broader social, political and economic structures around her (cf. Ellis 2004; Whitinui 2015) from outside in.

Decolonizing Cancer Care

> "Dear cancer, I hate you—you make me feel like I am a bad person that I did something wrong to deserve you sneaking up on me like you did and shattering my trust in myself, my body, and the whole universe. I hate you so much. All the people you sneak up on and take away, many good people, kind people. I think you are mean and careless—you should be more discerning. You take so much without asking."

This emotive *Indigenous First Voice/auto-ethnographic* entry from FOURNIER's cancer journal at the first stage of her diagnosis is used here as a trope for the sense of disempowerment one tends to internalize resulting from biomedical ways of understanding and explaining cancer. Within biomedical approaches the "patient" tends to be reduced to a helpless victim of genetics and family medical histories and for FOURNIER this contributed further to a profound sense of bewilderment and lack of control over her health. This is in sharp juxtaposition from the way she has experienced local Indigenous perspectives and ways of understanding disease and wellness, where the person is considered an inseparable part of a wider social, and natural world; a world where one is also connected to a powerful spirit realm, part of a broader collective rather than an individual whose body has become dis-eased. In this understanding, illness, including cancer, is seen as originating first in the spirit (cf. ISEKE 2013), and cannot be reduced to mere cells going haywire as is it often explained within biomedical paradigms.

We consider cancer a trope for colonialism, assimilation and capitalism, since, like cancer, these can profoundly impact one's being; they reshape or annihilate one's sense of self, and ways of living in fundamental and sometimes invisible ways (cf. COULTHARD 2014; HO 2011). SCHEPER-HUGHES and LOCK (1987) suggest that "cultural constructions of and about the body are useful in sustaining particular views of society and social relations" (*ibid.* 19). The body, and its various diseases, are also potentially a terrain, where capitalism manifests and shapes how we relate to, and feel about our bodies, and our health (cf. HO 2011; KLAWITER 2008). For example, our bodies tend to be valued based on their productivity, rather than their ability to sense and feel (LEVIN 1985). According to LEVIN (*ibid.*), MARX "formulated with remarkable awareness and understanding the most central goal: to 'humanize' or 'spiritualize' the senses, and bodily life in general, as part of the process of self-development and self-realization" (*ibid.* 237; cf. BAER *et al.* 2013; COBURN & NAVARRO 2015; COLLYER 2015). According to CSORDAS (1993), theories of embodiment, for example, may fall short as they may exclude or obscure other interconnected realms, such as the spiritual and emotional. Drawing on MARX, LEVIN (1985) argues that the body and the body politic are "an inseparable existential unit" (*ibid.* 237) and that we must change the political economy before we can evolve our potential to develop what he calls a "radical ontology of embodiment" (*ibid.*) and we argue here for one which includes these other realms as a way to resist the oppressive forces of colonialism and capitalism.

The impact of colonialism and capitalism includes limiting what kinds of health care is accessible, and to whom, how one navigates "care" when sick, and how the content of health care influences the ways we think and feel about our bodies and selves in relation to particular illnesses (cf. BOURASSA *et al.* 2004; COBURN 2010; KLAWITER 2008). While the reductionist hallmark of biomedicine is to separate the mind and spirit from the body (GRØSNETH 2001; HORDEN & HSU 2013; MOL 2003; SCHEPER-HUGHES & LOCK 1987; LUDTKE 2008; WELCH 2003) this imposed division represents another form of colonization and ultimately impacts how we conceptualize particular symptoms, and illnesses, including the tendency to reduce illness to just the cellular level (cf. HOKOWHITU 2009; JAIN 2013; LOCK & NGUYEN 2018). For example, reducing cancer to mere genetics, cells gone haywire, erasing the impact of not being able to access affordable, healthy food, diminishing the devastating impact of environmental degradation, industrial deregulation and the presence of known carcinogens in our food and water supplies, and so on. At a local and global level, these erasures obscure the role of government and industry from being held accountable for the continual and excessive extraction and polluting of resources from the earth for profit.

In an effort to "decolonize" cancer care for Indigenous Peoples, CANCER CARE ONTARIO (CCO), a provincial organization in Canada, implemented an *Indigenous Navigator* program in 2013 to help Indigenous Peoples navigate the heavily colonized and increasingly corporatized Canadian health care system (COBURN 2010). CCO formally recognizes the brutal treatment of Indigenous Peoples in residential schools and Indian hospitals, the criminalization of healing ceremonies (cf. KELM 1999), and ongoing experiences of racism and discrimination in the Canadian health care system (cf. TANG & BROWNE 2008). The program is available to anyone with a cancer diagnosis who self

identifies as Indigenous. It also helps link Indigenous people to *Indigenous Elders* and healers, as well as provides support and helps patients navigate the biomedical health care system. An Indigenous *Elder* is someone who is a respected member of an Indigenous community and is considered a "knowledge custodian" of their community's history, traditional teachings and ceremonies. *Elders* can also act as leaders, teachers and healers.

Through this program FOURNIER has been able to access an *Elder*, and a healer, both of whom have been profound mentors for her healing journey, which has included honouring her *Métis* ancestry and culture and resisting the impact of colonization in her own family. CCO is pivoted on providing a means for enhancing people's connection to a wider healing collective that draws on drumming, singing, shake tents, smudges, sweats, and other Indigenous spiritual practices considered essential parts of healing that must be embodied through all aspects of the self: physical, mental, emotional, spiritual, as well as community and the connection to land (cf. AUGER 2016; BARTLETT 2005; CHILSEA 2012; GRAVELINE-FRYE 1998; SMITH 2012; WANE *et al.* 2011).

One particularly potent element is the "shake tent"[4] a ceremony, which involves connecting to the spirit realm for healing (STRUTHERS & ESCHITI 2005). The shake tent is usually held on the land in the dark[5] by a healer with the help of an *oshkaabewis* ("ceremonial attendant"). FOURNIER experienced what is referred to in English as a "doctoring" during a shake tent indoors. This included laying down on the floor, covered with a coarsely textured, yet strangely inviting, brown bear pelt in a pitch dark room surrounded by sacred medicines and artefacts, with about twenty women, including two healers and other women from the community, standing around her in a circle, drumming and singing loudly. This was done to put her cancer "to sleep," remind her spirit that she is part of a community and is surrounded by ancestors and helpers, and needs to remain on this earth longer; it was done to help her spirit heal. Shake tents are re-emerging as an important method for healing trauma as a result of colonization within many Indigenous communities (cf. STRUTHERS & ESCHITI 2005). The following *First Voice* excerpts highlights the sensory components of FOURNIER's experience:

> "As soon as I saw that bear pelt I went right over and touched it and immediately started to cry. It felt course and soft at the same time – so thick and welcoming. I laid down on that pelt and cried for a long time; I felt so safe. I can't explain it, but I was drawn to it, and while I was lying there surrounded by medicines and all that fur I felt connected to something more powerful than I know how to even explain."

Then later during the "doctoring" ceremony:

> "The room is pitch dark and I am asked to lay down on this soft fur—it feels so warm and inviting and I feel myself relax and immediately and I just start to cry. There is a circle of women around me including a healer, holding space while drumming and singing. I can feel the energy in the room and I feel safe and surrounded—I cry for what feels like a long time and the singing and drumming keep getting louder and louder. Then it suddenly stops and everything gets quiet[…]."

Both of these quotes highlight an embodied sense of connectedness and safety that is integral to the healing ceremony. A critical component to FOURNIER's recovery and relief from the profound sense of bewilderment a cancer diagnosis caused. In contrast, here is another excerpt focusing on FOURNIER's sensory experience of biomedical cancer care:

I go into a small room and take off my clothes and put on the gown. I enter the room and am told to lie down. I lay down on a cold metal slab of a bed, the room is so bright and stark, and I feel really scared. I start to feel the drugs entering my body I feel them burning in my veins…then burning all through my body, it feels like I have no control and my body is burning up from the inside out. I feel so alone, I am alone. I close my eyes and try to breathe through it. Then the attendant comes back in the room, takes out the needle and escorts me out of the room.

One of the striking elements of difference between these experiences is not only the stark difference in their sensory aspect, but the emotion that is evoked in each: the contrasting sense of community and sense of aloneness, the sense of pain and fear and the sense of warmth and healing. The healing ceremonies evoke a sense of connectedness to something beyond everyday experience, a sense of belonging and support that extends beyond the physical into the spirit realm,

and also the emotional release that the ceremony helps bring about. All aspects of the self, the physical, mental, emotional, spiritual as well as a sense of belonging to community and connection to land are central to this healing ceremony.

In the biomedical encounter, one is placed in a queue, often there is a separate waiting room, where one sits quietly amongst other patients, and although there is a sense that we are all there for a similar reason, there is little or no conversation, and the anxiety in the room is deafening. There may be an occasional knowing or understanding look, but there is no space for connecting even in this common waiting area, yet we are likely all connected by anxiety and fear. We sit in our own chairs which are set up linearly in rows, and the walls have posters that remind us to get our flu shots, or to not speak loudly, and to turn off our cell phones. The medicine they give you tastes metallic and leaves a lingering bad taste in your mouth. For FOURNIER, making sense of these vastly different experiences requires compartmentalizing each form of care, however, she is intimately involved in each; her body, mind, spirit is profoundly impacted by both, yet in vastly different ways. This compartmentalization is only partially successful however, as she is the subject of both and as such she must navigate and linger in the in-between spaces to become whole—to bring the experiences into some form of cohesiveness.

Navigating care from both biomedical approaches and Indigenous healing ceremonies forces one into these liminal spaces: making sense of a bewildering disease, as well as finding a sense of internal reconciliation between these vastly different approaches. In one instance the sensory experience of care is immediate and inclusive. The living experience of the "doctoring" ceremony is empowering and rich with a sense of feeling a part of something larger than just a mere physical body, a sense of being "surrounded," being part of a larger collective, as well as being in a space of hope rather than just fear. In the biomedical experience one is part of a protocol of care that is standardized based on the particular cellular level characteristics of the cancer one is diagnosed with and has little to do with one's "self"

Two-Eyed Seeing and Holding Space for the Sacred

Two-Eyed Seeing/Etuaptmumk is one of many Indigenous epistemologies that is geared toward decolonizing healthcare practices in Canada (cf. IWAMA *et al.* 2009; MARTIN 2012). Although *Two Eyed Seeing/Etuaptmumk* is meant as a unifying narrative, its limitation, in the way it tends to be utilized in health care research, is that it can end up reifying a false binary between "Western" and "Indigenous" (cf. DEI 2009). This binary negates the array of nuance among "Indigenous" Peoples (cf. SHIVA 2000), and does not account for the way health care reform in Canada is being shaped by neoliberal ideologies, such as the increasing privatization of health care services (cf. MCGREGOR 2001; NAVARRO & SHI 2001), including becoming increasingly privatized (cf. FLOOD & ARCHIBALD 2001; LEYS 2009). Furthermore, within each term, "Indigenous" and "Western," there is nuance and complexity that must be explored, a need to understand and illuminate the external forces shaping each. OAKLEY's *Mi'kmaq* great grandmother, who raised her, used to refer to herself as "granny spider" saying there are many ways to see the world and taught her that health and that healing can never be boiled down to one or two "siloed approaches" (cf. WALDRON 2010).

Nonetheless, *Two Eyed Seeing/Etuaptmumk* does help highlight a way of seeing health and health care that includes, for example incorporating elements of Indigenous practice into biomedical public health care settings such as hospitals, clinics and a recognition such as shake tents, sweats, smudges, drumming, incorporating Indigenous knowledges and so on. It includes a recognition that health and illness involve wider social, emotional, biographical and spiritual spheres, not just a fixation on the physical body. Further, *Two Eyed Seeing/Etuaptmumk* as a "way" of understanding biomedicine's mind-body dichotomy is also helpful as it has the potential to draw attention to rather than obscure some of the tensions between differing perspectives and may protect Indigenous knowledges and healing ceremonies that are at risk of being assimilated, or contorted to fit within the boundaries of biomedicine. For example, in biomedicine a cancer diagnosis is placed into the biomedical assembly line of treat-

ment protocols, and its management is set in motion based on the cancer's cellular level characteristics. Instead of being seen as a whole person, the patient is viewed/treated more like a mechanical body, broken down into diseased parts such as healthy and unhealthy cells, diseased and healthy organs, that are alienated from one's whole "self" (cf. Broom & Tovey 2007; Grøsneth 2014). Further, not only is our body, mind, and spirit not considered as part of a unified whole during the clinical encounter; we tend to also be stripped from our physical and social environment (cf. Grøsneth 2014; Ho 2011). Here is another quote from Fournier's cancer journal that highlights these separations:

> "In the hospital everything is bright and cold, the lighting is stark and I feel like I am constantly under interrogation. There is nothing subtle or left to the imagination. On the way to surgery I am alone, my family is left to wait in a separate room. I am wheeled to the operating room lying down on a bed, it was so disorienting, I couldn't see where I was going and once I got to the surgery room everything was so cold, all shiny metal and more ultra-bright lights, the sounds in the room were echoey, and shrill, exaggerated by starkness of the room and the sterility of everything in there. Then I am transferred to a cold metal bed, and there are so many machines, monitoring machines that kept beeping. I was then pricked in the arm to get an IV and a mask was put over my mouth, I can no longer speak, or move…they tell me to start counting to 10 and the next thing I know I wake up groggy and confused in another room, a 'recovery' room by myself."

These are mundane experiences in the biomedical encounter, where disease is made to cohere through a range of alienating practices such as blood tests, surgery and CT scans, narratives, documents and files (cf. Mol 2003). To illustrate further, when Fournier told one of her biomedical practitioners that her mood was up and down after her cancer diagnosis (a common experience among cancer patients), they asked if she was crying a lot and handed her a paper with a depression scale questionnaire, with questions such as "in the past two weeks how often have you been bothered by the following: little or no interest in doing things; little interest or pleasure in doing things and feeling tired or having little energy?" The possible responses range from not at all to several days, more than half the days and nearly everyday. This depression scale was created by a large pharmaceutical company and is a standard evaluation form given to patients to assess their degree of depression and to determine prescription of psycho-trophic medications.

This depression questionnaire, an idiosyncratic cultural artefact endorsed by the pharmaceutical company who developed it, both objectifies and individualizes the illness experience in a peculiar manner, and also reifies any emotional experience into a tightly controlled and reductionist classification system to be measured. For Fournier, this scale did not fit – the questions were too generic and vague. The "solution" if one scores high on this scale is quite peculiar, but not surprising: pharmaceuticals, in this instance anti-depressants. Additionally, her family doctor suggested she take a vacation, to go somewhere and relax in order to recover psychologically from having cancer. This type of biomedical encounter leaves it up to the individual to navigate their way through this process and rely on pharmaceuticals for support, or having the privilege to take a vacation.

On the other hand, when Fournier talked about her low mood and sadness with the *Elder* and the healer, they both spoke about the need to cry to let the sadness out, and that not only her tears, but the cancer itself was medicine, a way of healing from intergenerational trauma, and the impact colonization and assimilation had on her family. She was not asked about the frequency of her crying, instead she was encouraged to express her emotions and to engage with ceremony with community to help heal. During this time, she received a spirit name, to help provide a sense of belonging, and community, a spiritual home. She also received a pipe: a sacred spiritual tool that is used to connect to the spirit realm. She was told that going through cancer and other deep personal struggles to help heal herself and her family earned her this honour. It is this connection to community and ceremony that grew out of her cancer experience that has had a major impact on Fournier's healing experience: It took a cancer diagnosis to help connect her to community and ceremony, as well as helping her reconnect to her family's Indigenous roots. For many Indigenous Peoples, particularly those who did not grow up

on reserve, grew up in urban settings, or whose families hid their identities to survive, it can be very difficult to find a sense of belonging to community.

Additionally, as mentioned earlier there is little recognition in the biomedical clinical encounter that the root of many cancers lies in the toxic activities from unregulated corporate industrial practices (cf. Kress & Stine 2017; Singer & Baer 2009; Tsing 2015), and a flagrant disregard of subaltern communities who bear a heavy cost from these activities, sometimes referred to as forms of environmental racism (cf. Waldron 2018). In short, as Brian McKenna (2012b) states "biomedicine focuses on diseased bodies, not the body politic" (*ibid.* 96; cf. Holmes 2013), yet as argued by Levin (1985) the body and the body politic have become one existential unit. Indeed, having cancer forces one to pay attention in ways one may not have before and commands our "bewildered attention" (cf. Little *et al.* 1998) and here, we purposefully place the "self" and its link to a wider collective at the fore (cf. Grønseth 2010; Holmes 2013). An Indigenous healing approach, as told here, enhances our interconnection with other people, the earth, animals, plants and the spirit realm, and helps one carve out space for a "healing journey." In this instance illness was transformed into powerful "medicine," and cancer a catalyst for intergenerational healing, resisting assimilation and strengthening Indigenous roots and traditions as well as developing a sense of community (cf. Cote-Meek 2014; Wane *et al.* 2011). Carving out spaces like this and navigating health care in a way that is meaningful, transformative and also effective is challenging, yet crucial, particularly when one is dealing with a serious diagnosis such as cancer (cf. McCabe 2008; Struthers & Eschiti 2005).

Carving a Space for the Sacred

We started writing this paper during a really hopeful moment in Canadian health care when Indigenous approaches were just on the cusp on being shaped and incorporated across the provinces. The meaning of this could include things like shake tents, smudges, or perhaps drumming in the forest and ways of strengthening people's connection to nature and to each other. For Oakley, picking an array of summer berries is a cherished link to her great grandmother and the extended family, for whom collectively gathering and processing these summer fruits was the main way to access fruit in the winter. It was part of a seasonal mainstay including fishing, hunting and getting together with relatives to also share stories and songs. The seasonal gathering of wild foods is as much a part of maintaining bodily health as a sacred way to build social health through getting together and processing the food as for example outlined by Turner and Clifton (2006) for the *Gitga'at*, a First Nations peoples from British Columbia:

> "[T]he harvesting processing, and use of this seaweed, undertaken for many centuries by the *Gitga'at* and their ancestors and still practiced today, is infused within all facets of *Gitga'at* culture and life ways, and is vital to their identity, health and well-being as a people [...] continued use in the face of economic restructuring and accelerating cultural change since the time of European contact is remarkable. In a sense, the use of seaweed represents the resiliency of a people [...] provides important opportunities for knowledge acquisition and communication, and promotes health and well-being through providing a nutritious food, requiring a healthy outdoor lifestyle, and promoting cultural values." (*ibid.* 160)

Without knowing the salience of a thing, the meaning and sacredness to individual and community health could be missed entirely as Lyons (2010) pointed out with regard to sleeping sickness in the *Belgian Congo* and the clearing and burning of bushes where the *Tsetse* fly lived but was disregarded by Europeans and instead harmful medicines with debilitating side effects were seen as the "pseudo" solution. There is also the more recent case in *Northern Ghana* where international health and aid agencies, informed by *Christian* concepts of death and disease, thought it important to eradicate *Guinea worms*, whereas for the local people the presence of the disease was an important part of their cosmology related to health and illness (cf. Moran Thomas 2013). We raise these cases because they highlight issues at play now, in the midst of the COVID19 crisis and the dominance of the germ theory approach to health and illness, a moment significantly different than where we began the paper. Much like the narrow,

invasive and depersonalised approach to "treating" cancer outlined by Fournier, the COVID19 crisis has once again affirmed the idea that there is only one acceptable "scientific" body of knowledge and all others are dangerous, suspect and risky. Funding is being prioritized toward the virus, as we can already see in Canada with increased wait-times overall let alone for incorporating elements that might bridge the mind-body dichotomy of biomedicine as Indigenous approaches could do. With the ending of the TRC undertaking, the rise of COVID-19 and associated funding, it is difficult to say where the current interest in Indigenous approaches to health care will lead in Canada. We hope that this paper might provide a modest example of how incorporating Indigenous approaches has a great deal of value to bridge the mind-body divide of biomedicine.

Concluding Thoughts

What does this mean for health care in general? While spaces are being carved out for Indigenous medicines/knowledges, we suggest a move to "multi-eyed seeing," maybe more like a "granny spider" to allow for the rich diverse approaches of Canada's Indigenous Peoples to be incorporated and valued, one that accounts for the impact of colonialism, and capitalism on how knowledges are shaped and enacted in the realm of health care. By maximizing our inter-relatedness to spirit, community, people, the environment and all other forms of life, we are actively decolonizing health care spaces and embracing Indigenous ceremony as profound acts of healing (Ward Gailey 2003).

There are sensory/aesthetic implications of healing raised by our analysis as well. Fournier's sensory experience of biomedical practices contrasts markedly with her experience of Indigenous healing practices. While the former tends to isolate individuals and separate the body from its social and spiritual context, the latter grounds healing in community and spirituality. As such, the shortcomings of biomedicine may be felt and experienced more profoundly by those for whom ceremony is integral to their way of life. Further, our exploratory analysis suggests rather than striving for a way to combine the strengths of both approaches, what is needed instead is to understand the tensions between them, where they originate, the implications for health and well-being, and for whom. This kind of approach challenges the dichotomies that were established during colonization, representing a first step in opening up space for the sacred in health care.

Both authors see in stark detail, the enhanced urgency to continue to create spaces for sacred Indigenous forms of healing that reunite the mind and body and recognize the intimate link between individuals and a wider social and natural environment. We hope that this paper will contribute to helping to see why it is important to continue to insist on incorporation of these elements into health care, perhaps now more than ever, as public health and biomedicine become increasingly technologized, and more comprehensive concepts of health and illness swept aside for universalised notions of public health and safety.

Notes

1 The Métis in Canada are specific cultural communities who trace their descent to First Nations and European settlers, primarily the French.
2 Indigenous medicines in this instance refers to healing ceremonies, plant medicines, teachings and life lessons.
3 During the colonial period Indigenous women who married non-Indigenous men lost their Indian status, as did their children as per the laws of the Indian Act prior to 1985; Indian status prior to 1985 was determined by paternal lineage only and as a result many women and children lost status.
4 A shake tent is referred to in *Ojibwe* as "jiisakaan."This ceremony was widespread amongst many Indigenous Peoples in Canada prior to colonization.
5 However this practice has been modified in some urban contexts and is held indoors.

References

Allen, Lindsay *et al.* 2020. Indigenous-led health care partnerships in Canada. *CMAJ* 192, 9: E208-E216.

Auger, Monique 2016. Cultural continuity as a determinant of Indigenous Peoples' health: a metasynthesis of qualitative research in Canada and the United States. *The International Indigenous Policy Journal* 7, 4: 1–24.

Baer, Hans, Merril Singer & Ida Susser. 2013. *Medical Anthropology and the World System: Critical Perspectives.* 3rd edition. Santa Barbara: Praeger.

Bartlett, Judith 2005. Health and wellbeing for Metis women in Manitoba. *Canadian Journal of Public Health* 96: S22–S27.

Bartlett, Cheryl, Murdena Marshall & Albert Marshall 2012. Two-Eyed Seeing and other lessons learned within a co-learning journey of bringing together Indigenous and

mainstream knowledges and ways of knowing. *Journal of Environmental Studies and Sciences* 2: 331–340.

Benoit, Cecilia, Dena Carroll & Munaza Chaudhry 2003. In search of a healing place: Aboriginal women in Vancouver's downtown eastside. *Social Science & Medicine* 56, 4: 821–833.

Blackstock, Cindy 2011. The emergence of the breath of life theory. *Journal of Social Work Values and Ethics* 8,1. Doi: https://jswve.org/download/2011-1/spr11-blackstock-Emergence-breath-of-life-theory.pdf

Bourassa, Carrie, Kim McNabb & Mary Hampton 2004. Racism, sexism and colonialism: the impact on health for Aboriginal women in Canada. *Canadian Women Studies* 24, 1: 23–29.

Broom, Alex & Philip Tovey 2007. The dialectical tension between individuation and depersonalization in cancer patients' mediation of complementary, alternative and biomedical cancer treatments. *Sociology* 41, 6: 1021–1039.

Browne, Annette J., Victoria L. Smye& Colleen Varcoe 2005. The relevance of postcolonial theoretical perspectives to research in Aboriginal health. *CNJR* 37, 4: 16–37

Brunger, Fern & Derek Wall 2016. What do they really mean by partnerships? Questioning the unquestionable good in ethics guidelines promoting community engagement in indigenous health research. *Qualitative Health Research* 26, 13: 1862–1877.

Bull, Julie 2010. Research with Aboriginal peoples: Authentic relationships as a precursor to ethical research. *Journal of Empirical Research on Human Research Ethics* 5, 4: 13–22.

Buroway, Michael 1998. The extended case study method. *Sociological Theory* 16, 1: 4–32.

Cameron, Laura *et al.* 2019. The Turtle Lodge: sustainable self-determination in practice. *AlterNative* 15, 1: 13–21.

Cannon, Martin 2007. Revisiting histories of legal assimilation, racialised injustice, and the future of Indian status in Canada. *Aboriginal Policy Research Consortium International* 97: 35–48.

Chase, Susan E. 2010. Narrative inquiry: multiple lenses, approaches, voices. In Wendy Luttrell (ed) *Qualitative education research: readings in reflexive methodology and transformative practice*. New York: Routledge: 208–236.

Chilisa, Bagele 2012. *Indigenous Research Methodologies*. London: Sage.

Chrisjohn, Roland & Tanya Wasacase 2009. Half-truths and whole lies: rhetoric in the "apology" and the truth and reconciliation commission. Speaking my truth: reflections on reconciliation and residential schools. In Gregory Young-ing *et al.* (eds) *Response, Responsibility, and Renewal. Canada's Truth and Reconciliation Journey*. Ottawa: Aboriginal Healing Foundation: 217–231.

Coburn, David 2010. Health and health care: a political economy perspective. In Dennis Raphael *et al.* (eds) *Staying alive: critical perspectives on health, illness, and health care*. 2nd edition. Toronto: Canadian Scholars Press: 65–91.

Coburn, David & Vincente Navarro 2015. Marxism, medical dominance, healthcare and health. In Fran Collyer (ed) *The Palgrave handbook of social theory in health, illness and medicine.* Basingtoke*:* Palgrave Macmillan: 405–423.

Cook, Catherine *et al.* 2019. Structures last longer than intentions: creation of Ongomiizwin – Indigenous Institute of Health and Healing at the University of Manitoba. *International Journal of Circumpolar Health* 78, 2. Doi: https://doi.org/10.1080/22423982.2019.1571381

Collyer, Fran 2015. Karl Marx and Frederich Engels: Capitalism, health and the healthcare industry. In *ibid.* (ed). *The Palgrave handbook of social theory in health, illness and medicine.* Basingtoke: Palgrave Macmillan: 35–58.

Corntassel, Jeff & Chaw-win-is & T'lakwadzi 2009. Indigenous storytelling, truth-telling, and community approaches to reconciliation. *English Studies in Canada*, 35, 1: 137–159.

Cote Meek, Sheila 2014*. Colonized classrooms: racism, trauma and resistance in post-secondary education*. Halifax: Fernwood.

Coulthard, Glen 2014. *Red skin, white masks: rejecting the colonial politics of recognition*. Minneapolis: University of Minnesota Press.

Csordas, Thomas J. 1990. Embodiment as a paradigm for Anthropology. *ETHOS* 18, 1: 5–47.

Csordas, Thomas J. 1993. Somatic modes of attention. *Cultural Anthropology* 8, 2: 135–156.

Czyzewski, Karina 2011. Colonialism as a broader social determinant of health. *The International Indigenous Policy Journal* 2, 1: 1–14.

Daschuk, James 2013. *Clearing the plains: disease, politics starvation, and the loss of Indigenous life*. Regina: University of Regina Press.

Dei, George S. 2009. Rethinking the role of Indigenous knowledges in the academy. *International Journal of Inclusive Education* 42: 111–132.

Dei, George S. 2013. Critical perspectives on Indigenous research. *Socialist Studies* 9, 1: 27–38.

Denzin, Norman K., Yvonna S. Lincoln & Linda Tuhiwai-Smith (eds) 2008. *Handbook of critical and Indigenous methodologies*. London: Sage.

Ellis, Carolyn 2004. *The ethnographic I: a methodological novel about autoethnography*. New York: Alta Mira.

Flood, Coleen & Tom Archibald 2001. The illegality of private healthcare in Canada*. Journal of the Canadian Medical Association*.164, 6: 825–30

Graveline, Frye J. 1998. *Circle works: transforming Eurocentric consciousness*. Halifax: Fernwood.

Grønseth, Anne S. 2010. *Lost selves and lonely persons*. Durham: Carolina Academic Press.

Grygier, Pat Sanford 1994. *A long way from home: the tuberculosis epidemic among the Inuit*. Montreal: McGill Queens University Press .

Ho, Fred 2011. *Diary of a radical cancer survivor: fighting cancer and capitalism at the cellular level*. Delaware: Skyhorse.

Hokowhitu, Brendon 2009. Indigenous existentialism and the body. *Cultural Studies Review* 15, 2: 101–118.

Horden, Peregrine & Elisabeth Hsu (eds) 2013. *The body in balance: humoral medicines in practice*. Oxford: Berghahn.

Hollenberg, Daniel & Linda Muzzin 2010. Epistemological challenges to integrative medicine: an anti-colonial perspective on the combination of complementary/alterna-

tive medicine with biomedicine. *Health Sociology Review* 19, 1: 34–56.

Holmes, Seth 2013. *Fresh fruit, broken bodies: migrant farmworkers in the United States.* Berkeley: University of California Press.

Iseke, Judy 2013. Spirituality as decolonizing: Elders Albert Desjarlais, George McDermott, and Tom McCallum share understandings of life in healing practices. *Decolonization: Indigeneity, Education & Society* 2, 1: 35–54.

Iwama, Marilyn *et al.* 2009. Two Eyed seeing and the language of healing in community-based research. *Canadian Journal of Native Education* 32, 2: 3–23.

Jacklin, Kristen & Wayne Warry 2004. The Indian health transfer policy in Canada: toward self-determination or cost containment? In Arachu Castro & Merrill Singer (eds) *Unhealthy health policy: a critical anthropological examination*. Walnut Creek: AltaMira: 215–234.

Jackson, M 1989a. Locking up natives in Canada. *University of British Columbia Law Review* 23, 2: 215–300.

Jackson, Michael 1989b. *Paths Toward a Clearing: Radical Empiricism and Ethnographic Inquiry*. Indiana University Press: Bloomington.

Jain, S. Lochlann 2013. *Malignant: how cancer becomes us.* Berkeley: University of California Press.

James, Matt 2012. A carnival of truth? Knowledge, ignorance and the Canadian Truth and Reconciliation Commission. *International Journal of Transitional Justice* 6, 2: 1–23

Josephides, Lisette & Anne S. Grønseth (eds) 2017. *The ethics of knowledge creation: transactions, relations and persons*. Oxford: Berghahn.

Kelm, Mary E. (1999). *Colonizing bodies: Aboriginal health and healing in British Columbia, 1900-50.* Vancouver: UBC.

Kelton, Paul 2007. *Epidemics and enslavement: biological catastrophe in the native southeast, 1492–1715*. Lincoln: University of Nebraska Press.

Klawiter, Maren 2008. *The biopolitics of breast cancer: changing cultures of disease and activism.* Minneapolis: University of Minnesota Press.

Kovach, Margaret 2009. *Indigenous methodologies: characteristics, conversations, and contexts.* Toronto: University of Toronto Press.

Kress, John W. & Jeffrey K. Stine (eds) 2017. *Living in the anthropocene: earth in the age of humans*. Washington: Smithsonian Institution.

Lane, Harlane 1999. *The mask of benevolence: disabling the deaf community*. New York: Dawnsign.

Laugrand, Frederic & Jarich Oosten 2014. *Hunters, predators and prey: Inuit perceptions of animals*. Berghahn.

Leslie, Charles & Allan Young 1992. *Paths to Asian medical knowledge: comparative studies of health systems and medical care.* Berkeley: University of California Press.

Levin, David M. 1985. The body politic and the political economy of the human body. *Human Studies* 8, 3: 235–278.

Leys, Colin 2009. Health care under capitalism. In Colin Leys & Leo Panitch (eds) *Morbid symptoms: health under capitalism*. Wales: Merlin: 1–29.

Little, Miles *et al.* 1998. Liminality: a major category of the experience of cancer illness. *Social Science & Medicine* 47, 10: 1485–1494.

Lock, margaret & Vinh-kim nguyen 2018. *An anthropology of biomedicine*. 2nd edition. Malden: Wiley-Blackwell

Low, Setha M. 2003. Embodied space(s): anthropological theories of body, space, and culture. *Space and Culture* 6, 1: 9–18.

Ludtke, Karen 2008. *Dances with spiders: crises, celebrity and celebration in southern Italy.* Oxford: Berghahn.

Lyons, Maryyinez 2010. *The colonial disease: a social history of sleeping sickness in northern Zaire.* Cambridge: Cambridge University Press.

Mackey, Eva 1997. *The cultural politics of populism: celebrating Canadian national identity*. In Cris Shore & Susan Wright (eds) *The anthropology of policy: perspectives, governance and power*. London: Routledge: 136–164.

Mann, Barbara A. 2009. *The tainted gift: the disease method of frontier expansion*. Oxford: Praeger.

Manitowabi, Darrel & Marion Maar 2018. We stopped sharing when we became civilized: a model of colonialism as a determinant of Indigenous health in Canada. *Journal of Indigenous Social Development* 7, 1: 1–19.

Manitowabi, Darrel & Marjory Shawande 2013. Negotiating the clinical integration of traditional Aboriginal medicine at Noojmowin Tej. *Canadian Journal of Native Studies* 1: 97–128.

marshall, albert 2019. Public lecture, University of Toronto, November 7 2019. https://www.dlsph.utoronto.ca/event/talk-by-elder-albert-marshall-eskasoni-first-nation/ (2020-12-24)

Martin, Debbie 2012. Two-Eyed Seeing: a framework for understanding Indigenous and non-Indigenous approaches to Indigenous health research. *Canadian Journal of Nursing* 44, 2: 20–42.

Martin-Hill, Dawn 2003. *Traditional medicine in contemporary contexts: protecting and respecting Indigenous knowledge and medicine*. Ottawa: National Aboriginal Health Organization.

Martinez-Cobo, J.S. 1981. Study of the problem of discrimination against indigenous populations. New York: United Nations

McCabe, Glen 2008. Mind, body, emotions and spirit: reaching to the ancestors for healing. *Counselling Psychology Quarterly* 21, 2: 143–152.

Mcgregor, Sue 2001. Neoliberalism and health care. *International Journal of Consumer Studies* 25, 2: 82–89.

McKenna, Brian 2012a. The clash of medical civilizations: experiencing "primary care" in a neoliberal culture. *Journal of Medical Humanities* 33, 4: 256–272.

McKenna, Brian 2012b. Medical education under siege: critical pedagogy, primary care, and the making of "slave doctors". *International Journal of Critical Pedagogy* 4, 1: 95–117.

Menzies, Peter 2008. Developing an Aboriginal healing model for intergenerational trauma. *International Journal of Health Promotion and Education* 46, 2: 41–48.

Mol, Annemarie 2003. *The body multiple: ontology in medical practice*. Durham: Duke University Press.

Moran-Thomas, Amy 2013. A salvage ethnography of the Guinea worm: witchcraft, oracles and magic in a disease eradication program. In João Biehl & Adriana Petryna (eds)

When people come first: critical studies in global health. Princeton: Princeton University Press: 207–239.

Murphy, Fiona 2011. Archives of sorrow: an exploration of Australia's stolen generations and their journey into the past. *History and Anthropology* 22, 4: 481–495.

National Inquiry Into Missing And Murdered Indigenous Women and Girls 2019. Reclaiming power and place: the final report. volume 1b. https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Final_Report_Vol_1b.pdf (2020-10-17).

Navarro, Vincente 2007. *Neoliberalism, globalization, and inequalities: consequences for health and quality of life*. New York: Baywood.

Navarro, Vincente & Leiyo Shi 2001. The political context of social inequalities and health. *Social Science and Medicine* 52: 481–491.

Neu, DEAN. 2000. Accounting and accountability relations: Colonization, genocide and Canada's first nations. *Accounting, Auditing & Accountability Journal* 13, 3: 268–288.

Nichter, Mark 2009. Coming to our senses: appreciating the sensorial in medical anthropology. *Transcultural Psychiatry* 5, 2: 163–197.

Oakley, Robin 2006. Collective rural identity in Steinkopf, a communal coloured reserve 1926–1996. *Journal of Southern African Studies* 32, 3: 489–503.

Oakley, Robin 2019. Lorenzo Veracini: the settler colonial present. *Itinerario* 43, 2: 386–390. doi:10.1017/S0165115319000469

Oakley, Robin 2021. "The wrong names": non-status Aboriginality, misfortune and elusive well being. In Anne S. Grøsneth & Jonathan Skinner (eds) *Mobilities of wellbeing: migration, the state and medical knowledge.* Ethnographic Studies in Medical Anthropology Series. Durham: Carolina Academic Press: 119–142.

Palmater, Pam 2011. *Beyond blood: rethinking Indigenous identity*. Saskatoon: Purich.

Paul, Daniel. 2006. *We were not the savages: collision between European and Native American civilizations.* 3rd edition. Halifax: Fernwood.

Robbins, Julian A. & Jonathan Dewar 2011. Traditional Indigenous approaches to healing and the modern welfare of traditional knowledge, spirituality and lands: a critical reflection on practices and policies taken from the Canadian Indigenous example. *International Indigenous Policy Journal* 2, 4: 1–17.

Robinson, Danielle *et al.* 2017. Approaches to incorporating Indigenous health into the Canadian medical school curriculum. *University of Western Ontario Medical Journal* 86, 2: 57–59.

Rudin, Jonathan 2008. Aboriginal over-representation and R. v. Gladue: where we were, where we are and where we might be going. *Supreme Court Law Review: Osgoode's Annual Constitutional Cases Conference* 40: 687–713.

Scheper-Hughes, Nancy & Margaret M. Lock 1987. The mindful body: a prolegomenon to future Work in medical anthropology. *Medical Anthropology Quarterly,* 1, 1: 6–4.

Shiva, Vandana 2000. Cultural diversity and the politics of knowledge. In George S. Dei *et al.* (eds) *Indigenous knowledges in global contexts: multiple readings of our world.* Toronto: University of Toronto Press: xii–x.

Sider, Gerald 2014. *Skin for skin: death and life for Inuit and Innu.* Durham: Duke University Press.

Singer, Merrill & Hans Baer 2009. *Killer commodities: public health and the corporate production of harm*. Lanham: AltaMira.

Smith, Derek 2001. The policy of 'aggressive civilization' and projects of governance in Roman Catholic industrial schools for Native Peoples of Atlantic Canada, 1870–95. *Anthropologica* 43, 2: 253–271.

Smith, Linda T. 2012. *Decolonizing methodologies: research and Indigenous peoples*. 2nd edition London: ZED.

Sparrow, Robert 2010. Implants and ethnocide: learning from the cochlear implant controversy. *Disability and Society* 25, 4: 455–466.

Stote, Karen 2015. *An act of genocide: colonization and the sterilization of Aboriginal women*. Halifax: Fernwood.

Struthers, Roxanne & Valeri Eschiti 2005. Being healed by an Indigenous traditional healer: sacred healing stories of Native Americans. Part 2. *Complementary Therapies in Clinical Practice* 11, 2: 78–86.

Tang annie Y. & Annette J. Browne 2008. 'Race' matters: racialization and egalitarian discourses involving Aboriginal people in the Canadian health care context. *Ethnicity & Health* 13, 2: 109-127.

Truth and Reconciliation Commission of Canada 2015. *Honouring the truth, reconciling for the future: summary of the final report of the Truth and Reconciliation Commission of Canada*: http://www.trc.ca/assets/pdf/Honouring_the_Truth_Reconciling_for_the_Future_July_23_2015.pdf (2020-10-17)

Tsing, Anna L. 2015. *The mushroom at the end of the world: on the possibility of life in capitalist ruins*. Princeton: Princeton University Press.

Turner, Nancy & Helen Clifton 2006. The forest and the seaweed: Gitga'at seaweed, traditional ecological knowledge, and community survival. In Andrea Pieroni & Lisa Leimar Price (eds) *Eating and healing: traditional food as medicine*. New York: Food Products: 153–178.

Valeggia, Anna & Josh J. Snodgrass 2015. Health of Indigenous Peoples. *Annual Review of Anthropology* 2015 44, 1: 117–135

Veracini, Lorenzo 2015. *The settler colonial present*. London: Palgrave MacMillan.

Vogel, Lauren 2015. Broken trust drives native health disparities. *Canadian Medical Association Journal* 187, 1: E9–E10.

Waldron, Ingrid 2010. The marginalization of African Indigenous healing traditions within Western medicine: reconciling ideological tensions and contradictions along the epistemological terrain. *Women's Health & Urban Life* 9, 1: 50–68.

Waldron, Ingrid 2018. *There's something in the water: environmental racism in Indigenous and Black communities*. Halifax: Fernwood.

Walters, K. L.; Mohammed, S. A.; Evans-Campbell, T.; Beltrán, R. E.; Chae, D. H. & Duran, B. 2011. Bodies Don't Just Tell Stories, They Tell Histories: Embodiment of Historical Trauma among American Indians and Alaska Natives. *Du*

Bois review : social science research on race 8, 1: 179–189. https://doi.org/10.1017/S1742058X1100018X

Wane, Njoki N., Energy L. Manyimo & Eric J. Ritskes 2011. *Spirituality, education and society an Integrated Approach*. Rotterdam: Sense.

Ward Gailey, C. 2003. Community, state and questions of social evolution in Marx's ethnological notebooks. *Anthropologica* 45: 45–57.

Welch, John S. 2003. Ritual in Western medicine and its role in placebo healing. *Journal of Religion & Health* 42, 1: 21–33.

Wexler, Lisa M. & Joseph P. Gone 2016. Exploring possibilities for Indigenous suicide prevention: responding to cultural understanding and practices. In Jennifer White *et al.* (eds) *Critical suicidology: transforming suicide research and prevention for the 21st century.* Vancouver: UBC: 56–70.

Wilson, Shawn 2001. What is indigenous methodology? *Canadian Journal of Native Education* 25, 2: 175–179.

Wilson, Shawn 2008. *Research as ceremony*. Halifax: Fernwood.

Whitinui, Paul 2015. Indigenous Autoethnography: exploring, engaging, and experiencing 'self' as a Native method of inquiry. *Journal of Contemporary Ethnography* 42, 2: 456–487.

Manuscript received: 04.12.2019
Manuscrtipt accepted. 24.12.2020

CATHY FOURNIER is a PhD candidate in the Interdisciplinary PhD program at Dalhousie University, with a specialization in Social/Medical Anthropology and Indigenous Studies. Cathy's thesis titled, Creating space for the 'sacred' in cancer care: Integrating Indigenous medicines into health care examines how decolonized and indigenized spaces of healing are created and held during cancer care. She draws on her own experiences navigating both Indigenous healing and biomedicine for a cancer experience, while considering the broader context of the ongoing impact of colonization, the Indian Act and neoliberal capitalism on Indigenous Peoples. Through her doctoral research Cathy aims to contribute and expand the Two Eyed Seeing principle, using anti-colonial and critical political economy perspectives.

Dalhousie University, Halifax, NS. Canada
e-mail: cathy.fournier@dal.ca

ROBIN OAKLEY PhD is an Anthropologist interested in the relationship between economic constraints and cultural values in relation to health and policy. She analyzed caregiving strategies for the elderly in Namaqualand, South Africa, among a community who enjoyed communal land tenure until the late 1990s. She is currently comparing the Namaqualand reserves that pre-dated the Canadian reserve system by examining the migration routes of Mi'kmaq who were forced off reserves recognized by Joseph Howe in St Margaret's Bay, Nova Scotia in the 1800s. She is interested in exploring common sense approaches to health such as guaranteed income, food, shelter, caregiving, public curative systems when people fall ill and the salience of socio-cultural nuances of these elements in practice.

Dalhousie University, Room 1128, 6135 University Avenue
PO Box 15000, Halifax, NS B3H 4R2. Canada
e-mail: oakleyr@dal.ca

Maya Cosmovision

Exploring Formative Processes of *Q'eqchi'* Medical Aesthetics, Morality, and Healing Practice

ANDREW R. HATALA & JAMES B. WALDRAM

Abstract Throughout history, individuals and communities have developed complex cultural visions of the world around them shaped by local ecology, history, language, and interactions with neighboring peoples and their ways of life. To better understand, interpret, and appreciate the contemporary healing practices of *Q'eqchi'* Maya healers, this article describes two "formative processes" or "interpretive activities" of *Q'eqchi'* cosmovision: a relationship to the Mountains and Valleys; and a moral economy of permission. Each of these aspects influence the interpretive structures of *Q'eqchi'* medical reality and thereby shapes *Q'eqchi'* conceptions of illness and health and the medical "objects" to which traditional healers attend. Through a detailed case study drawn from over ten years of ethnographic fieldwork with *Q'eqchi'* Maya communities in Southern Belize, this paper outlines a contemporary worldview and ethos where aspects of medical reality are spread out beyond interactions between patients and healers to include vital relationships with the spirits and local ecologies, aesthetic moralities of social and spiritual significance. In this "cosmic-centered" therapeutic framework, we can appreciate more fully how *Q'eqchi'* Maya knowledge and aesthetic ways of being shape contemporary therapeutic encounters in ways that externalize and personify the source of affliction and suffering.

Keywords Indigenous knowledge, Q'eqchi' Maya, Morality, Healing, Ethnography

Introduction: Cosmovision as an Aesthetic Practice

Over ten years of ethnographic fieldwork among *Q'eqchi' iloneleb'* or healers[1] in Southern Belize has revealed a complex network of relationships that informs an aesthetic vision of reality in which cosmological and spiritual notions are often the key referent. "Cosmovision" is thus the term frequently used by local Maya community members and *iloneleb'* to describe the worldview and ethos engendered within contemporary *Q'eqchi'* communities: a vision underpinning psychological, ontological, epistemological, moral and aesthetic realities. Following Sharman's (1997) "Anthropology of Aesthetics," we view aesthetic perception as an attachment of values to experience, and that its expression or embodied performance is a re-creation of experience through which those values are socially reconstituted or transformed. *Q'eqchi'* cosmovision is therefore not only a medium of perception, it is a medium of experience, a mode of embodied engagement with the world in which human and spiritual realities often deeply interrelate (Csordas 1990; Hatala & Caal 2020).

For the *iloneleb'* in the *Maya Healers Association* of Belize we worked with, their worldview and ethos involve complex networks of relationships that include interpersonal, intrapersonal, environmental, cosmological, and spiritual facets. Following critical insights reflective of the "ontological turn" in anthropology (Bessire & Bond 2014), it could be said that *Q'eqchi'* ontology *is* the relationships or process of nurturing relationships engendered through their vision of and actions taken within the world. Indeed, as Molesky-Poz (2006) also described,

> "Maya link cosmovision to spirituality, or say that their worldview is found within Maya religiosity. We can infer that the term Maya cosmovision

> has an inevitable ontological or religious aspect, however implicit, that expresses the 'lived' experience of Mystery from a human perspective situated in historical experience, struggle, and gratitude" (*ibid.* 44f).

The locally informed notion of relationality lived and experienced among *Q'eqchi'* communities (*i.e.*, relations between individuals and a kind of "Mystery") can shape the assumed structures of reality (*i.e.*, the facts of the world) and guide or inform the approved values or aesthetic styles of life, offering a formative set of practices "through which Maya feel, think, analyze, understand, and move reciprocally in the cosmos" (Molesky-Poz 2006: 35).

Rather than "belief" as a cultural category, the focus here is on the "formative processes," "interpretive activities," or "ontological schemes of practice" of *Q'eqchi'* cosmovision through which aspects of reality—and especially medical reality, aesthetic knowledge, and healing practice—are "confronted, experienced, and elaborated" (cf. Cassirer 1955; Descola 2010; Good 1994: 69). In so doing, we draw attention toward an "aesthetics of everyday experience" (Desjarlais 1992) that infuses Q'eqchi' medical reality, and thus the ethnographic account that follows will build upon the ontological orientation of several literary critics, anthropologists, and philosophers who argue that there exists no grand distinction between aesthetic and ordinary experiences (cf. Desjarlais 1992; Dewey 1980; Good 1994). We therefore examine the aesthetic principles of *Q'eqchi'* cosmovision which can shape and constrain how Maya healers approach their craft; the way healers kneel and pray, make sacrificial offerings, speak and pick medicines all reflect the aesthetic values of embodied *Q'eqchi'* cultural sensibilities. Indeed, As Desjarlais (1992) reminded us, "an aesthetics of experience does not tie solely into a system of beliefs, meaning or logical criteria" but rather, "refers to a schema of value" that are "embodied and so appear self-evident" insofar as "they go beyond the cognized sort common to intellectual reasoning" (*ibid.* 1108). As such, this study will enhance our understanding of everyday events, doings, sufferings, and healings which illumine *Q'eqchi'* Maya experience writ large, and particularly their medical worlds and healing practices.

Following this line of reasoning, key questions explored throughout this analysis involve: What are the interpretive and aesthetic activities that are at work or in tension among contemporary *Q'eqchi'* cosmovision, and particularly for *Q'eqchi' iloneleb'* in Southern Belize? How are the central aspects of *Q'eqchi'* medical reality, and thereby healer attention, constituted in their contemporary healing practice? And how do healers construct nosological medical systems as epistemological structures through such activities?

Although the topic of *Q'eqchi'* cosmovision, both historically and contemporaneously, is vast and deserving of more detailed descriptions than can be offered here, two vital and interrelated aspects emerged through our long-term ethnographic engagement with members of the Maya Healers Association that are discussed here from a *iloneleb'* perspectieve: (1) a relationship to the Mountains and Valleys; and (2) a moral economy of permission. Following this, we analyze and explore, through an ethnographic case study of a spirit "attack" and resultant healing encounter, how these aspects of cosmovision influence the interpretive structures of *Q'eqchi'* medical and aesthetic reality, and thereby shape the nosology or epistemological structures of *ilonel* medical knowledge and healing practice (Hatala *et al.* 2015; Hatala & Waldram 2016, 2017).

Research Context and Methodology

The analyses presented here are based on collaborative research with members of the Maya Healers' Association (MHA) of Southern Belize (formerly the *Q'eqchi' Healers' Association*) that has been ongoing since 2004. Maya peoples comprise some 31 distinct cultural groups inhabiting Mexico and several other countries in Central America. The *Q'eqchi'* represent nearly ten percent of the total population of Belize, living primarily in the Southern district of Toledo. The *Q'eqchi'* people maintain a rich "traditional" system of healing notwithstanding centuries of colonization and more recent intrusions by North American evangelical groups (Bourbonnais-Spear *et al.* 2005; Watanabe 1992).[2] Despite a strong presence of Maya healing practices in Belize, there are growing trends within *Q'eqchi'* communities away from the utilization of traditional healing services in fa-

vor of available biomedical services (Waldram *et al.* 2009; Waldram & Hatala 2015), a trend also observed over the last few decades among other Maya communities in Mexico and Central America (cf. Ayora-Diaz 1998; Kahn 2006; Pitarch 2007; Watanabe 1992).

In response to these changes, several grassroots Indigenous groups have emerged as part of the ongoing "ethnic revitalization" of Maya culture (Wilson 1995). The MHA is one such group in Belize with as many as ten active *iloneleb'*, which formed more than a decade ago to promote their activities. As part of their growth, the Maya healers requested that research into their healing practices be undertaken with the goal of demonstrating their effectiveness to the health officials in the Belize government, medical practitioners in their region, and to their own people, especially those moving away from more traditional ways of living and cultural practices.

Our research began in 2004 and has involved ethnographic observations and documentation of over 150 healing encounters through video recording and over 200 detailed interviews with both *Q'eqchi'* healers and their patients (Hatala *et al.* 2015; Hatala & Caal 2020; Hatala & Waldram 2016, 2017; Waldram & Hatala 2015; Waldram 2015, 2020). Interviews with healers and patients occurred in the *Q'eqchi'* language through a local translator and cultural expert who also served as a cultural broker and ethical advisor, which ensured respect for the traditions and patients' privacy and adherence to local ethical protocols was upheld. The standardized version of the *Q'eqchi'* language approved by the *Academia de Lenguas Mayas de Guatemala* (ALMG; Guatemalan Academy of Mayan Languages) is used throughout. Secondary translations of all recorded interviews by five additional *Q'eqchi'* language experts also occurred. The English-language passages shared in this article are these translations, and reflect varying levels of English-language expertise. We chose to modify these passages only for clarifying meaning. The research has received ethical approval from both the University of Saskatchewan Behavioral Research Ethics Board and the National Institute of Culture and History (NICH) of the Government of Belize. In representing this work to a wider audience, the *Q'eqchi'* healers involved in this research have requested their real names be used to maintain integrity of their voice, knowledge, and experience.[3]

The Mountains and the Valleys in *Q'eqchi'* Cosmovision

Throughout history, individuals and communities have developed complex visions of the world around them shaped by local ecology, history, language, and interactions with neighboring peoples and their ways of life. These visions, views, and perspectives of the world function to provide cognitive, perceptual, and embodied patterns, norms, or acceptable models of and for engagement with their internal and external worlds. The more deeply perspectives of *Q'eqchi'* cosmovision are grasped, the more it is realized that, like Hallowell's (1960: 23) observations among Canadian *Ojibwa* communities, "social relations" between human beings and other-than-human "persons" are of central importance to *Q'eqchi'* visions of and experiences with the world. Foremost among these relations for *iloneleb'* of Southern Belize are the trinitarian connections between *Qaawa'* (creator God), the *Spirits of the Mountains and the Valleys*, and humanity. As one healer, Emilio, explained about the complex connections between *Qaawa'* and these spirits:

> "*Qaawa'* is God with powers beyond this world. The spirits of the Mountains and Valleys are beings who take care of the animals, trees and the resources contained within the jungle and our natural environment. *Qaawa'* looks after the people as do the Mountain and Valley spirits. The two beings are *Kojoj* and *Itzam*. These two powers give us our life because that's what we depend on and that's where the animals live and natural resources are. They both have power which protect us, but *Qaawa'* gives us our life."

Emilio later clarified that *Kojaj* and *Itzam* are the names given to the respective spirits of the Mountains and Valleys. "They are a couple," he continued,

> "The male is *Kojaj* and the female is *Itzam*. For our healing work, or when we plant our crops, we do *mayejak* [ceremonies or rituals] to them for permission and we request that the animals or birds do not destroy the plants. They are the ones that guard the animals. That's why we offer them the

food, drink, *copal pom* and candle; to protect our plants and crops. That's the way it is. Everything is paired off, the sun, the moon. That's the way the Maya calendar and history is."

For the *Q'eqchi' iloneleb', Qaawa'* generally signifies an overarching singular creator God "with powers beyond this world" who is responsible for all life on Earth, which includes other kinds of spirits like those of the Mountains and Valleys. The earth is a territory maintained by *Qaawa',* who, in a sense, assumes stewardship of the land and everything above, on and below its surface. *Qaawa'* is thus responsible for the creation of reality, being exalted above or distinct from that reality, while maintaining a continual relationship with creation. In this perspective of *Q'eqchi'* cosmovision, a sacred order exists in the world, a spiritual world permeates the human and natural order, and humans are subject to these sacred and natural laws. In this view, there have been and continue to be important communications and relationships occurring between humans and the realm of the spirits (cf. Thompson 1972; Watanabe 1992; Waldram 2020).

The *Spirits of the Mountains and the Valleys,* in a way, act as God's masculine and feminine representatives or stewards who take care of the natural resources within their purview. These spirit beings are conceptualized within a broad notion of *Q'eqchi'* other-than-human "persons" (cf. Hallowell 1960). Acting upon their own volition, they are considered living beings that form part of the community and environment, upholding relationships with individuals in the community who in turn act as they would engage in any other dealings with "persons" that understand and respond to their communications and offerings.

In the *Popul Vuh* (the Maya book of creation), the twin Creators, "Heart of Heaven" and "Heart of Earth" say to each other: "Let's make humans to be the providers and nurturers" (Tedlock 1996: 57). In this way, Maya mythology and narrative history naturalize humans as guardians of the Earth. Later in the Maya creation narrative the twin creators discuss the importance of making offerings to nurture and build a relationship between themselves, the earth, and the spirits. They describe how the first humans made aromatic offerings of *copal pom* (a local tree sap or resin) to honour the first dawn, "crying sweetly as they shook [...] the precious *copal*" (*ibid.* 161).

Today, this aesthetic perception and style of life, where cultural values are linked to experience, continues among local *iloneleb'* and *Q'eqchi'* community members in various ways. As Emilio mentioned, "[W]e do *mayejak* [ceremonies or rituals] to them [spirits of the Mountains and Valleys] [...] They are the ones that guard the animals—that's why we offer them the food, drink, *copal pom* and candle. That's the way it is." Q'eqchi' *mayejak* or ceremony, from this perspective, is a contemporary "language of relationship," it is a "visible activity of the reciprocal relation in which persons maintain connection and harmony" (Molesky-Poz 2006: 44), and the way a relationship with other-than-humans is nurtured.

"With practicing and appreciating our place that is around us, our environment, forest, mountains, plants," another healer, Francisco, explained, "we have to ask blessings to all the spirits for us to move among them peacefully; that nothing should affect our lives." With these requests and offerings, Francisco continued, "that we make to the spirits of the Mountains and Valleys, to the Creator, and spirits of the different things, that is how we can avoid being affected negatively in our lives. This is how we have the ability to do work as healers."

In *mayejak, iloneleb'* often shared that different elements come together through a process likened to an attunement, reducing the dissonance between separate objects or ideas (*i.e.*, material and spiritual facets of reality) and between people and the environment, thereby strengthening and fostering relationships. Such attunement, as in musical instruments, refers to forming an accord to create an aesthetic of harmony (Molesky-Poz 2006). Thus, through various offerings of prayer, the local *iloneleb'* honor the vital forces of the earth and sky, the sacred Mountains and the Valleys, and engender a process of attunement between disparate facets or elements of reality.

Taken together, the members of the MHA, embody a worldview and ethos that, to a great extent, centers on complex networks of "social" relationships among themselves, *Qaawa',* and the spirits of the Mountains and Valleys in their social, spiritual, and ecological environments. These relationships enable *iloneleb'* to provide integral medical

and healing services to support their own personal and communal balance and well-being, as well as that of their patients (Hatala & Waldram 2016). The Q'eqchi' *iloneleb* involved in this study developed their various relationships to the spirits of the Mountains and Valleys, local sacred ecology, and *Qaawa',* over the course of a lifetime of embodied practice, illustrating how worldview and ethos sharply orient toward the cosmos and spiritual world—forming their cosmovision.

A Moral Economy of Permission

The notion of relationality, around which revolves contemporary understandings of *Q'eqchi'* cosmovision, is a locally informed cultural vision of the world offering a form of practice and perception that "reveals itself through a deeply imagined social consensus" that has been "naturalized" and "formulated by an active history" (Kahn 2006: 66). For the *Q'eqchi'* healers we worked with, notions of relationality are often rooted in a moral rhetoric that contains guidelines for "appropriate" or "proper" interactions among members of their community, their local ecology, the spirits of the Mountains and the Valleys, a host of other spirits and saints, and *Qaawa'* the Creator. Thus, the "language of relationship" (Cajete 2000: 178) expressed by the *iloneleb'* is deeply moral and infringements to this sacred moral order can lead to misfortune and illnesses of various sorts.

During ethnographic work with *Q'eqchi'* communities in Southern Belize, our research team has come to view morality as a historicized set of relational imperatives that socially bind groups of "people" together, embodied in distinctive symbolic forms and modes of human activity. In addition to human beings, "people" from this view encompasses a host of *other-than-human* beings that colour the landscapes of *Q'eqchi'* cosmovision (Hallowell 1960; Molesky-Poz 2006). Far from solely a "mentalistic" notion, abstracted from "embodied knowledge," visceral affect, and social or historical forces, morality in this context implies tacit, aesthetic, and practical ways of being-in-the-world (cf. Csordas 1990; Good 1994: 51). It is an action-in-place, active adherence to a "socialized and moralized imaginary" (Kahn 2006: 67). In this way, embodied moral visions are built up over time and are in dialogue with other social and political systems, ideologies, or ways of life. As Kahn observed during her work with *Q'eqchi'* communities in Livingston, Guatemala, "[r]eligious ideas about reciprocity, nature, and exchange with deities/outsiders, and economic interchanges that involve paying respect to landowners and tribute to institutions, have merged into a field of morality with a broad scope" *(ibid.* 66). These ideas of "reciprocity," "exchange," or "economic interchanges" regarding payments and offerings required to maintain or establish "proper" or "appropriate" relations, pervade *iloneleb'* sentiments of morality and medical ontology, while shaping contemporary notions of relationality or an embodied sense of "relational complementariness" (Molesky-Poz 2006: 44).

Historically, the earliest Maya glyphs recognized were those of offerings such as fish, iguana, a turkey head, the bound haunch of a deer, ducks and various forms of vegetation. These were all pictorially recognized as payments or exchanges between humans and the *other-than-human* realm (cf. Molesky-Poz 2006; Thompson 1972). Indeed, burial remains at the ancient city of *Tikal,* stone carvings at *Xunantunich* and *Chich'en Itza,* lintels of *Cahal Pech,* and stela at *Nim Li Punit* and *Lubaantun,* commonly depict various forms of ceremonial offerings. As Thompson (1970) argued, "essentially, Maya religion is a matter of a contract between man and his gods. The gods help man in his work and provide him with his food; in return they expect payment" (*ibid.* 170). In this context, making offerings to the Mountain and Valley spirits is a matter of survival and well-being, and an essential and practical component of everyday life. *Mayejak* (*i.e.*, the making of offerings, or "feeding the fire" in contemporary ceremonial practice) continues to be a foundational moral and aesthetic activity engendered through *Q'eqchi'* cosmovision: "We ask on the Valleys and Mountains to help and offer a payment," Emilio described, and "the incense is used for payment." In a story regarding whether or not there are ways in which people can protect themselves against illness, another healer Manuel Choc suggested that "you'll have to ask for permission so that you won't get a sickness. It's like paying a certain fee, but it's not with money. It's with *copal* [a local tree sap or resin] incense and candles offered to the spirits."

Similarly, when asked about certain prayers that help with healing, Francisco explained:

> "Yes, there is a prayer said at a certain time. It is said to the spirit of the sickness saying that they've done enough to the ill person. Through *mayejak*, the spirit of the illness is transferred to the sacrifices we make. It's like an *Alcalde* [community leader], if you've done something wrong they will charge you and that money is to pay for the crimes that were committed. It is like paying a certain fee so the sickness comes out of the person. It's called *toj* [payment]."

Exchanges between *iloneleb'* and the spirits of the Mountains and the Valleys, which resemble a kind of economic tribute, embody the essential cultural logics that underlie the *iloneleb'* notions of morality and thereby shape and inform their medical knowledge. When individuals do something wrong, as in Francisco's analogy of transgressions against an *Alcalde* or community leader, *toj* is required to mend or repair the moral infringements.

Throughout conversations with the members of the *Maya Healers Association*, the illustrative idiom of "permission" surfaced repeatedly, a pivotal notion revealing locally grounded cultural frameworks and "formative processes" (cf. Cassirer 1955). Permission is a concept expressing a moral fabric stitched together by local notions of relationality on the one hand, and economic "payment" or tribute on the other. As Manuel Choc outlined:

> "Let's say with fishing or hunting, we ask for permission to the Valleys and Mountains. The river is being created by God and we can find some food there. When we don't ask for permission, bad things can happen like falling into the river or getting some sickness."

These notions are in recognition of humans' role in a larger fabric of reality, as one participant group, no more or less important than any other. However, unlike all other beings in the environment, humans, in Maya cosmovision, are seen as reliant on the highest number and most diverse range of other beings for their survival, when considering food, shelter, and clothing. As Manuel Choc later described:

> "It's the same with hunting: if you don't ask permission, you might fall down and hurt yourself or cut yourself or get an illness. It's like if you have some poultry, like chicken or turkey. If I go and get one without asking, a neighbor might get upset. It's the same with the Valleys and Mountains, if you ask permission you can go freely."

Manuel Choc further explained that in asking for permission you first address *Qaawa'* the Creator, and then the other spirits:

> "It's like a father who has a lot of things. He [*Qaawa'*] gave it to them so they look after them. The Valleys and Mountains are there over us and if you don't ask permission it's like you're thieving from them. The spirits are given power by God. They wanted to be in the light and that's why they are given power to feed and take care of animals. They become aggressive at times because they have power over us and that's why we need to ask permission. Let's say a rich person that has huge amount of cattle living in an area tells you to take care of them. If a person later enters into that field you have all the right to speak to that person in a good way if it's the first time. If this is happening often, the rich person might authorize you to shoot the person. It's the same thing with the Valleys and Mountains. If you're not asking permission, it's like they have to ask an animal to attack you. Once you ask for permission, you're free to go anywhere. It's like paying some fees, but only in *mayejak*. In *mayejak* you ask for permission."

Within ancient Maya knowledge and contemporary *Q'eqchi'* cosmovision, humans are not "owners" of the earth and its resources. Rather, they are "nurturers" of their ecology and their spirits (Molesky-Poz 2006; Tedlock 1996). When fishing, hunting, walking through the valley forests, swimming in the mountain rivers, or climbing in a limestone cave, humans are obliged to request permission from *Qaawa'* and the spirits of the Mountains and Valleys who are the guardians of the earth and its resources. Manuel Choc's metaphors of the landowner and a trespasser appropriately convey this sentiment. When a permit is not properly obtained, the "owner" (the spirits of the Mountains and Valleys) may "get angry" and can reprimand the moral infraction through snakes, other animals, and through illness. In this excerpt, Manuel Choc also implies that these impacts may not be immediate and a person may

not be reprimanded for a single infraction. However, after several infractions it is likely that some misfortune will befall the violator. In essence, the practices of making offerings, to the Mountain and Valley spirits in this case, is a preventative measure of maintaining a relational balance between one's self and the spiritual and ecological environments in which one lives. They are practices of humility that nurture protection from illness and misfortune.

The notions of "permission" and "payment" reveal a *Q'eqchi'* theory of morality linked to notions of misfortune, agency, responsibility, protection and risk. Properly obtaining permission through payment or *toj* during *mayejak* is a protection against a host of potential problems or "risks" that may negatively impact an individual while in the wilderness. In these perspectives of *Q'eqchi'* morality and cosmovision, one is aware that the transgressions of obligations will catch up with an individual sooner or later unless that person does something to reverse the situation. When someone has done something wrong, or failed to properly ask for permission, he runs the risk of being "scolded" by or getting a "lashing" from the spirits of the Mountains and the Valleys. The *Q'eqchi'* idiom of permission expresses the moral obligations of "social," or perhaps more aptly "cosmological" responsibility; it is a principle of personalistic reciprocity. According to the *Q'eqchi' iloneleb'* we worked with, therefore, morality, as the cultivation of rightful, responsible conduct, of purposeful action-in-place (cf. Kahn 2006), is an important route to protection and prevention of illness and other misfortune or suffering. Morality is thus imbued with ontological, epistemological, aesthetic, and axiological characteristics insofar as the explanation of generalized events or notions of misfortune in the everyday world are grounded in what could be called a "moral causal ontology" (Shweder 2003), where individual transgressions of obligation, omissions of duty or ethical failures are cultural imperatives underlying explanations of and causes for events related to misfortune, and especially illness.

Awas and a Case of Spirit "Attack"

It was the peak of the harvest in Southern Belize and most families living in the *Jalacte* village, in Southern Belize near the Guatemala border, were out in their corn or bean fields for long hours each day in the unrelenting sun. One afternoon, while harvesting, Ronaldo suddenly felt weak and became momentarily unconscious, falling to the ground while shaking his limbs for several minutes. Ronaldo's father quickly attended to his son who soon regained consciousness and strength while he rested at their home the following day. A momentary bout of exhaustion or overheating was suspected. It was nearly two weeks later when, again out in the fields, a second incident occurred, this time more severe. Ronaldo had fallen to the ground, but this time did not regain consciousness and also appeared to be foaming at the mouth. His father, with the help of neighbours, brought Ronaldo back to the family home in Jalacte. Breathing softly but steadily, Ronaldo remained unconscious. The family was severely worried and decided to call on the help of local *iloneleb'* Emilio, who lived nearby, and his brother Francisco, who also happened to be visiting Jalacte from Punta Gorda nearly two hours away.

Once they arrived, Emilio right away began by placing his hands on Ronaldo's head and began uttering some healing prayers. While grasping Ronaldo's wrists and softly uttering his prayers, Emilio was pulsing, listening to the blood, "speaking" to the pulse and the spirit of Ronaldo to assess his condition (cf. Hatala & Waldram 2017). After grasping Ronaldo's wrists, Emilio then moved to feel the pulse at Ronaldo's forehead. With eyes closed, Emilio's hands remained on Ronaldo's head for a short time while he continued praying. Emilio then moved his hands over and across Ronaldo's head and body and down to his chest twice, performing the *jilok* or spiritual massage. Stopping on his chest, Emilio placed both hands upon the boy, bowed his head, and continued his prayers. Ronaldo was breathing heavily and remained motionless on the hammock inside the family home. Repeating the *jilok* motion several times, Emilio then took hold of Ronaldo's wrists and once again continued his prayers. "In the prayer, I'm talking to the power of God," Emilio later explained, "or the power of the Valleys and

Mountains. They have high power over the earth and I borrow them to put down the heat of the sickness."

This process ended as Emilio bent down and picked up a water bottle full of green medicinal liquid prepared earlier that day. Ronaldo understood Emilio's instructions and took the bottle and drank the medicine. Ronaldo finished about one-third of the liquid when Emilio said "*Bueno*" and then placed the bottle on the ground behind Ronaldo. As he lay on the hammock, Ronaldo smacked his lips together from the bitter taste of the medicine. At this point Emilio and Francisco were able to ask Ronaldo a few questions about his condition and experience.

"I was attacked and I feel like I don't know," Ronaldo explained. While in the middle of harvesting beans he remarked that his head suddenly felt as if it "was going up and down, going up and down."

"Just in the middle of while you were harvesting?" Francisco questioned further. "Yes," Ronaldo replied.

"And you don't know why it happened?" Emilio probed again.

"No."

"And then your parents brought you here?" Emilio continued.

"Yes," he said while moving his left arm on his head, "but I don't know when they brought me."

"Well we're glad you're feeling better now," Francisco gently responded, not trying to push the conversation too far.

"Thanks God yes," Ronaldo replied while holding his chest.

Through the discussions that occurred between Emilio, Francisco and Ronaldo's father they came to "emplot" and diagnose Ronaldo's case as a general form of spirit "attack" condition, and more specifically as a form of *rilom tzuul* (cf. Hatala & Waldram, 2017).

"It just started off with *kaanil* (fright), and they [the patient and his family] let it go until it got serious," Francisco explained during a later interview, "It got serious after a month and that time it turned to *eet yajel* [epilepsy] and later turned to the more serious one which is *rilom tzuul* [sickness caused by mountain spirit]." Ronaldo's first illness symptoms, then, were attributed to a case of *kaanil*. It was thought Ronaldo was frightened one day while working the fields or walking by a river and was never properly treated. This initial "fright" episode left him vulnerable, like a weakened immune system, to the later conditions of spirit "attack." Francisco thus proceeded at his home to treat Ronaldo for his current case of *rilom tzuul*. Over the next three days, Francisco and Emilio continued to treat Ronaldo with a combination of *Q'eqchi'* healing practices—herbal medications, traditional healing prayers, and the *awas* (a form of ceremonial sacrifice) procedure.

Later that same evening around midnight Francisco planned to perform an *awas* ceremony for Ronaldo, to extract the spirit of the illness through the sacrificial offering of an animal, in this case a duck. Francisco arrived at Ronaldo's home approximately thirty minutes before midnight and found his father seated in a green plastic lawn chair beside Ronaldo who lay in the same hammock as earlier that afternoon. In the dark of night, Francisco's figure assumed a prayerful position, one hand on his forehead, slightly bent over, with his other hand over his knees gasping onto the top of a large white bag used for collecting corn or beans in the fields. Francisco remained in prayer for nearly two minutes with his brother Emilio looking on while Ronaldo, barely visible, remained in the hammock with legs sprawled out over the edges.

Francisco then opened the large white bag and put his hand inside. Immediately, loud screeching sounds pierced the quiet night. The bag began to move. Francisco kept a calm, stern face. After a few seconds, Francisco slowly pulled his hand from the bag while the screeching continued. In his grasp was a large, white duck flapping its wings hysterically as it hung upside-down while Francisco held its legs. Eventually the duck calmed and its wings stilled. Francisco continued his prayers while holding the duck in his left hand. Francisco later explained that "[t]hat's the way it is, with *rilom tzuul*. That's the way we know that, that's what to give that sickness, the duck."

After a minute or so, Francisco stood and moved a step closer to Ronaldo who remained calm in the hammock. Ronaldo's parents watched on from several meters away. With his right hand holding the head and his left hand holding the feet, Francisco moved the duck, chest down, over and across Ronaldo's body. He started at the head

and moved the duck across the body several times; at places he touched Ronaldo with the belly of the duck, at others he remained about an inch above Ronaldo's exposed skin and clothes. His prayers continued. "I was doing the *jilok*," Francisco later describes, "to tell the sickness that it has done enough and to stop disturbing the body and spirit." The *jilok* in this case was being done with the duck in hand, bringing the duck in close contact with Ronaldo and his spirit.

After four repetitions with the duck across Ronaldo's body, Francisco moved about ten steps away and slowly stretched the neck of the duck until it was dead. Ronaldo and his parents watched with little emotional expression or change in disposition. The duck's wings flapped for several minutes as the nervous system slowly shut down. Francisco then came back to Ronaldo, while the duck's wings flapped slowly, and continued the *jilok* movements over and across Ronaldo's body for several more minutes while he continued uttering his healing prayers.

Satisfied with this process, Francisco then placed the duck, wings still moving slowly, back into the white bag. He secured the bag and resumed his prayers. With the entire bag, Francisco stood once more and began moving the bag rhythmically over and across Ronaldo's body. After four movements of the large white bag, Francisco signalled that it was time to dispose of the bag and bird. We piled into the truck and headed off to properly offer the duck to the Mountains and Valleys.

This process of *awas* is central to the spirit "attack" conditions (cf. Hatala *et al.* 2015), and is observed in several different forms of contemporary *Q'eqchi'* medicine. "The *awas* works for a sickness that a person is suffering from," Francisco explained, "the *awas* is used to replace that person to the sickness so those evil spirits will see the replacement belongs to them. It's like a change or payment [*toj*]."

It is difficult to translate the *Q'eqchi'* term *awas*. Often, the translators employed throughout this project used multiple terms or phrases in combination, the most common of which were: sacrifice, replacement, ransom, offering, exchange, and payment. Several phrases or idioms are also used to communicate this aspect of *Q'eqchi'* medicine, such as "taking out the days" of the sickness, "taking out the scent" of the sickness, removing the "pain" of the condition, or to "lure away" the "evil spirit" of the illness. As Francisco further described regarding the offering of the duck during Ronaldo's *awas* ceremony,

> "When I use it alive I'm telling the Mountains and Valleys that it is a replacement of the patient on what he has done and what is happening to them. We pray over it when it's still alive. We will give the duck as payment [*toj*] to them, that's why we use it alive. When I kill it then I give it to the sickness. We'll tell them its enough of what they've done and they should leave."

The "attack" and subsequent "feeding" of the "spirits" here are serious and debilitating enough such that the *iloneleb'* and the patient's family must offer a *toj* (*i.e.*, payment) for the spirit of the illness, a ransom or "replacement" to free the patient from the spirit of the illness. The illness then begins to "feed" on the offering or animal. In this way, the moral positioning of the patient is a central concern with these spirit "attack" conditions, since the spirits of the Mountains and Valleys have the responsibility to preserve the moral and social values of *Q'eqchi'* communities.

Yet the moral adjustment or healing does not occur at the level of the patient, but is directed at the spiritual or cosmological level between the patient and the relationships with the *Spirits of the Mountains and Valleys.*

At midnight, as the truck rolled along the dirt roads outside Punta Gorda, Francisco and Ronaldo's father exchanged few words. We drove for about ten minutes before arriving at a small, wooden bridge where Francisco signalled us to stop. Francisco then jumped out and moved over to the bridge and looked out to the small stream below. Francisco bent down over the edge of the bridge and began offering prayers with the now motionless white bag in hand. The area was pitch black and a cacophony of cricket and other insect noises filled our ears. Lightening also flashed several kilometres in the background. Francisco remained in this spot for nearly five minutes. When satisfied with his prayers, Francisco turned the bag over and dumped the duck into the water below.

During the following two days Ronaldo was closely watched and treated by Francisco and

Emilio at his home. Ronaldo remained weak and motionless, although generally seemed to be on the path to recovery. About a week later, much of Ronaldo's strength had returned as he was able to get up from the hammock and move himself into a chair for parts of the day. His parents were delighted to see this development and hopes remained high for a full recovery.

Cosmovision and the Moral Aesthetics of "Attacks"

As we explored elsewhere (Hatala *et al.* 2015), the *Q'eqchi' iloneleb'* we worked with conceptualize *rilom tzuul* as a kind of spirit "attack" illness that primarily involves an inciting incident of "contact" with an "evil" spirit. The *Q'eqchi'* healers suspect that Ronaldo had done something to offend the spiritual realm in some way and did not properly seek permission from the Spirits of the Mountains and Valleys. Ronaldo's symptoms frame the illness narrative as an "attack," of not following the normal social order. In addition to the herbal medications for symptoms, the healers offer a duck to the spirit of the illness that is "polluting" Ronaldo's body (*i.e.*, *awas*). In this respect, this case was simple and straightforward: the *Q'eqchi'* healers were sought for the expertise, a diagnosis or emplotment of the case was made and a treatment regimen commenced (cf. Hatala & Waldram 2017).

There are two concepts that are central within spirit "attack" conditions that underlie the logic of its diagnosis and treatment. The first involves a force or entity that is present with the individual that was neither there to begin with nor part of the natural state of being-in-the-world. This is typified in *iloneleb'* discourse regarding the intrusion of an "evil" spirit that has not only "attacked" the individual, but has remained within, continuing to cause harm and illness. In this way, the "evil" spirit is described as "feeding" on the patient which persists until a "payment" is properly made to the Valleys and Mountains, the keepers of the moral and social order. The second important notion is the link of this illness to morality, that the "attack" was provoked by some kind of moral infringement and is a punishment from *Qaawa'* and the Spirits of the Mountains and Valleys. As the *iloneleb'* explain, an individual who is "attacked" most likely did not properly request "permission" from the spirits of the Valleys and Mountains, and thus did not follow the traditional moral and social code that abounds amidst *Q'eqchi'* communities. Thus, it is through a general notion of a *Q'eqchi'* moral economy of permission that the illness of *rilom tzuul* as a kind of spirit "attack" can be appropriately understood and interpreted.

Underlying discourses of spirit "attack" illnesses are expressions of cosmic and social order, about a moral and aesthetic way of being-in-the-world, and about respecting the forces that inhabit the world which are greater than and enveloping the human realm. The treatment of these cases, then, like we saw with Ronaldo, often involve a central notion of *awas*, a gift or payment [*toj*] to the spirit world that corrects and brings the moral infringement back to a normal state, to reestablish order. In this way, *iloneleb' mayejak* during healing activities performed in the pursuit of health and wellness can be recognized as a localized ecological language, a "language of relationship" embodied in the tone, gestures, sentiments, and epistemological and aesthetic structures of contemporary Maya cosmovision. As such, *iloneleb'* visions of the world engender an intimacy between the people and the environment, blurring the lines between the earth, its personalistic spirits, and the *Creator*. In nearly all that they do, the *Q'eqchi'* healers in the *Maya Healers Association* humbly asked permission from the *Spirits of the Mountains and Valleys* and from *Qaawa'* when doing their work.

As we have seen, however, the focus of therapeutic attention and *mayejak* is not at the individual patient, but rather at the level of the spirits beyond the individual. Thus, even though the cause is often attributed to the level of individual moral culpability, the patient is not held "responsible" for their condition and therefore is not the center of therapeutic engagement in any overt cognitive or conscious manner. It is a moral causal ontology that repairs bonds with the individual and the spiritual world through an engagement with the embodied and aesthetic lived aspect of the patient experience and cosmovision. For the *Q'eqchi'* healers, then, their *mayejak* and engagement with the spiritual forces involved and at the level of patient bodily practice cuts across the conscious awareness of the patient; that is, the patient need not fully "know" about the symbolic and metaphori-

cal power associated with *awas*, but rather when it occurs the patient is "persuaded" at the aesthetic level of bodily sensation that something powerful has taken affect (cf. Hatala & Waldram 2016). This process then more closely exemplifies "restorative healing," in which the goal is to eliminate pathology and return the patient to a presickness state, and therefore a need for meaningful communication between healer and patient is often minimized (cf. Waldram 2013, 2015).

As others have also outlined, (cf. Crapanzano 1980; Young 1976), malevolent spirits can be a way of speaking about illness states by "externalizing" them. The potential of *Q'eqchi'* understandings and experiences of spirit attack are, however, not limited to an increased sensitivity to local explanatory frameworks or cultural practices. Rather, there are potential benefits to "externalizing" medical discourses (Young 1976), namely that attributing causation to spirits allows the sufferer to externalize the suffering, while personifying the moral cause of suffering that situates therapeutic attention outside and away from the person and toward an entity that can be influenced, taken control of, and overcome through specific medical techniques (cf. Hatala & Waldram 2016). As a result, the ill person is not permanently morally "damaged" or doomed to live in perpetual illness.

Curing and the Illness Narratives of Spirit "Attacks"

Throughout our work with the MHA and its members, we have posited that illness and disorders recognized by the *Q'eqchi' iloneleb'* contain narratives with recognizable genres and variations unfolding over time (Hatala *et al.* 2015). As Montgomery (2006) similarly observed with clinicians operating in Western biomedical contexts, *Q'eqchi'* healers work to simplify narratives of disease and disorder "with the hope of reducing them to the bare plot of readily made diagnosis and an obvious therapy. When they succeed, as they often do, the automaticity, the normality that clinicians value is restored" (*ibid.* 80). From this view, *Q'eqchi' iloneleb'* and biomedical clinicians together operate through assumed structures of reality, their paradigm, worldview or, in this case, their cosmovision. When illness is "emplotted" or "domesticated" (Hatala & Waldram 2017) within assumed structures and ontological perspectives, the "automaticity of expertise" (Flemming & Mattingly 2008) or "normality" of a particular therapeutic approach can seamlessly unfold. The cosmovision of the *Q'eqchi'* healers, their "language of relationship," and their empirical knowledge together foster the "normal" or ordinary vision of *Q'eqchi'* nosology: it represents the "known" conditions that can impact or "attack" a person, the cumulative historical knowledge of ages past combined with years of empirical knowledge, embodied experience, and practice (cf. Hatala *et al.* 2015; Waldram & Hatala 2015; Waldram 2020). The *Q'eqchi' iloneleb'* cosmovision, together with their nosology of illness and disorder, provide a paradigm for the interpretation and construction of meaning within a particular case of illness.

Byron Good (1994) concluded his "Medicine, Rationality and Experience" by suggesting that illness be conceived as an aesthetic object. Just as with a painting or fictional narrative, Good argued that multiple perspectives and points of view are required to fully comprehend the illness experience. As with most theory underpinning the narrative accounts of illness experiences, Good's reflections primarily originate from the patient's perspective and move towards a "heteroglossia" of narrative constructions and a plurality of views regarding illness accounts of experience. "Any act of objectification," Good (1994) contended,

> "is a moment of synthesis, but the 'multiple strata' resist closure. For each actor involved, alternative representations and the complexity of the object challenge any particular formulation" (*ibid.* 170).

For the *Q'eqchi' iloneleb'* we worked with and their illness perspectives, although multifarious and overlapping, do not inherently resist closure, nor do their narrative accounts of illness experience challenge a particular attempt at formulation. Their views of an illness condition are not typically fraught with anxiety and despair, confusion or ambiguity as differing interpretations of an illness episode are in competition. For *iloneleb'* there is in many ways a certitude, a surety built from their ability to diagnose and interpret the different signs and symptoms available amidst various unfolding medical dramas to which they attend (cf. Waldram 2020). This therapeutic process is infused with and shaped by their perspec-

tives and understandings of cosmovision and their "narrative genres" of diagnosable illness conditions (cf. Hatala *et al.* 2015; Hatala & Waldram 2017). From the perspective of *iloneleb'* or medical practitioners, then, is it reasonable to expect such an indeterminate heteroglossia as Good observed for patients' narratives and experiences? Why is there such a discrepancy in the determinacy of the medical object when shifting our gaze from the patient to the healer? From the view of Emilio, Francisco and the other members of the MHA, their job is to create closure, to cure (Waldram 2020). Their cultural work is distinguished by a confident resolution of the particular plot and case at hand. The *Q'eqchi'* healer's job, in a sense, is to create focus or a center around which the medical drama can unfold in order to resolve multiple points of view and discount alternatives. And even as we illustrate elsewhere in the face of a "new" illness conditions, *iloneleb'* operate on the basis of known therapeutic approaches and diagnostic categories infused with a moral economy of permission and relational complementarity inherent to their cosmovision (cf. Waldram & Hatala 2015).

Conclusions

To better understand, interpret, and appreciate the contemporary healing practices of *Q'eqchi'* Maya *iloneleb',* this article described two "formative processes," "interpretive activities" or "ontological schemes of practice" of *Q'eqchi'* cosmovision: a relationship to the Mountains and Valleys, and a moral economy of permission (cf. Cassirer 1955; Descola 2010; Good 1994). Each of these aspects influence the interpretive structures of *Q'eqchi'* medical reality and thereby shape *Q'eqchi'* conceptions of illness and health, wellness and balance (cf. Hatala *et al.* 2015; Hatala & Waldram 2017). From this perspective, *Q'eqchi'* cosmovision provides a provisional overarching aesthetic structure that characterizes the telling and interpreting of stories related to medical conditions and healing practices.

As Good (1994) observed, medical and psychological anthropologists have a vital role to "investigate how local medical worlds formulate and respond to illness, comprehend aspects of reality, produce distinctive forms of medical knowledge, and shape a crucial dimension of human experience" (*ibid.* 177). It is these perspectives of *Q'eqchi'* cosmovision that inform local medical worlds and produce distinctive forms of medical knowledge including narratives of illness and health. On the one hand, cosmovision can be explained by the healers through descriptions of the specific rationale behind each ceremonial offering and the ways that making payments to the spirits of the Mountains and Valleys are an essential part of their relational survival and vision. Their vision of reality, from this view is a conscious concern with the assumed structures of reality and cultural models that link their reality and provide templates for action. On the other hand, cosmovision is implicit and tacit; it is a moral and historicized way of being in the world that implies a kind of "everyday reasoning" or "everyday aesthetics" that "reveals itself through a deeply imagined social consensus" which has been "naturalized" and "formulated by an active history" (cf. Desjarlias 1992; Kahn 2006: 66). From this perspective, engagement with reality for the *Q'eqchi'* Maya is an unconscious and embodied aesthetic lifestyle conforming to and supported by the assumed structures of the world as a place where reciprocal, ceremonial behaviors engender well-being and security for those who participate.

To a great extent these aspects—the cognitive and embodied, the lived and imagined—come together and are reinforced by the two-fold function of *mayejak*, or *Q'eqchi'* ceremony. *Mayejak* can be performed in order to strengthen the relationships between individuals, their environments, and the *other-than-human* realm, which is ever-present (*i.e.*, attunement). Like we observed with the ethnographic example, *Q'eqchi'* ceremony also occurs as a local moralized *action-in-place* whereby "payments" are offered so "permission" (and in this case a kind of "forgiveness") may be granted. The interpretive and symbolic contours of *Q'eqchi'* healing are evident in these interrelated functions of *mayejak* and from them we see a vision of medical reality that is spread out beyond interactions between patients and healers—interactions that include relationships with the spirits and local ecologies, moralities of social and spiritual significance. In this "cosmic-centered" therapeutic framework, *iloneleb'* perform *mayejak* in the cool darkness of a limestone cave, among the warmth of a family hearth, or on the peaks and dips of the

local mountains and valleys in order to discern and diagnose a medical condition, read their patients story, and placate the spirits required to assist in restoring balance to the cosmological and moral disruption illnesses can carry and represent (cf. Hatala & Waldram 2017). A *Q'eqchi'* moral economy of permission, then, depicts a central aspect of their cosmovision that shapes "crucial dimensions of human experience" and "distinctive forms of medical knowledge" (Good 1994: 177), helping us appreciate more fully how *Q'eqchi'* Maya knowledge and aesthetic ways of being construct contemporary therapeutic encounters in Southern Belize.

Acknowledgements

The research received ethical approval from both the University of Saskatchewan Behavioral Research Ethics Board and the National Institute of Culture and History (NICH) of the Government of Belize. We wish to acknowledge the assistance of Victor Cal, coordinator of the Maya Healer's Association, all members of the Healers' Association, and our interpreters employed over the years: Pedro Maquin, Rosy Maquin, Lydia Makin, and Federico Caal. We would also like to offer special acknowledgement to Tomas Caal who served as the main translator, language expert, and cultural guide for the duration of this research project and accompanied the first and second author during all interviews. Importantly, Tomas Caal also served as a cultural broker and ethical advisor to the research project by ensuring respect for the traditions and patients' privacy, and adherence to local ethical protocols.

Funding for research with the Maya Healers' Association has been provided by the Social Sciences and Humanities Research Council of Canada (# 435-2012-0634).

Notes

1 The word *ilonel* (pl.: *iloneleb'*) in *Q'eqchi'* means "seer," "to see," or the "one who sees," as involving the ability to prognosticate disease.

2 To avoid a presentation of culture that is static or bounded to a single place and time, we often place the word and concept of "traditional" in quotes when referring to the *Q'eqchi'* healing system to signify that this system, although drawing on a long history of empirical knowledge and practice, has shifted and changed over the years in relation to or interactions with other systems of thought and medical practice.

3 All interviews and video data recorded were subjected to a thematic analysis (Denzin *et al.* 2008). Initial themes were highlighted and analytic files were constructed on specific areas of interest (*i.e.*, *Q'eqchi'* cosmovision, diagnosis, etiology, and treatment approaches). This first stage of analysis ultimately transformed the entirety of the analytic files into a series of interrelated themes. A second phase of analysis examined the compiled list of emergent themes and analytic files to identify connections therein. Analytic and theoretical ordering of super- and subordinate themes then helped to make sense of the connections between and among the emerging illness conditions. After the initial analysis and coding process, the authors began to share the results with the MHA members and wider *Q'eqchi'* community and organizations supporting the research process. This allowed for the opportunity of the healers, collaborating organizations, and community stakeholders to respond to the findings and interpretations and support the development of recommendations emerging from the research. Following these community consultations, several joint meetings were held with the MHA members to further discuss and integrate feedback for the production of publications, presentations, and final reports. This iterative process ensured that the presentation of the findings in this article are, as much as possible, an accurate portrayal of the knowledge and experiences of the MHA healers.

References

Ayora-Diaz, Steffan 1998. Globalization, Rationality and Medicine: Local medicine's Struggle for Recognition in Highland Chiapas, Mexico. *Urban Anthropology* 27, 2: 165–195.

Bessire, Lucus & David Bond 2014. Ontological Anthropology and the Deferral of Critique. *American Ethnologist* 41, 3: 440–456.

Bourbonnais-Spear, Natalie *et al.* 2005. Plant use by the Q'eqchi' Maya of Belize in Ethnopsychiatry and Neurological Patholgy. *Economic Botany* 59, 4: 326–336.

Cajete, Gregory 2000. *Native Science: Natural Laws of Interdependence*. Santa Fe: Clear Light.

Cassirer, Ernst 1955. *The Philosophy of Symbolic Forms. Vol. 1: Language*. New Haven: Yale University Press.

Crapanzano, Vincent 1980. *Tuhami: Portrait of a Moroccan*. Chicago: University of Chicago Press.

Csordas, Thomas J. 1990. Embodiment as a Paradigm for Anthropology. *Ethos* 18, 1: 5–47.

Denzin, Norman, Yvonna Lincoln & Linda Tuhiwai Smith 2008. *Handbook of Critical and Indigenous Methodologies*. London: Sage.

Descola, Philippe (ed) 2010. *La Fabrique des Images*. Paris: Somogy.

Desjarlais, Robert 1992. Yolmo Aesthetics of Body, Health and 'Soul Loss'. *Social Science & Medicine* 34, 10: 1105–1117.

Dewey, John 1980. *Art as Experience*. New York: Perigee.

Flemming, Hayes & Cheryl Mattingly 2008. Action and narrative: two dynamics of clinical reasoning. In Joy Higgs

et al. (eds) *Clinical reasoning in the health professions*. 3rd edition. Philadelphia: Elsevier: 110–126.

Good, Byron 1994. *Medicine, rationality, and experience: an anthropological perspective*. Cambridge: Cambridge University Press.

Hallowell, Alfred I. 1960. Ojibwa ontology, behavior, and world view. In Stanley Diamond (ed) *Culture in history: essays in honor of Paul Radin*. New York: Columbia University Press: 19–52.

Hatala, Andrew. R. & Tomas Caal 2020. Embodiment, Empathic Perception, and Spiritual Ontologies in Q'eqchi' Maya healing: An Ethnographic Exploration. *Ethos* in print.

Hatala, Andrew. R., James B. Waldram & Tomas Caal 2015. Narrative structures of Maya mental disorders. *Culture, Medicine and Psychiatry* 39, 3: 449–486.

Hatala, Andrew. R. & James B. Waldram 2016. The role of sensorial processes in Q'eqchi' Maya healing: a case study of depression and bereavement. *Transcultural Psychiatry* 53, 1: 60–80.

Hatala, Andrew R. & James Waldram 2017. Diagnositc emplotment in Q'eqchi' Maya medicine. *Medical Anthropology* 36, 3: 273-286.

Kahn, Hilary E. 2006. Seeing and being seen: the Q'eqchi' Maya of Livingston, Guatemala, and beyond. Austin: University of Texas Press.

Molesky-Poz, Jean 2006. Contemporary Maya spirituality: the ancient ways are not lost. Austin: University of Texas Press.

Montgomery, Katheryn 2006. *How doctors think: clinical judgement and the practice of medicine*. Oxford: Oxford University Press.

Pitarch, Pedro 2007. The political uses of Maya medicine: civil organizations in Chiapas and the Ventriloquism Effect. *Social Analysis* 51, 2: 185–206.

Sharman, Russel 1997. The anthropology of aesthetics: a cross-cultural approach. *Journal of the Anthropology Society of Oxford* 28, 2: 177–192.

Tedlock, Barbara 1982. *Time and the Highland Maya*. Albuquerque: University of New Mexico Press.

Tedlock, Dennis 1985. *Popol Vuh: the definitive edition of the Mayan book of the Dawn of Life and the Glories of Gods and Kings*. New York: Simon & Schuster.

Thompson, John E. S. 1990. *Maya history and religion*. Norman: University of Oklahoma Press.

Waldram, James B. 2013. Transformative and restorative processes: revisiting the question of efficacy of Indigenous healing. *Medical Anthropology* 32, 3: 191–207.

Waldram, James B. 2015. "I don't know the words he uses": therapeutic communication among Q'eqchi' Maya healers and their patients. *Medical Anthropology Quarterly* 29, 3: 279–297.

Waldram, James B. 2020. *An imperative to cure: principles and practice of Q'eqchi' Maya medicine in Belize.* University of New Mexico Press.

Waldram, James B., Victor Cal, & Pedroc Maquin 2009. The Q'eqchi' Healer's Association of Belize: an endogenous movement in heritage preservation and management. *Heritage Management* 2, 1: 35–54.

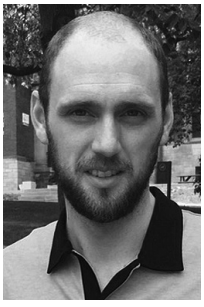
Waldram, James B. & Andrew R. Hatala 2015. Latent and manifest empiricism in Q'eqchi' Maya healing: a case study of HIV/AIDS. *Social Science & Medicine* 126: 9–16.

Watanabe, John 1992. *Maya saints and souls in a changing world*. Austin: University of Texas Press.

Wilson, Richard 1995. *Maya resurgence in Guatemala: Q'eqchi' experiences*. Norman: University of Oklahoma Press.

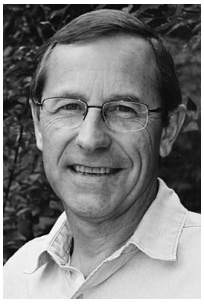
Young, Allan 1976. Internalizing and externalizing medical belief systems: an Ethiopian example. *Social Science & Medicine* 10: 147–156.

Manuscript received: 05.12.2019
Manuscript accepted: 25.12.2020



ANDREW R. HATALA, PhD, is a medical and psychological anthropologist with interest in cultural psychiatry and health psychology and currently an Assistant Professor in the Department of Community Health Sciences at the University of Manitoba. His previous research explores the therapeutic practices for and conceptions of mental illnesses and disorders in both Canadian and Belizean Indigenous contexts. His published works focus on Indigenous healing and epistemology, Indigenous nosology of mental illness and disorder, culture and spirituality, and resilience and well-being among Aboriginal youth populations.

Department of Community Health Sciences.
Max Rady College of Medicine, University of Manitoba,
Winnipeg MB. Canada.
e-mail: andrew.hatala@umanitoba.ca



JAMES B. WALDRAM, PhD, is a medical and psychological anthropologist appointed to the Department of Archaeology and Anthropology at the University of Saskatchewan. His research is in the anthropology of healing and therapy, and he has undertaken research in many Canadian and Belizean Indigenous communities, prisons, hospitals, and clinics. He is the author of *Hound Pound Narrative: Sexual Offender Habilitation and the Anthropology of Therapeutic Intervention* (2012, University of California Press)

Department of Archaeology and Anthropology.
University of Saskatchewan, Saskatoon SK. Canada
e-mail: j.waldram@usask.ca

Seeing Lights

Healing in a Meditation Class in Beirut

JOHANNA KÜHN

Abstract This article links "sensorially engaged anthropology" (Nichter 2008) to the research of contemporary spiritual practices in the Middle East by exploring the notion of healing among practitioners of a meditation class in Beirut. Based on ten months of ethnographic research, participants' sensory processes during the meditation class are analysed. The author shows how the central aspect of the practice, the sensation of *seeing lights*, can be understood as a bodily mediated attempt to learn and experience love for oneself. This attitude was the basis for healing, as from the practitioners' perspective only a self-loving individual could possess the ability to build a life according to one's wishes and thus heal from difficult life situations. In this way, the practice proposed a notion of healing as the acquisition of individual agency that reflected the aspirations of the primarily female and middle-class practitioners. Particularly against the backdrop of the recent economic crisis in Lebanon, efforts to build a self-determined life—one that balanced the drive for autonomy and individuality with the need for embeddedness in the social environment—played a central role in the practitioners' lives. More broadly, the article demonstrates that focusing on the sensory experiences of those involved in healing practices not only enables a better understanding of how people manage to become better, but also draws attention to the fact that repetitive learning and experience of sensations are the means by which contemporary spiritual practices (re)produce and reaffirm distinctive values centred around the question of how to live one's life.

Keywords sensory anthropology, meditation, healing, Lebanon, agency, middle class, individuality, autonomy

Introduction

> "It was Friday and we had a *Development and Enlightenment Program.* This is one of the most powerful programs in meditation that Rayhan gives. So I entered. [Rayhan said:] 'You are welcome! Please have a seat!' [I answered:] 'Okay!' I have no clue what's gonna happen. [He said:] 'So, lay back!' Well okay. He started talking and I just went flowing from place to place. [Afterwards Rayhan asked:] 'What did you see?' [I answered]: 'I've seen lights.' He was like: 'It's your first time? [...] you've seen lights? […] For *Allāh*, I think you are ready! You're ready for what you find out yourself!' So I kept coming to meditation." (Nabila, 6 December 2017)[1]

Rayhan, a single man in his early thirties with experience in the sales and tourism sector, was first introduced to meditation courses and energy-based healing methods (*e.g.* Reiki) in the expat community of Dubai. After his return to Lebanon he created his own kind of meditation, and—backed by silent partners and with the help of his family—opened a spiritual centre. In a flat in a newly constructed apartment building in the south-west of Beirut, a short walk north of the National Museum, he offered meditation sessions up to three evenings a week from Monday to Friday for a fee of 15–35 US dollars.[2] The mostly female audience experienced a two-hour class encompassing two elements. One involved using angel tarot cards[3] to answer practitioners' questions or advise them on challenging situations by delivering messages from angels. The other element was a combination of incense sticks, loud relaxing music (to drown out the traffic outside), the sound of singing bowls, and the emotionally loaded voice of Rayhan guiding the participants through a journey to imaginary environments. In this part, attendees sought the sensation of *seeing lights*—an

experience that provided the jumping off point for the following analysis of this meditation practice.

Rayhan's meditations are part of Beirut's flourishing field of yoga classes and meditation courses (henceforth referred to as contemporary spiritual practices).[4] Despite criticism from some Christian and Muslim religious authorities, who see these practices as incompatible with religion, such leisure activities are increasingly popular among the middle classes of Lebanese society. Though they vary in content and procedures, a prominent feature of these practices is the idea of healing; whether they be physical illnesses, psychological problems or social conflicts, practitioners are seeking healing for troublesome aspects of their lives. This focus on healing is not specific to Beirut. In his study on the *New Age* movement in the Global North, Heelas (1996: 81) states that "[i]n a general sense of the term, the entire New Age has to do with 'healing'."

The conference *Aesthetics of Healing: Working with the Senses in Therapeutic Contexts* called for the "black box" of healing to be opened. It drew on sensory anthropology, a field that invites us to integrate the study of sensory processes and conceptualisations into anthropological work (cf. Bull & Mitchell 2015; Pink 2015; Pink & Howes 2010). Central to the conference were the bodily processes and sensory experiences of those involved in healing. The inclusion of sensory approaches is not only relevant for the analysis of healing practices, where ideas of sickness and notions of "becoming better" are manifold in their forms, their purposes and the sensory perceptions they trigger. It also offers a fresh look at contemporary spiritual practices. By paying attention to "the embodied sensibilities the practice cultivates" (Dox 2016: 3), contemporary spiritual practices become embodied experiences that are entangled with the social, political, religious and economic circumstances in which practitioners are living (cf. Nichter 2008: 186) rather than "representations of something" (Kurz 2017: 202).

In the academic literature, much has been written about *New Age* practitioners in the Global North (Aupers & Houtmann 2006; Hanegraaff 1996; Hauser 2013; Heelas 1996; Redden 2005), but except for Israel (Ruah-Midbar 2012; Ruah-Midbar & Zaidman 2013; Werczberger & Huss 2014), little has been said about those in the Middle East.[5] With the analysis of Rayhan's meditation class, I contribute a sensorially sensitive insight into the field of contemporary spiritual practice in Lebanon. I begin my analysis by describing the practitioners' life situations, which were characterised by challenges stemming from social expectations and the economic crisis. I then analyse the centrepiece of Rayhan's meditation class, the sensation of *seeing lights*. I show that it can be understood as a bodily mediated attempt to learn and experience love for oneself. In the practitioners' perception, self-love was the basis for healing: only a self-loving individual had the ability to build a life according to one's wishes. Thus, the practice's notion of healing can be understood as establishing oneself as a powerful agent in order to shape a self-determined life. To conclude, I discuss the wider implications of the practices. I show that the meditation classes centred around specific values that informed the practitioner's aspiration of living an individual life while maintaining social embeddedness. In this sense, contemporary spiritual practices may be considered a leisure activity that expresses and reproduces the middle-class lifestyle of the practitioners, which is itself informed by the drive for individuality and autonomy.

The data presented are part of my research on contemporary spiritual practices and energy-based healing methods in Lebanon.[6] During ten months of ethnographic research carried out between March 2017 and December 2018, I conducted (mostly English-speaking) narrative interviews with 46 spiritual practitioners, participated in weekly yoga, meditation and Kabbalah classes, and attended multi-day workshops on energy-based healing methods in public centres and in private meetings of practitioners. My research approach is based on the understanding of "learning and knowing as situated in embodied practice and movement" (Pink & Howes 2010: 332). I was not only a participating observer, but an active apprentice of the aforementioned practices (cf. Pink 2015: 103–107; Kanafani & Sawaf 2017: 8f). For instance, I sensorially engaged myself in Rayhan's meditations with the aim of "grasp[ing] the task that the field subject must master in order to be minimally competent in his or her domain" (Luhrmann 2010: 220). Through this "emplaced and active participation" (Pink 2015: 116), I aimed

to better comprehend the sensory dimensions of my interlocutors' narratives and thus their spiritual practice itself.

Spiritual Practitioners in Beirut

Referring to *New Age* practices in the Global North, Fedele & Knibbe (2013: 7ff), Heelas (1996: 137), Sutcliffe & Gilhus (2014: 5ff) and Utriainen (2014: 243) have argued that participants are predominantly urban middle-class women, and navigate their lives in an uncertain, paradoxical and complex world. Also, Zhang (2015, 2018) demonstrates how a mixture of spiritual practices, psychology and (neuro)science gained popularity among China's urban middle class as its members strive for happiness and well-being "in a time of profound urban restructuring" (*ibid.* 2015: 316).

My interlocutors shared similarities with the examples outlined above. Practitioners lived in various parts of Beirut and its suburbs. Many rejected sectarian self-perceptions such as Sunni or Maronite[7], and through this expressed their stance against political sectarianism[8] and the ways in which it is reflected and reinforced in everyday life. While rejecting the politicisation of religious belonging, practitioners identified as Muslim, Christian or Druze. Nonetheless, they distanced themselves from established religious authorities and institutions, not least because they were considered to be (potentially) enmeshed with the sectarian political leadership of the country. In this sense, interlocutors understood contemporary spiritual practices as a way to independently seek an understanding of their faith and its practices, *e.g.* praying and fasting.

The majority of practitioners I met during my research were single women in their twenties and thirties or divorced single mothers aged around fifty to sixty. Their marital status was not only a shared aspect of their lives, but also a topic often raised in the interviews. Many interlocutors talked about problems centred around the issue of marriage and, relatedly, reproduction (cf. Inhorn 2012): the inability to marry, the wish not to marry, increasing social pressure because of advancing age and the absence of a marital partner and offspring, the social and personal consequences of a failing marriage, resulting expectations on a potential new partner, or life as a single mother.

These narratives crystallised certain challenges the interlocutors faced in trying to balance the expectations of their social environment and their drive for an autonomous and self-determined life. While interviewees considered family ties, for example, an important source of emotional support and closeness, and a reliable safe haven in (recurring) times of political crisis and insecurity, they also pointed to the negative aspects: expectations and control. Difficult decisions—*e.g.* quitting a long-hated but secure job—were not easily taken when facing the needs of (dependent) loved ones or the risk of being left without any support. A few interlocutors openly expressed the feeling of being held to social and moral standards by their wider social environment which they did not consent to and that in fact stood in opposition to the life they wished for themselves. Examples ranged from everyday questions of whether to engage in party-related leisure activities or move out of the parental home, to more structural factors such as career choices or, as mentioned, questions of marriage and reproduction. Indeed, it seemed that for the mostly female practitioners, many of the problems of negotiating individuality and autonomy within one's social environment were intertwined with the questions of marriage and relationship—a struggle that was further intensified by economic problems.

Lebanon has public debts of more than 150% of its GDP (Farha 2019: 220–221), dramatic inflation, "failures in public services, health, education, and social welfare" (Baumann 2019: 61), an estimated 60% of the population living under the poverty line defined by the World Bank and a 40% unemployment rate (Chikhani 2020).[9] Additionally, the country has faced widespread political protests since October 2019. During the time of my research in 2017 and 2018, the economic downward spiral had already begun. For my interlocutors, the most immediate consequence was unemployment. Finding a job in one's field of study for an adequate salary became an increasingly difficult endeavour. Even those who counted themselves lucky enough to be employed were seeking further sources of income to cover the rising cost of living.

With the debts of their educations on their (parents') shoulders, the promise of education as the key to a decent life slowly crumbled. For qualita-

tive reasons, private education is favoured over the public schools and universities in Lebanon, and a semester at one of the private universities costs anywhere from around 4,000 US dollars to 15,000 US dollars depending on the institution's reputation. As such, getting a (private) education means making a substantial financial investment, but one considered likely to pay off. As Baumann (2019: 69) states, "[e]ducation is the key to reproduce middle class existence and to economic security" (cf. Zbib 2014). However, at least for my interlocutors, the recent economic crisis cast doubt on the inevitable link between high-quality education and future employment. Given salaries of, for instance, 1,000 US dollars per month for a full-time position held by an early career employee, investment in education, a value which had been held in such high esteem, turned out rather ambivalently in reality (cf. Sengebusch & Sonay 2014: 8).

Unemployment had consequences beyond the lack of a prestigious job. Financing one's own room or apartment, conducting a master's programme and travelling abroad became difficult for the younger generation. For some, participating in everyday (leisure) activities that required money (*e.g.* meeting friends in cafés in other parts of the city) had to be calculated wisely. Older interlocutors were confronted with failing family businesses or shrinking maintenance from (ex-)husbands. On a day-to-day level, the economic crisis reduced the means available for living an autonomous life, and even intensified dependence on the social environment from which the interlocutors sought to become more independent.

While telling me about their profound struggles and expressing feelings of exhaustion and being overwhelmed (some having been diagnosed with depression), practitioners left no doubt that in their view there was only one sustainable way to approach their current situation: to distance themselves from the "low energy discussions"[10] of political problems, economic dead ends and social expectations of how to live one's life, and immerse themselves in the individual "spiritual journey," *e.g.* by practicing meditation, in order to create the life they desired.

Seeing Lights

Nabila, a single woman in her twenties who lived in the southern suburbs of Beirut, had pursued a university degree in the medical sector, but struggled to find employment in that field. When I first met Nabila in December 2017, she had only recently started to attend Rayhan's classes. Nonetheless, she attributed major changes she undertook in her life to meditation. In the absence of employment options, she worked as a teacher, an occupation she severely disliked. Shortly after starting meditation, she quit that job. Additionally, she took off her veil—a decision that not all of her close family approved of. In our interview, she spoke of broad support, but also of rejection from her social environment. Nabila adamantly stated that "spirituality doesn't stand in the face of any religion" (Nabila, 6 December 2017). She explained that she had long been dubious about wearing the veil, but only through meditation had she found the strength to take this step and "confront everyone that might stand in my way" (*ibid.*). For Nabila, meditation was the practice that enabled her to realise her goals despite obstacles. Accordingly, she spoke enthusiastically about Rayhan's classes and her ability to see lights (see the introductory quote of this article).

In general, great significance was attached to the sensation of *seeing lights*. The ability and intensity of *seeing lights* was subject to ongoing discussion among practitioners inside and outside of class, as it was a desired experience that Rayhan encouraged his students[11] to seek out. Furthermore, it served as a marker of progress for an apprenticeship in the spiritual realm. Listening to conversations between Rayhan and his students after class, I learnt that the practitioners literally saw lights behind their closed eyes. Other practitioners told me about additional "messages", such as letters, a silhouette of an angel, or the face of an important religious figure. Those visual sensations were accompanied by feelings of warmth, stillness and relaxed limbs. I additionally heard practitioners sighing, starting to breathe more deeply, and occasionally crying. In this sense, *seeing lights* was a complex array of bodily sensations experienced by the practitioners during the meditation session.

More precisely, the sensation of *seeing lights* took place when Rayhan vocally guided the participants through imaginary environments. He gave a brief outline, while attendees had to add supplementary details based on their own ideas and wishes. The imaginary environments were landscapes or buildings, occasionally inhabited by animals or otherworldly beings. In addition, Rayhan's guidance was filled with descriptions of various forms of light and prompts for his students to "feel" those lights. Sometimes Rayhan centred these journeys around a specific question, such as "What do you want to have in your life?", asking participants to furnish the environments with items representing desired characteristics or life situations. Nabila contrasted the peaceful experience of these imaginary environments with the chaotic real environment around her:

> "It is really addicting, because in the chaos, in this world, you find peace, you create peace, a reality of your own. Everything is realistic, but a touch from inside, spiritual touch, because you decide what you want to have in your life, whom do you want to have in your life, what things to accept and what others things to not accept." (Nabila, 6 December 2017)

Nabila's self-created environments had similarities with her everyday surroundings but contained something beyond them: "a touch from inside, a spiritual touch" that originated in the fact that she decided how things were, including her relationships with other people and her own capabilities. In this sense, imaginary environments were a model for the real environment Nabila desired and the corresponding version of herself that she sought to create. As she suggested, these imaginary environments were a source of "peace" for her, but were also informed by a version of herself that possessed unlimited agentive power. Against the backdrop of economic uncertainty and a drive for individuality and autonomy, the imaginary "spiritual" environment became a refuge where desired but hard-to-achieve life goals were visualised.

In this way, sensations during meditation intersected with practitioners' visions of their desired lives. The experience of *seeing lights* affirmed the practitioners' meditation experience. Moreover, the meditation experience encompassed the practitioners' desired life situation. In the view of the participants, it was meditation, understood as the nexus of *seeing lights* and the visualisation of one's desired life, that enabled them to realise the life they were aspiring toward. As Nabila emphasised:

> "Because really, from inside, I became stronger. Stronger, more confident, self-accepting. Actually brave, courageous. I can come up and do whatever I want. So this is how meditation opened a door to life changing" (Nabila, 6 December 2017).

What, then, is the link between meditation and life changes? Or, to put it another way, how exactly did meditation and its centrepiece *seeing lights* become a life-changing force for the practitioners?

Cultivating Love

A frequently used statement among practitioners was the phrase "I work" (or *'anā beshtighil*). In fact, working seemed to be the *modus operandi* of the practitioners (cf. Heelas 1996: 28f). It took the form of a teacher's encouraging invitation for his (struggling) students to continue their spiritual work, or an interlocutor's summary of what had happened in her life during my absence from Lebanon ("I worked on myself" (Hadiya, 2 December 2018)). An aspect of this work on oneself was the act of facing unpleasant and painful aspects of one's life (cf. Heelas 1996: 4). More precisely, the practitioners aimed to let go of negative memories from the past and ideas about themselves, which were perceived as false beliefs that were blocking them and preventing healing from taking place. During his classes, Rayhan led the attendees to their childhood memories and invited them to take a look at unhappy experiences in order to leave them behind: "We are willing to clear what is no longer serving us right now, in this session, through the divine energy, love and light, peace, trust" (Rayhan, 26 January 2018). As a substitute, he urged his students to adapt a view of themselves and of their lives that was inspired by love.

The desired experience of and capacity for love were discussed prominently among the practitioners. Many named it as a goal of their spiritual apprenticeship. Love was directly linked to sensations experienced during the practice which, in the long term, developed into a state of being, a perspective on life and a general attitude with

which situations, people and problems were best approached. Rayhan also repeatedly referred to the concept of love as a centrepiece of his practice: "We're only searching for light and love and happiness and joy" (Rayhan, 12 December 2017). As this quote indicates, the concept of love was frequently mentioned in the same breath as the concept of light and the idea of reaching a state of well-being and comfort. By inviting the attendees to see light and feel love, Rayhan connected the sensation of *seeing lights* with states of being protected and of giving and receiving love. As he wrote more recently:

> "It's okay to get lost in the darkness for few seconds [...] those seconds can be weeks or months but when you choose love only [then] you will survive [...] the light will come ... the light will shine [...] you can only survive if you choose love again and again and again" (Rayhan, 3 July 2020).

When I asked for a verbal description of love, many interviewees struggled to find an answer. While some explained it as an everyday guideline of how to treat people respectfully, or equated it with other concepts such as "the source," the universe or God (*Allāh*), most interlocutors described love as a state of being that could only be felt bodily, not explained in words. When asked what love is, Leyla, another spiritual practitioner I interviewed during my research, paused, closed her eyes, breathed in and out slowly, opened her eyes, smiled faintly, and said: "That!" (Leyla, 22 November 2018). Instead of a verbal explanation, Leyla literally demonstrated to me her understanding of love, which was first and foremost a sensory process within herself. The fact that she circumvented a verbal translation, and instead used bodily movements to make me understand what she perceived as the aim of her practice, shows that for my interlocutors, love was less of a cognitive construct in the sense of Heelas' (1996: 2) *lingua franca* of the *New Age* movement and more of an individual, sensorially defined, embodied part of their practice.

The significance of emotions such as love has been analysed with regard to (contemporary) spiritual practices. Albanese (1999) states that within *New Age* practices, love is overwhelmingly promoted "as the resolution for human ills" (*ibid.* 319), with the absence of positive emotions perceived as the cause of various illnesses. Chen (2014) shows how *New Age* practices in Taiwan encompass "feeling rules" that are centred around the self-reflexive observation and management of emotions that are said to induce self-transformation. Neufend (2019: 105f) demonstrates how Lebanese Sufi practitioners (re)produce emotions through the practice of vision: gazing at items considered and named beautiful is a routinised way to evoke happiness (*ibid.* 108). In her analysis, Neufend draws, *inter alia*, on Scheer's (2012) conceptualisation of emotions from a Bourdieuian perspective. Scheer perceives of emotions as an embodied practice that is socially and culturally shaped and continuously managed via the body *(ibid.* 193ff, cf. Bourdieu 1997). In this context, Scheer (2012) understands "the use of rituals (in the broadest sense) as a means of achieving, training, articulating, and modulating emotions for personal as well as social purposes" (*ibid.* 210).

Considering both the aforementioned literature and the practitioners' practices and discourses, I argue that *seeing lights* can be understood as a routinised bodily mediated attempt to experience (self-)love. By aiming for the sensation of *seeing lights*, the abstract goal of love was brought into a bodily form, a do-able sensation that the practitioners could learn by way of a routine weekly practice. In particular, the practice was meant to evoke an immediate form of love: the practitioner's love for herself. The desired consequence of this acquisition was a respectful appreciation of oneself, including one's physical appearance, abilities, (emotional) characteristics and past. In this way, the practitioners collectively developed a new form of sensual self-perception that was informed by an accepting and compassionate stance towards oneself. The significance of Rayhan's practice laid, therefore, within its repetitive sensory processes (cf. Downey 2015) which constituted the way in which the spiritual goal of self-love was learnt by the practitioners. This was especially true given that a self-loving stance towards oneself was considered a requirement for becoming an individual with the power to overcome obstacles and realise one's desired life situation—in short, to enable the process of healing to take place.

Healing

Amira, a single woman in her mid-thirties with a university degree in the field of humanities who had resigned from what she described as a well-paid but unbearable job abroad, loved to talk about her spiritual practice. In the course of our conversations about her experiences with and opinions about various "modalities," two topics recurred in her narrative: her difficulty in finding permanent employment—a job that could support her and that matched her idea of meaningful work—and her situation as a single, unmarried woman. The latter aspect increasingly evoked questions within herself about the importance of a relationship and marriage, as well as inquiries from her social environment commenting on her age and the reasons for her marital status. While Amira emphasised that she was neither willing to settle for an unhappy marriage nor comply with unbearable working conditions, her narrative highlighted the consequences her decisions entailed: the unresolved wish for a family of her own and the fear of being a (financial) burden to her parents. Even so, she said she was confident that everything would work out fine in the end. According to her, every development in her life was not only meant to be, but held a necessary "learning experience" that would trigger her personal development and eventually bring her closer to her goals. Her spiritual practice was an essential part of this ongoing process of self-improvement. By meditating she aimed to construct the desired version of herself:

> "With meditation, I was like a puzzle, with every time you put a piece in the puzzle you have a clearer picture to your image. So, for me this is meditation. It helps me to bring out the best of me. […] I am making Amira, a new Amira that is best for me and for everyone around me. But first it's for me. I don't do it for anyone, for my parents, for my society. I'm doing it for me. If I'm not good, I can't love God. I can't be a good daughter. I can't be a good citizen. So first, I have to be me and to love myself. If that's what they call selfish, okay. I'm selfish. I don't mind. I love myself. If I don't love myself, I can't love you, I can't love God" (Amira, 22 January 2018).

Amira compared her weekly meditation practice to the completion of a puzzle. According to her understanding, in every class she revealed another (hidden) aspect of herself, which would eventually uncover the best version of herself: someone who is "best for me" and the people around her. Even though she referred to becoming a contributing member of her family and her society, and even to deepening her relationship with God, Amira stated that she pursued this process for herself first and foremost. In this way, she prioritised her individual goals over the (possibly divergent) expectations of her social environment. This was a potential source of conflict she implicitly addressed: in her view, being herself and loving herself might be interpreted as being "selfish" by her social environment. Nonetheless, she was convinced that she had to "be me" and love herself before she was able to be "a good daughter," "a good citizen" and a faithful Muslim. Thus, she not only expressed her desire for individuality and autonomy, but also understood a self-determined life as the basis of, and not the opposite of, becoming a contributing member of her social environment.

As became clear in Amira's quote, self-love was crucial for the transformation of herself and her life. The ability to love herself was a basic requirement for becoming a successful person in multiple realms—realms that had so far been characterised by challenges and problems. In other words, the "new," self-loving Amira would be able to become whoever she wanted to be and obtain whatever she wished to have. At the end of 2018, I learnt what the life of the "new Amira" encompassed. Amira happily told me that she was engaged to a Lebanese-Canadian man. She was adamant that it was due to her constant meditation practices and the resulting transformation of herself that she attracted the attention of her husband-to-be. Thus, her continuous healing process and her efforts toward making "a new Amira" had finally paid off. The marriage was planned and she intended to move to Canada as soon as her immigration papers were ready. There, Amira joked, she would fulfil her dream of opening a spiritual centre and sharing her ideas about education. Thus, the "new Amira" would be healed from what the "old Amira" suffered from: the lack of a job and marital partner that suited her wishes and expectations while also answering the (un)spoken questions and comments from her social environment.

Agency

Utriainen (2014: 242) argues that the core of *New Age* practices is "religious agency," which she understands as "making things happen" with the support of otherworldly entities. The aim of those endeavours could be "personal healing," "transformation of the whole universe" or "a way, or a style, of sensing oneself and the world around oneself a little differently" (*ibid.* 243). Similarly, my interlocutors mentioned healing as a goal of their spiritual practice. My analysis illustrates that their spiritual practice fostered the cultivation of self-love while aiming to transform the practitioners and their lives. In fact, Amira's story demonstrates that the ability to love oneself, the power to realise the life one desired, and the practice's aim of healing were all closely entangled. Experiencing and successfully establishing love for oneself was considered the core of healing, as only a self-loving individual would be able to take action when wanted and needed, and thus be able to transform the troublesome aspects of the practitioners' lives that they sought healing from. I therefore argue that in the course of Rayhan's classes, healing can be understood as a form of acquiring individual agency. More precisely, the successful cultivation of self-love provided the practitioners with "a disposition toward the enactment of 'projects'" (Ortner 2006: 152). These "projects" were concrete individual goals such as finding a job or a partner, pursuing their desired career or developing a new perspective on their religion.[12] By emphasising their ability to act and to transform themselves and their lives according to their wishes and against all odds, Nabila, Amira and Hadiya turned precarious situations into a menu full of options while establishing a picture of themselves as powerful autonomous agents.

The fact that some individual problems stemmed from circumstances that were simply beyond the power of an individual was rarely mentioned among my interlocutors—despite practitioners' long narratives about the economic and political crisis and the double-edged sword of social embeddedness. Rendering social and economic circumstances invisible and ascribing failure to lack of will and commitment, and therefore as individual responsibility, has been identified as part of the neoliberal discourse (cf. Glauser 2016). Also, the practitioners' perspective covered structural aspects by portraying both the problems and their solutions as residing solely within (the sphere of) the individual. As a result of this viewpoint, "one is always faced with one's self as a project that must be consciously steered through various possible alliances and obstacles" (Gershon 2011: 539). In the framework of contemporary spiritual practitioners, this meant that the practitioners were "perceived as the 'owner' of their condition[s]" (McClean 2005: 643), and healing was fostered or prevented by the performance of the practitioner herself (cf. Heelas 1996: 82).

Consequently, a fellow practitioner's lack of healing was addressed in the form of appeals to continue the work on oneself. It was common knowledge that healing required time and effort. Practitioners stressed the individuality of the healing process: everyone would receive healing and transformation of their life at their "divine timing," i.e. when they were ready for it. And being ready, in turn, required work and effort. This meant that in addition to the teleological path of *seeing lights*, cultivating self-love and therefore healing, practitioners sometimes also had to develop perseverance. Dealing with challenging life situations in an active, self-determined way could also mean, above all else, to learn something from the situation. Actively working with this "learning experience" meant taking a cue as to where further work on oneself was necessary in order to successfully complete the healing process within the individual "spiritual journey."

Meditation and Faith

Healing, viewed as the acquisition of individual agency through self-love, not only concerned mundane aspects such as gaining a job or a marital partner, but also encompassed religious aspects. For instance, Hadiya, a part-time life coach and single mother in her fifties, emphatically described the moment when she sensually experienced and verbally expressed her love for God after meditation—a state of being and an attitude towards God that she was not able to reach during years of textual study of Islam.

> "Hadiya, now? Now you are saying *beʿbadak* [I worship you]? Now? What were you doing there,

> studying religion? There you should say this! I didn't. This is my special experience, my own experience that I didn't get to this point through years of studying religion. I had it through meditation. I went directly to God. I loved him. I adored him and worshipped him. I was shocked! Really! This [studying religion] is the time we learn, but I didn't feel it. I didn't know the meaning! It's only words, passing, passing." (Hadiya, 29 January 2018)

Hadiya contrasts her study of Islam with her sensual experience during meditation. She critically asks herself why her studies were "only words, passing, passing," which neither evoked any bodily or emotional reactions nor made her understand the meaning of loving God. She had previously engaged in intensive religious practice and expected to be able to experience a deep relationship with God through that—a hope that was not fulfilled and, as a result, made her increasingly question the ways in which her faith was interpreted and taught to her. Hadiya did still emphasise the importance of the knowledge she sought in her previous studies and religious practices, as it enabled her to make connections between Islam and meditation practices. Nonetheless, she made clear that only her personal experience during meditation provided her with the toolset needed to bodily experience her adoration of God in all its depth. In that sense, meditation was her own distinct "experience"—an intimate sensation that altered her faith (cf. Bull & Mitchell 2015: 3) and constituted a way to seek a religious and individual understanding of Islam separately from established religious practices, authorities and norms.

Like Hadiya, many interlocutors had a spiritually informed view of their Islamic, Christian or Druze faith that emphasised individual autonomy over religious authorities. In fact, they explicitly distanced themselves and their practice from established religious practices. This became visible in the terminology used by practitioners. Most interviewees used the English term spirituality and rejected the common Arabic translation *rūḥāniyya* (cf. Chodkiewicz 1995) as an inappropriate description of their practices. *Rūḥāniyya* is what is done in churches and mosques, as some interlocutors curtly stated. In contrast, spirituality was the broad field of the interlocutors' individual practices (meditation among them), the associated sensual experiences, and autonomous interpretations of scriptures, religious practices and norms. Many practitioners considered the latter as more "modern" and "free" and less "conservative." They also emphasised that such a stance towards religion was free from political-sectarian implications.

The aim of distancing oneself from sectarianism and the religious networks (considered to be) entangled with it also became visible in Rayhan's classes. Although he frequently referred to figures and stories from the Bible and the *Qur'ān*, he never discussed religious issues (let alone differences) in class. Similarly, personal positioning within the courses took the form of mentioning one's general faith if necessary, namely Druze, Muslim or Christian, while avoiding explicit sectarian self-description (even though names or residential areas could speak louder than words). Furthermore, participants made sure to talk respectfully about each religion, regardless of whether a member of that faith was present or not. I interpret this behaviour on the practitioners' part as an attempt to establish the meditation practice as outside of sectarian politics and different to established religious practices. Firstly, courses had to be accessible and comfortable for people of any faith and background. Secondly, engaging in a leisure activity that was spiritually informed and offered links to one's faith, but expressed distance from sectarianism and established religious practices, was especially appealing to those who understood themselves as cultivating a way of living individually and beyond the sectarian-political separation of the country and the associated power structures (cf. Neufend 2019: 107). I therefore argue that, in a broader sense, the meditation practice was centred around distinct values, namely the drive for individuality and autonomy in mundane and religious aspects of life.

Individuality and Autonomy

I have illustrated that the aim of living one's life according to individual desires, even in opposition to one's social environment, was central to the practitioners' narratives and life trajectories. As Amira stated:

> "For me you have to be a leader, because God creates leaders. We came to life as leaders. So why do we restrain ourselves to traditions, and society and this stuff? They turn us into followers and I don't wanna be a follower." (Amira, 22 January 2018)

Both this quote and her story as presented earlier strongly reflect the ethos of a person who reaches the life they aspire to through constant effort and, if necessary, in the face of opposition—a life in which she can then give back to society while maintaining individuality and autonomy. A similar focus on life becomes visible in Rayhan's meditation. The practice encompasses a notion of healing that can be understood as the acquisition of individual agency through constant self-improvement, more precisely through the bodily mediated process of learning self-love through the sensations of *seeing lights*. By way of this, it aims to enable the practitioners to shape their lives as desired. As such, constant work and learning, individuality and autonomy seemed to be part and parcel of the meditation practice in the sense that they permeated the practitioners' attitudes towards their lives. Thus, attending meditation classes constituted a leisure activity that fostered the practitioners' aim of realising a life as "a leader," to borrow Amira's term.

However, practitioners' narratives also hinted at a careful balance of individuality and autonomy on the one hand and social embeddedness on the other. As Nabila, Amira and Hadiya's stories show, marriage was an important goal for them and belief in God was beyond question, even if whom to marry and when, and how to express faith, were considered to be first and foremost individual decisions and only to a lesser extent a concern of one's social environment. As such, living a self-determined life while securing the desired amount of social embeddedness encompassed a respectful manner of distancing; practitioners stressed the importance of respecting divergent world views and ways of life (especially with regard to religiosity). Furthermore, they aimed to encounter possible differences in a way that circumvented open conflict. This approach became clear when Rayhan discussed his way of dealing with members of his extended family who had religious ideas he could not agree to:

> "I go inside the thing. When I start to see things that are not matching, I grab my learnings and I say goodbye [laughing] […] I run quickly. I tried to be as gentle as I can to leave with easiness" (Rayhan, 12 December 2017).

Although Rayhan was clear about where to draw a line between his faith and other people's (stricter) religious viewpoints, he found it important to distance himself in a smooth and peaceful way that did not render future interactions impossible.

Authors have stressed the entanglement of leisure activities, values and middle-class identities (cf. Deeb 2006; Heiman *et al.* 2012; Neubert 2014). In their work about young pious Shi'ite Muslims in Beirut's southern suburbs, Deeb and Harb (2013) show how consumption and leisure activities serve as a marker for a distinct middle-class identity informed by both a religious stance and mundane expectations. Kaplan and Werczberger (2017) argue that the rise of a "Jewish New Age" among secular middle-class Israelis can be interpreted as a class-specific way of answering the intensified pressure to frame one's identity in religious terms. Winegar (2016) asserts in her analysis of Egyptian demonstrators' practice of cleaning the spaces of their political protests in Cairo that "[b]ecoming middle class […] in many contexts, is a deeply moral project" insofar as those people "often seek to distance themselves from what they view as rich people's immoral extravagances and poor people's lack of sophistication" (*ibid.* 611; cf. Birkholz 2014; Liechty 2012: 271f).

Inspired by this body of literature, I propose the idea that my interlocutors' emergence in contemporary spiritual practices also served as a form of (re)assuring "middle class subjectivities" (Heiman *et al.* 2012: 5). Based on their cultural and economic capital (cf. Bourdieu 1992), the spiritual practitioners may be considered middle class – though due to the recent economic crisis, this might be an endangered position in terms of their economic capital. Against this backdrop, the practices both expressed and reaffirmed the practitioner's (desired) way of living, which was based on constant learning and work on oneself, and which centred around individuality and autonomy: a life according to one's own wishes and desires, em-

bedded in familiar and social networks but not dependent on them, while expressing one's faith independently from interpretations and practices of established religious institutions and authorities. In this way, fundamental identificatory values were expressed and reproduced in the course of the consumable leisure activity of meditation: the drive for autonomy and individuality based on individual work and learning. Also, the practice of balancing social embeddedness with autonomy and individuality may be interpreted, in Winegar's (2016) sense, as a careful and morally anchored positioning between divergent pools of society. Against the backdrop of the groups and individuals of society that Amira termed "followers" and those that Baumann (2019: 72) describes as "self-serving elites," achieving a self-determined life by individually shaping e.g. one's career and relationship, all while contributing to and supporting the social surrounding on one's own terms, indeed claims a moral position in the middle of Lebanese society. From that position, contemporary spiritual practices serve as one means of successfully completing this project of a self-determined middle-class life, while at the same time reifying the importance and significance of the underlying values informing that lifestyle.

Conclusion

Contemporary spiritual practices are popular among the middle classes in Lebanon, where they are understood as a way to increase well-being and foster healing. Based on ethnographic material collected in 2017 and 2018, I showed that the meditation sessions offered in a spiritual centre in Beirut aimed at a specific form of healing: the acquisition of individual agency. The core of those classes consisted of the routine pursuit of *seeing lights*, a complex array of bodily sensations. I argued that the practitioners' goal of *seeing lights* can be interpreted as an embodied form of experiencing and learning self-love. This attitude was the basis for healing, as—from the practitioners' perspective—only a self-loving individual could possess the ability to create a life according to one's wishes and, thus, heal from troublesome life situations. In other words, the meditation practice with its sensation of *seeing lights* was "an art for crafting lives and futures" (Utriainen 2014: 254) for the participants.

The practitioners' narratives show that their goal was to live a self-determined life centred around the aspects of marriage and employment. Efforts to individually shape those aspects stood in potential conflict with the expectations and obligations of the social environment. In fact, balancing the drive for individuality and autonomy in mundane and religious aspects of life with the need for social embeddedness and the concerns of economic shortage was a constant challenge for the practitioners. Against this background, the meditation sessions that centred around constant learning and self-improvement were not only a way of achieving healing by acquiring individual agency, but in a broader sense a leisure activity that fostered the practitioner's aim of living a self-determined life by reassuring and reproducing underlying values such as individuality and autonomy.

Heelas (1996) states that in *New Age* practices, "*authority* lies with the *experience* of the *Self*" (*ibid.* 29, emphasis i. orig.). For the meditation classes analysed in this article, this statement is valid in a very literal sense: individual sensory experience constitutes the centrepiece of the practice. The sensual procedures that were collectively shared and individually experienced were what enabled healing to take place. In this way, the practitioners' senses and bodies were rendered the instrument through which the goal of the practice—healing in the form of individual agency—was reached. Thus, my analysis underlines the necessity of a "sensorially engaged anthropology" (Nichter 2008: 186) in the study of of contemporary spiritual practices and their associated healing procedures. Integrating the inquiry of sensory experiences and processes into the research not only enables us to grasp "the sense of spirit people cultivate in the practices" (Dox 2016: xxi), but also broadens our understanding of the notions of healing within contemporary spiritual practices, showing that healing is achieved in manifold ways. For the meditation practice I analysed, it is the sensory experience that eventually delivers the abstract (spiritual) goal of love, and from a wider perspective individuality and autonomy, into something doable. However, with a disastrous economic crisis and a tumultuous political landscape, further re-

search is needed to investigate how contemporary spiritual practices and their form of "self-cultivation" (Zhang 2018: 46) will continue to shape the ways in which Lebanese women like Hadiya, Nabila and Amira go about their lives.

Notes

1 Names of interlocutors and meditation classes are changed.
2 The US Dollar and Lebanese Lira are used interchangeably in Lebanon. Fees for the classes varied depending on individuals' financial situations.
3 Rayhan used the angel tarot cards of Doreen Virtue, a US American author of multiple *New Age* self-help books and angel tarot sets. The cards consist of a small picture showing humans, angels or human-angel interactions along with a short paragraph written in English that deals with either a specific topic such as authenticity, self-care, relationships, etc. or delivers a message ascribed to a specific (arch-)angel.
4 In academic literature, *New Age* is a common term for these practices, but it was used by my interlocutors only as a discrediting description, *e.g.* for practices of teachers who were suspected to be primarily interested in economic benefits. I use *New Age* (practices/movements) when referring to the respective academic literature. When discussing my research, I use the term contemporary spiritual practices (cf. Dox 2016; Fedele & Knibbe 2016: 196) to describe the yoga, meditation and Kabbalah lessons I attended, and the term energy-based healing methods for practices like Reiki and Pranic Healing. This distinction is helpful because the latter practices were not necessarily framed or understood in a spiritual sense.
5 Notwithstanding the work on established forms of spirituality, *e.g.* Sufism (cf. Clarke 2014; Neufend 2019).
6 The research is part of the project *Private Pieties. Mundane Islam and New Forms of Muslim Religiosity: Impact on Contemporary Social and Political Dynamics* funded by the European Research Council (grant agreement no. 693457).
7 The Syriac Maronite Church of Antioch is a Christian religious group and one of the 18 sects officially recognised by the Lebanese state.
8 The *Tai'if* agreement that ended the Lebanese civil war (1975–1990), in which sect served as an axis of differentiation and mobilisation, aimed to ensure the peaceful coexistence of the 18 different religious groups by way of institutionalised power sharing, *e.g.* in the form of a sectarian quota for political positions (Traboulsi 2012: 250f). Aside from this, social and economic relations are often established along sectarian lines and corresponding clientelistic structures (cf. Kriener 2019; Nucho 2016; Salloukh *et al.* 2015; for an analysis of anti-sectarian protest cf. Sengebusch 2019). Thus, religious affiliation is an ever-present factor in everyday life, although rarely verbalised outside of one's "own" sect because of its conflict-laden and potentially divisive consequences.
9 Several factors led to the economic crisis: after the Lebanese civil war, the period of reconstruction under prime minister Rafik al-Hariri was based on a neoliberal agenda of privatisation, massive international borrowing and government debt (Baumann 2016). Economic problems intensified during phases of internal political instability, the Israeli war on Lebanon in 2006 and, most recently, the Syrian war and the associated refugee crisis (van Vliet 2016: 96ff). Additionally, corruption and "self-serving elites" (Baumann 2019: 72) contributed to the country's disastrous situation (Salloukh *et al.* 2015: 2; Chikhani 2020). The Lebanese economy generally relies on remittances from the diaspora and the banking and real-estate sector, which is closely entangled with "government debt management" (Baumann 2019: 66) and offers investment only for those who already have substantial financial means and social connections (*ibid.* 66ff; Farha 2019: 219ff).
10 Rayhan's language was shaped by technical expressions. For instance, "low energy" or "high energy" beliefs that had to be "erased" or "downloaded." His terminology underlines the interlocutors' emphasis on pursuing practices that are based on science and hard facts rather than "blind belief" (cf. Voss 2013: 119f), but may also be read as a mechanical approach to the project of self-transformation.
11 Rayhan referred to the participants of his meditation classes as "students."
12 Rayhan's mediations may also form part of what Illouz (2008) termed "therapeutic emotional style"—a set of "'techniques'—linguistic, scientific, ritual" (*ibid.* 14f)—centred around the management of individuals' emotions in order to provide "a way for actors to devise strategies of action that help them implement certain definitions of the good life" (*ibid.* 20).

References

Albanese, Catherine L. 1999. The Subtle Energies of Spirit: Explorations in Metaphysical and New Age Spirituality. *Journal of the American Academy of Religion* 67, 2: 305–325.

Aupers, stef & Dick Houtman 2006. Beyond the Spiritual Supermarket: The Social and Public Significance of New Age Spirituality. *Journal of Contemporary Religion* 21, 2: 201–222.

Baumann, Hannes 2016. *Citizen Hariri: Lebanon's Neoliberal Reconstruction*. Oxford: University Press.

Baumann, Hannes 2019. The Causes, Nature, and Effect of the Current Crisis of Lebanese Capitalism. *Nationalism and Ethnic Politics* 25, 1: 61–77.

Birkholz, Sina 2014. Struggles of Distinction: Young Women Constructing Their Class Identity in Egypt's Americanized Milieu. *Middle East: Topics & Arguments* 2: 46–62.

Bourdieu, Pierre 1992. Ökonomisches Kapital – Kulturelles Kapital – Soziales Kapital. In: *ibid. Die verborgenen Mechanismen der Macht: Schriften zur Politik & Kultur*. Hamburg: VSA: 49–79.

Bourdieu, Pierre 1997[1980]. *Sozialer Sinn: Kritik der theoretischen Vernunft*. Frankfurt/Main: Suhrkamp.

Bull, Michael & Jon P. Mitchell 2015. Introduction. In *ibid.* (eds) *Ritual, Performance and the Senses*. London: Bloomsbury: 1–10.

Chen, Shu-Chuan 2014. Theorizing Emotions in New Age Practices: An Analysis of Feeling Rules in Self-Religion. In: Steven J. Sutcliffe & Ingvild S. Gilhus (eds) *New Age Spirituality: Rethinking Religion*. London: Routledge: 227–241.

Chikhani, Nicolas 2020. *Whither Lebanon? Crises and (Re)Solution*. Talk at the Orient-Institut Beirut, 21 July 2020 (accessed via live stream).

Chodkiewicz, M. 1995. Rūḥāniyya. In: C.E. Bosworth *et al.* (eds). *The Encyclopaedia of Islam. New Edition, Volume VIII*. Leiden: Brill: 593–594.

Clarke, Morgan 2014. Cough Sweets and Angels: The Ordinary Ethics of the Extraordinary in Sufi Practice in Lebanon. *Journal of the Royal Anthropological Institute* 20, 3: 407–425.

Deeb, Lara 2006. *An Enchanted Modern. Gender and Public Piety in Shi'i Lebanon*. Princeton: University Press.

Deeb, Lara & Mona Harb 2013. *Leisurely Islam: Negotiating Geography and Morality in Shi'ite South Beirut*. Princeton: University Press.

Downey, Greg 2015. The Importance of Repetition: Ritual as a Support to Mind. In: Michael Bull & Jon P. Mitchel (eds) *Ritual, Performance and the Senses*. London: Bloomsbury: 45–61.

Dox, Donnalee 2016. *Reckoning with Spirit in the Paradigm of Performance*. Ann Arbor: University of Michigan Press.

Farha, Mark 2019. *Lebanon: The Rise and Fall of a Secular State under Siege*. Cambridge: University Press.

Fedele, Anna & Kim E. Knibbe 2013. *Gender and Power in Contemporary Spirituality: Ethnographic Approaches*. New York: Routledge.

Fedele, Anna & Kim E. Knibbe 2016. From Angel in the Home to Sacred Prostitute: Unconditional Love and Gendered Hierarchies in Contemporary Spirituality. In: Lena Gemzöe *et al.* (eds) *Contemporary Encounters in Gender and Religion: European Perspectives*. Palgrave Macmillan: 195–216. DOI: 10.1007/978-3-319-42598-6.

Gershon, Ilana 2011. Neoliberal Agency. *Current Anthropology* 52, 4: 537–555.

Glauser, Laura 2016. *Das Projekt des unternehmerischen Selbst: Eine Feldforschung in der Coachingzone*. Bielefeld: Transcript.

Hanegraaff, Wouter J. 1996. *New Age Religion and Western Culture: Esotericism in the Mirror of Secular Thought*. Leiden: Brill.

Hauser, Beatrix (ed) 2013. *Yoga Traveling: Bodily Practice in Transcultural Perspective*. Cham: Springer. DOI: 10.1007/978-3-319-00315-3.

Heelas, Paul 1996. *The New Age Movement: The Celebration of the Self and the Sacralization of Modernity*. Oxford: Blackwell.

Heiman, Rachel, Mark Liechty & Carla Freeman 2012. Introduction: Charting an Anthropology of the Middle Classes. In: Rachel Heiman *et al.* (eds) *The Global Middle Classes: Theorizing Through Ethnography*. Santa Fe: School for Advanced Research Press: 3–29.

Illouz, Eva 2008. *Saving the Modern Soul: Therapy, Emotions and the Culture of Self-Help*. Berkeley: University of California Press.

Inhorn, Marcia C. 2012. *The New Arab Man: Emergent Masculinities, Technologies and Islam in the Middle East*. Princeton: University Press.

Kanafani, Samar & Zina Sawaf 2017. Being, Doing and Knowing in the Field: Reflections on Ethnographic Practice in the Arab Region. *Contemporary Levant* 2, 1: 3–11.

Kaplan, Dana & Rachel Werczberger 2017. Jewish New Age and the Middle Class: Jewish Identity Politics in Israel under Neoliberalism. *Sociology* 51, 3: 575–591.

Kriener, Jonathan 2019. When Crisis Promotes Proximity: Patterns of Social Control at the Lebanese University. *Middle East: Topics & Arguments* 13: 64-76.

Kurz, Helmar 2017. Diversification of Mental Health Care: Brazilian Kardecist Psychiatry and the Aesthetics of Healing. *Curare* 40, 3: 195–206.

Liechty, Mark 2012. Middle-Class Déjà-Vu: Conditions of Possibility, from Victorian England to Contemporary Kathmandu. In: Rachel Heiman *et al.* (eds) *The Global Middle Classes: Theorizing Through Ethnography*. Santa Fe: School for Advanced Research Press: 271–299.

Luhrmann, Tanya 2010. What Counts as Data? In: James David & Dimitrina Spencer (eds) *Emotions in the Field: The Psychology and Anthropology of Fieldwork Experience*. Stanford: University Press: 212–238.

McClean, Stuart 2005. 'The Illness is Part of the Person': Discourses of Blame, Individual Responsibility and Individuation at a Centre for Spiritual Healing in the North of England. *Sociology of Health & Illness* 27, 5: 628–648.

Neubert, Dieter 2014. What is 'Middle Class'? In Search of an Appropriate Concept. *Middle East: Topics & Arguments*, 2: 23–35.

Neufend, Maike 2019. The Practice of Vision: Sufi Aesthetics in Everyday Life. In: von Scheve, Christian *et al.* (eds) *Affect and Emotion in Multi-Religious Secular Societies*. London: Routledge: 96-113.

Nichter, Mark 2008. Coming to Our Senses: Appreciating the Sensorial in Medical Anthropology. *Transcultural Psychiatry* 45, 2: 163–197.

Nucho, Johanna R. 2016. *Everyday Sectarianism in Urban Lebanon: Infrastructures, Public Services, and Power*. Princeton: University Press.

Ortner, Sherry B. 1996. Making Gender: Toward a Feminist, Minority, Postcolonial, Subaltern, etc., Theory of Practice. In: *ibid. Making Gender. The Politics and Erotics of Culture*. Boston: Beacon Press: 1–20.

Ortner, Sherry B. 2006. Power and Projects: Reflections on Agency. In: *ibid. Anthropology and Social Theory. Culture, Power, and the Acting Subject*. Durham: Duke University Press: 129–153.

Pink, Sarah 2015. *Doing Sensory Ethnography.* 2nd Edition. London: Sage.

Pink, Sarah &David Howes 2010. The Future of Sensory Anthropology / The Anthropology of the Senses. *Social Anthropology* 18, 3: 331–340.

Redden, Guy 2005. The New Age: Towards a Market Model. *Journal of Contemporary Religion* 20, 2: 231–246.

Ruah-Midbar, Marianna 2012. Current Jewish Spiritualities in Israel: A New Age. *Modern Judaism* 32, 1: 102–124.

Ruah-Midbar, Marianna & Nurit Zaidman 2013. 'Everything starts within': New Age Values, Images, and Language in Israeli Advertising. *Journal of Contemporary Religion* 28, 3: 421–436.

Salloukh, Bassel F. *et al.* 2015. *The Politics of Sectarianism in Postwar Lebanon*. London: Pluto.

Scheer, Monique 2012. Are Emotions a Kind of Practice (And is That What Makes Them Have a History)? A Bourdieuian Approach to Understanding Emotion. *History and Theory* 51, 2: 193-220.

Sengebusch, Karolin 2019. *Die Proteste gegen den libanesischen Konfessionalismus: Die Politik und das Politische in einer sozialen Bewegung*. Wiesbaden: Springer.

Sengebusch, Karolin & Ali Sonay 2014. Caught in the Middle? On the Middle Class and its Relevance in the Contemporary Middle East. *Middle East: Topics & Arguments* 2: 4–10.

Sutcliffe, Steven J. & Ingvild S. 2014. Introduction: "All mixed up"—Thinking about Religion in Relation to New Age Spiritualities. In: *ibid.* (eds) *New Age Spirituality: Rethinking Religion*. London: Routledge: 1–16.

Traboulsi, Fawwaz 2012. *A History of Modern Lebanon*. Second Edition. London: Pluto.

Utriainen, Tehri 2014. Doing Things with Angels: Agency, Alterity and Practices of Enchantment. In: Steven J. Sutcliffe & Ingvild S. Gilhus (eds) *New Age Spirituality: Rethinking Religion*. London: Routledge: 242–255.

van Vliet, Sam 2016. Syrian Refugees in Lebanon: Coping with Unpreceded Challenges. In: Maximilian Felsch & Martin Wählisch (eds) *Lebanon and the Arab Uprisings: In the Eye of the Hurricane*. London: Routledge: 89–103.

Voss, Ehler 2013. From Crisis to Charisma: Redefining Hegemonic Ideas of Science, Freedom and Gender among Mediumistic Healers in Germany. In: Anna Fedele & Kim E. Knibbe (eds) *Gender and Power in Contemporary Spirituality: Ethnographic Approaches*. New York: Routledge: 115–125.

Werczberger, Rachel & Boaz Huss 2014. Guest Editors' Introduction: New Age Culture in Israel. *Israel Studies Review* 29, 2: 1–16.

Winegar, Jessia 2016. A Civilized Revolution: Aesthetics and Political Action in Egypt. *American Ethnologist* 43, 4: 609-622.

Zbib, Youssef 2014. Public Education: A Route into Lebanon's Middle Class in the 1960s and Early 1970s. *Middle East: Topics & Arguments*, 2: 63–73.

Zhang, Li 2015. Cultivating Happiness: Psychotherapy, Spirituality, and Well-Being in a Transforming Urban China. In: Peter van der Veer (ed) *Handbook of Religion and the Asian City: Aspiration and Urbanization in the Twenty-First Century*. Oakland: University of California Press: 315–332.

Zhang, Li 2018. Cultivating the Therapeutic Self in China. *Medical Anthropology* 37, 1: 45-58. DOI: 10.1080/01459740.2017.1317769.

Manuscript received: 03.02.2020
Manuscript accepted: 25.12.2020

JOHANNA KÜHN is a doctoral candidate at the Institute of Social and Cultural Anthropology and a research fellow and scientific coordinator in the ERC-project "Private Pieties, Mundane Islam and New Forms of Muslim Religiosity: Impact on Contemporary Social and Political Dynamics" at the University of Göttingen. She studied Social Anthropology, Sociology and Economics at the University of Bayreuth, the University of Göttingen and the University of Haifa. Her regional focus is on the Middle East, where she has conducted ethnographic research on gendered political protest. In her dissertation, she focuses on contemporary spiritual practices in Lebanon's capital Beirut. In particular, she is interested in the gendered facets of these practices and their link with established belief systems among urban middle-class females.

University of Göttingen, Institute of Social and Cultural Anthropology
Theaterstraße 14, D-37073 Göttingen
e-mail: johanna.kuehn@sowi.uni-goettingen.de

Negotiating Self

Aesthetics of Mediumship and Embodied Healing in Brazilian Umbanda

TESSA BODYNEK

Abstract The incorporation of spiritual entities is an integral element of *Umbanda* rituals and cosmology. In this state, mediums are approached by spiritual entities, such as the so called *guias* ("spiritual guides") or *orixás* (Afro-Brazilian deities). Subsequently, the mediums are incorporated by them. Sensory impressions before, during and after this period cast light on underlying circumstances and personal connections to these spiritual entities. Moreover, the perception of emotional stimuli developing in the medium's body is relevant in the context of incorporation. Together with the incorporated entity, mediums give advice, help, bless or heal their consultants; many of whom are not themselves *Umbandists*. This article examines the role of embodied healing and the aesthetics of mediumship from the perspective of an *anthropology of the senses*. In addition to the examination of lived sensory experiences, this article gives a voice to the members of the specific *Umbanda* group in the Brazilian metropolis of São Paulo, where I conducted ethnographic fieldwork. I carried out my research activities in the spiritual community *Tenda de Umbanda Caboclo de Oriente* (TUCO), focusing on ethnographic methods such as participant observation and formal as well as informal interviews, plus personal conversations with various members of the group. The example I refer to of the many different forms of contemporary urban *Umbanda* practices is particularly relevant within the context of academic discourse, adding another layer to the existing research on the wide variety of spiritual communities in Brazil's metropolises. As an implicit add-on, this article draws a line between the *Umbandist* cosmology and healing practices and the society in which the religion emerged and constantly is reproduced. It connects contemporary theories and debates concerning the *anthropology of the senses* and *aesthetics of healing* with *Umbanda* knowledge and practice, and the personal experiences of my interlocutors.

Keywords spiritual healing – health care – senses – self – emotion – embodiment – religion – medicine

Introduction

To discuss the *aesthetics of healing* means to address a rather recent area of investigation in the subdiscipline of *anthropology of the senses*. It is concerned with the sensory perception in the context of healing and focuses on the self in embodied healing practices and personal experiences in different medical as well as religious settings. Csordas (1994) identified the self as the center of efficacy in most healing systems, equally in spiritual, alternative and biomedical ones. In this sense, the self implies psychopathological aspects as well as symbolic meaning, social relationships and the actual transformation of symptoms. Kirmayer and Lee (2019: 2) argue on this behalf for a more reflexive use of the meanings of self in different cultural environments and question the cross-cultural application of classical psychotherapy and biomedical methods. In her work on suffering in the mediumistic Afro-Brazilian religion *Candomblé*, Seligman (2014: 298) locates the self at the intersection of body and mind. Doing this, she deconstructs the obsolete dualism of body/mind and pronounces the self at the center of perception. Suffering, she states, can threaten the integrity of the self. Because of that, an effective healing practice must approach both the cognitive and embodied aspects of self. Concerning the *aesthetics of healing*, the experiential and sensorial level of (self-)perception in healing practices becomes prominent. Only recently, various authors started to examine the interface of sensorial perception and emotions in different medical and

religious settings and are thus highlighting a more experiential approach to healing and the senses (cf. Csordas 2002; Desjarlais 1992; Kurz 2015, 2017; Mol 2002; Selim 2015; Stodulka 2015). An elaborated view regarding the different dimensions of embodied healing became highly relevant in the research area of medical anthropology.

My ethnographic research on embodied healing in the mediumistic Brazilian religion[1] *Umbanda* focuses on the importance of sensorial impression, individual experience, and emotion in the state of incorporation (cf. Halloy 2012; Pierini 2016; Seligman 2010, 2014). In this altered state of perception, the mediums host spiritual entities in their bodies. Thus, the spirits can act, communicate and participate actively in the weekly rituals of the *Umbanda* group. The development of one's skill set as a medium is often confusing and challenging, especially in the early stages. Without experience it can be difficult to identify which emotions, feelings, and impressions belong to the self, and which belong to the incorporated entity. Vinícius[2], one of my interlocutors and practicing mediums at TUCO, states:

> "I always say that mediumship appears in your life like a feather—it's very light. It starts in your life like a very light thing and it will end up like a stone. It will fall above you with all the force. So, the first feelings of my mediumship were a lot about: Am I me or am I entity? Am I me or am I *guia*? Am I me or am I *orixá*? It is a lot about defining all the energy!"[3]

Becoming a medium implies to deal with a wide range of emotions that differ from the way the person felt and thought about her/his life before the incorporation of spiritual entities. For many of my interlocutors it means a huge change in their everyday lives. The development of their mediumistic skills affects their tasks and responsibilities in the *tenda*[4] and constantly transforms them. During workshops, lessons and private rituals, the mediums start to embody knowledge (cf. Seligman 2014: 22f) about the expression and the handling of emotions and feelings of their incorporated entities. Furthermore, they interact in the weekly public rituals in a new way: incorporated by the respective entity, the mediums attend consultants by giving advice, blessings and help. Moreover, they prescribe herbal and homemade medicine, heal and provide relief from bodily and mental suffering (cf. Macedo 2015: 35ff).

Central to this paper are the themes of personal experiences, embodied feelings, and sensorial impressions in this context. With regard to the relevant role of spiritual healing, incorporation and mediumistic consultations in *Umbanda*, this article is guided by the following questions:

How are sensory perceptions interconnected with the experiences of mediums during rituals and healing processes in *Umbanda*? How do the mediums describe their relationships to their spiritual guides and what influence does their work have on the mental and physical health of other members of the religious community? What personal strategies are developed in the handling of illness and disease? What role does the tension between biomedical and *Umbandist* healing strategies play?

My approach to answer these questions was ethnographic and therefore very personal. I did not attempt to comprehend the entirety of *Umbanda* knowledge and practice during the relatively short duration of my stay.[5] Instead I contacted mediums of the TUCO, had personal conversations, gathered the voices of my interlocutors, and used my own individual experiences to contribute to my thesis. Reflecting on my positionality in the field, I want to add that I have not been a passive observer but, quite the opposite, actively participated in the activities at TUCO, generating a unique experience, as I made friends and endeavored to empathize with situations as openly as possible, particularly on a sensory level. My methodology relied on an experiential approach that has emerged in the *anthropology of senses* and pleads for an integration of perception into the process of research and into its analysis (cf. Howes 2011; Pink 2015). During the course of my research my conversation partners repeatedly made clear to me the importance of my own experiences. To gain a better understanding of their knowledge system and cosmology they considered it necessary for me to "feel" it myself. To this end, during my visits at TUCO, I placed an emphasis on my own sensory experiences: the smell of the scents, the sound of the drums, chants and softly whispered words, the richness of the colorfully decorated altars and the taste of ritual food. By focusing on these details,

I was better able to feel "all the energy" of the atmosphere created.

Accordingly, I structure my discussion into several subsections. First, I will introduce into the religious context of *Umbanda*. Second, I will reproduce some relevant debates deriving from an *anthropology of the senses* to situate my research and this article in a contemporary theoretical and discursive environment. Subsequently, I refer to our discourse on the *aesthetics of healing* and connect some of my findings with related debates in this field. Finally, I will frame and analyze the importance of sensory perception in the context of mediumistic experiences of my interlocutors and in aligned *Umbandist* healing practices. In particular, I will discuss the (sometimes very individual) perception of the relationship between biomedicine and spiritual healing in *Umbanda*. Overall, this article aims to shed some light on the importance of aesthetics and emotions in therapeutic settings, and especially with regard to Brazilian *Umbanda* healing practices.

Healing Practices and Knowledge in *Umbanda*

Brazilian *Umbanda* reveals various religious, cultural and social facets. It's kaleidoscopic character is often described as "syncretic," meaning that elements from different religions, denominations or philosophies merge into a new (religious) practice. Accordingly, various "elements" interconnect in a harmonious way, but "original traces" remain evident, pointing at origins in other belief systems (Scharf da Silva 2004: 14). However, contemporary discussions in social and cultural anthropology tend to dismiss the concept of *syncretism* in religious and cultural discourses (Stewart & Shaw 1994). Especially with regard to the use of the concept as an analytical basis for political purposes, such as emphasizing the "purity" of certain religious traditions and their "contamination" by new "elements," the associated notion of cultural and religious continuity is highly problematic. The concept seems particularly redundant when one considers that all societies and religions have been (and still are) influenced by a diverse cultural and religious environment. Espírito Santo (2018: 82f) points out that, in this sense, all religions have been "creolized" to a certain extent and are, therefore, constantly evolving. Nevertheless, the term is often used by *Umbandistas* themselves to denote the diversity and multicultural origins of their religion. For example, Mãe Zuleide, the "priestess" and director of TUCO, explains how she understands the role of syncretism:

> "*Umbanda* is in everything—in every religion. If you take a bible, you will see that the name of God and everything that's in the bible, is religion. Thus, the religion is—for every place it has it's syncretism. […] The only difference between one religion and another is the human being."[6]

She stresses the multi-religious foundation of *Umbanda* and the resulting need for religious tolerance. Accordingly, one of the main components of *Umbanda* are Afro-Brazilian religions that emerged in Brazil during the period of colonialism and enslavement, a prominent example being the religion of *Candomblé*. Prandi (2004: 36) points out that the slow process of convergence of various social, cultural and ethnic elements makes it difficult to trace the sources of various Afro-Brazilian characteristics back to a specific point of origin, but a certain fusion of African elements is significant in *Umbanda*. Further, practices are strongly influenced by various forms of European Spiritism, especially *Kardecismo*. This movement bases on theories and reflections of French Spiritist Allan Kardec, who is barely known in France nowadays. However, his ideas and the resulting Spiritist doctrine are very prominent in Brazil, and especially in the urban areas of Southern Brazil (cf. Scharf da Silva 2004: 50). *Umbanda* further consists of other elements and origins, including such deriving from Catholicism or Indigenous religions. This interplay of various religious and spiritual components provides *Umbanda* with a special, multi-faceted appearance (Engler 2012: 13f) without any alleged universal doctrine. Accordingly, the existing variety of beliefs and practices in the different *tendas* is too diverse and difficult to summarize, and, therefore, I will only outline some of the most important aspects of cosmology and ritual practice that appear most prominent to me, even if they are not shared by all *tendas* in similar ways.

A central aspect of *Umbanda* are weekly public and private rituals.[7] Most of these are marked by the mediumistic incorporation of spiritual entities. Mediums sing and dance to the drums until

they enter a state of trance. While they are in this state of mind, they incorporate spiritual beings, who provide one-to-one consultations for clients who are not necessarily members of the *tenda,* but decided to accept the spiritual and social support and service provided by the group (*ibid.* 16). *Umbanda* consultations are usually open to the public and free of charge. This derives from the concept of charity (*caridade*) and their aim to care for others. These values are prominent in most of the *tendas* and therefore highly esteemed. Thus, people of different religious, cultural and social backgrounds attend the services of *Umbanda* as well as those from other spiritual providers (Espírito Santo 2018: 119ff).

Central to this practice is the belief in spiritual guides (*guias*). These entities are believed to be spirits of different categories, for example *caboclos* or *caboclas* who represent young, dynamic and vivacious indigenous spirits. Entities of this category are known to have good intentions, to help in difficult situations and to have healing powers. Equally known for their healing capacities are *pretos velhos* and *pretas velhas.* They are referred to as spirits of deceased slaves, who were brought to Brazil in colonial times. Apart from their healing qualities, they seem to have little in common with the young and lively *caboclos* and *caboclas*: they usually behave calmly, move slowly and walk shakily with a pronounced stoop. Even their voices sound shaky and low. In opposition to the spirits of Indigenous warriors, they represent a more humble and "Christianized" other, often reciting the Lord's Prayer, Hail Mary or similar Christian prayers (cf. Engler 2017: 205f). Other notable categories of *guias* include the alleged morally ambivalent *pombagiras* (women "of the street") and their male counterparts, *exús.* They are considered as "gatekeepers," and, therefore, paving the path of working with the spiritual energy.

There are other categories of spirits such as gypsies, sailors, children, *baianos* (spirits from the Northeastern state of Bahia, representing a mainly Afro-Brazilian population), mermaids and cowboys (*ibid.*; cf. Macedo 2015: 34f). This variety of categories of *guias* also represents aesthetic differences regarding their incorporation in the spiritual sphere of *Umbanda*. Where one spirit moves slowly and shakily another is vivacious and playful, where one is obscene, another is conservative—there is a whole variety of aesthetics in the vast field of a fluid and lively cosmology. Moreover, this diverse set of spirits has enabled *Umbanda* to incorporate sociocultural and historic conditions in the development of it's cosmology. This seems to be characteristic of other spirit mediumship movements all over the world, as in Haiti's *Voudou,* Cuban spirit mediumship or in Niger's possession spirit rites (cf. Espírito Santo 2018: 3).

As well as working with the *guias, orixás* play a major role in the cosmology of *Umbanda*. The deities of the *Yoruba* pantheon "came" to Brazil during colonial times and the slave trade. Today, they are widely known throughout the Afro-Brazilian religions, most prominently in *Candomblé*. In *Umbanda*, they are not necessarily seen as deities, but certainly as forceful guardians and "higher" spiritual guides. Working with these different categories of spiritual beings thus connects various religious and cultural knowledges and shapes the multi-layered structure of *Umbanda* practice (cf. Pressel 1974: 135).

During the rituals, *guias* and *orixás* are incorporated by several mediums who are then consulted by *Umbandists* and other clients alike. They primarily focus on the recovery from illness or physical suffering, resolving social or emotional problems, or addressing financial and worldly challenges (Engler 2017: 204). From this perspective, *Umbanda* can be seen as an alternative or complementary provider of psychological and physical healthcare, but in this respect it is not unique. The already mentioned Spiritist movement of *Kardecismo* is known for its activities in the Brazilian health sector and even has proper psychiatric clinics that offer both, biomedical, psychological, and spiritual treatment (cf. Kurz 2017). However, while *Umbanda* may not be as institutionalized as these Kardecist psychiatries, its practices play an important role in the personal physical and psychological healthcare of many people in Brazil's metropolitan areas. Many of my interlocutors, for instance, referred to *Umbanda* as a complementary aspect in the handling of their personal health. Antônio, another medium and one of my interlocutors at TUCO, points out that for him everything needs to be in "balance" between *biomedicine* and *religious healing*.

In order to understand the intersection of health-related issues and *Umbanda*, I suggest to take a closer look at the role of sensory perception and the personal interaction with healthcare. Therefore, the following subsections demonstrate the relevance of the senses in the context of spiritual healing. First, I will introduce the discursive background of the *anthropology of the senses*, which underlines the necessity of sensory perception and experiences in debates of social and cultural anthropology and offers a short introduction into contemporary discussions in this field of study. Further, I demonstrate some of my findings in the context of the *aesthetics of healing* and the sensory perception of my interlocutors during rituals and in the state of incorporation.

Anthropology of the Senses

An increased engagement with the senses emerged in social and cultural anthropology in the late 1980s and was influenced by the preceding debates and theories about *embodiment*, a concept forwarded by Csordas (1994: 269). It relies on the assumption that bodily experiences are the existential foundation of culture and self. In this context, emotions, feelings and the senses function as a means of understanding bodily experiences and thus have also been addressed by social scientists. Among others, Feld (1990), Howes (1991), and Stoller (1989, 1997) have been pioneers in the anthropological study of the senses and sensory experience. Howes (1991), for example, called for a rethinking of anthropology that would be effective by integrating the senses into the collected data. Of course, this approach did not lack criticism and, therefore, Ingold (2008) initiated and influenced a widespread debate on principles of research in this area. Within this scope, the singularity of sensory perception in a certain culture should be discussed in terms of more reflexive examinations of diverse sets of sensory perception and their manipulation in different cultural environments, as well as the problem to compare cultural differences of these sets. Ingold (*ibid.* 285) thus suggests a rethinking of anthropological research, away from a "collective sensory consciousness of society" and towards a "creative interweaving of experience in discourse and to the ways in which the resulting discursive constructions in turn affect people's perceptions of the world around them" (*ibid.*). Within this critique, Ingold focuses on the centrality of human perception and its individuality. He points out the importance of the senses as lived experiences and therefore at the moment of perception itself. Contrary to former works, Ingold highlights the multisensoriality of perception. Vision should not be seen as a dominant and objectifying sense, rather it could be seen as inter-relational with the other senses (*ibid.* 287).

Building on the notion of experiencing through all the senses, the need for a reflexive engagement in ethnographic research is significant. Emerging from anthropological considerations of a *reflexive turn* in the discipline and the aligned debate about a *writing culture* (Clifford & Marcus 1970), the importance of the researcher's body and his/her own experiences becomes clear. This especially has been pushed by Stoller (1997) in which he explains the idea of embodying knowledge by the senses in the example of his fieldwork about sorcery in West Africa:

> "The full presence of the ethnographer's body in the field also demands a fuller sensual awareness of the smells, tastes, sounds and textures of life amongst others. It demands [...] that ethnographers open themselves to others and absorb their worlds. Such is the meaning of embodiment." (*ibid.* 23)

Accordingly, the study of "the senses" in anthropology has strongly been influenced by theoretical explorations of processes of *embodiment*. In conducting ethnography, the researcher, too, may recognize that his or her bodily experience produces meaning. Moreover, the researcher is "consumed by the sensual world" in which his or her body perceives pain, feelings and emotions. For instance, Stoller refers to pain in his body during his fieldwork as teaching him profound lessons in *Songhay* sorcery (*ibid.*). He termed this a *sensuous scholarship,* acknowledging the embodied implication of the scholar and thus his or her own bodily experiences. Following this, he mandated a critical awareness of the senses, an attentiveness to one's own voice and a recognition of the political relevance and consequences of one's own academic works, even in the field itself (*ibid.* 34). Pink (2015) argues that *anthropology of the senses* urges

debates concerning the relation of sensorial experiences and culture. She reflects on the status of the often prominent sense of vision and its relationship to other modes of sensing and demands a certain form of reflexivity concerning one's own investigation as an experiencing researcher in the field. In this context, she highlights that while anthropologists tend to structure and establish certain sets of references and categories to understand collective knowledge about the senses and experiences, one should keep in mind that these models of understanding are likewise constantly produced and influenced by their cultural and social environment (*ibid.* 13). In this context, Nichter (2008) points out that sensory experience is not only grounded in the individual, but is embedded in social and cultural settings, and, thus always influenced by certain situations and shared meanings, and values: "Sensorial anthropology explores how sensations are experienced phenomenologically, interpreted culturally, and responded to socially" (*ibid.* 166). This implies, and I am emphasizing it here, to understand any social practice and environment as processual and constantly changing, and, thus, to focus on individual and experiential facets producing different sets of lived reality (Espírito Santo 2018).

Aesthetics of Healing

As a continuation of debates regarding the *anthropology of the senses*, this section refers to the field of *aesthetics of healing*. "Aesthetics" in context of religion can be thought of in two different ways. First, and arguably most prominently, they can be considered a form of expression, like in arts, theater, music, or dance. Secondly, aesthetics can refer to the Greek etymology of *aisthesis*—the study of perception and the senses. Central to this analysis is the experience of the individual and his or her physical and mental impressions. In this process, symbols are produced and infused with religious or spiritual meaning. The individual is at the center of this approach and constantly positions her- or himself in a circle of aesthetic perception and aesthetic expression (Münster 2001: 11). Kurz (2017) summarizes these aspects in a way that

> "Aesthetics of healing are not reduced to the (symbolic) communication and incorporation of external ideas and values, but on the contrary are directed towards the inner perception of self." (*ibid.* 204).

With the example of Brazilian Kardecist Spiritism, he emphasizes the centrality of individuals and their sensorial perceptions in a particular environment. Accordingly, *aesthetics of healing* do not just relate to the external appearance and performance of healing practices, but also to inner feelings and ways of (self-)perception. Kurz argues that in Spiritist healing practices, working with the senses is integrated especially in terms of processes of self-awareness and an acknowledgment of sensorial experiences. In this regard, he addresses the concept of *interoception* as fruitful for the sector of performance studies and reflects on the sensory perception of stimuli generated in the body. More specifically, according to Kurz, the special atmosphere in healing rituals and the reduction or changing of external stimuli results in an increased awareness of individual feelings and sensations (*ibid.* 203f). From this perspective, therapy would address the personal confrontation with individual problems and challenges by manipulating perception which is often skewed by one's own bias. Through healing practices and the incorporation of spiritual entities, the individual would be given the opportunity to deal with his or her problems in a safe and extraordinary environment. Taking this as a theoretical background of my discussion, I will examine in the following section practices at TUCO, especially considering the personal encounters and experiences of my interlocutors.

Experiencing Mediumship in *Umbanda*

> "We were at a celebration on the beach. We opened a *gira*[8] at the beach and I started feeling really bad, really bad. I felt some pain in my body and I buried an *orixá* in me. […] The people were incorporated by Iemanjá. One of these Iemanjás came to embrace me and when she embraced me, she pushed my personal Iemanjá. After that, my personal Iemanjá began to dance. I started to lose control of the movements of my body. I was really conscious, but couldn't manage to open my eyes. She began to dance and that's it."[9]

This statement of my informant Beatriz describes her first experiences with mediumship. It is a first hand account of her incorporating with her "personal vibration" of Iemanjá (*orixá* of the ocean). A young woman in her early twenties, Beatriz studies drama and theatre studies, and performs as an actress in Brazilian television. Even though her grandfather founded TUCO, and, thus, *Umbanda* has always been present in her life, she only recently started to develop her mediumistic skills.

At first, Beatriz was surprised by "all the energy," and frightened at the prospect of losing control of her body. She explained how difficult it was to let go and "trust the entities," which she perceives as "energetic vibrations." After some time, these feelings of uncertainty and fear changed toward trust and affection for her *guias* and *orixás*. The "awakening" of these mediumistic skills seems to mark a special moment in the life of any medium. Many describe it as a profound inner process that tends to transform attitudes and notions about the outer world and cosmology, but also about the self: "Am I me or am I entity? Am I me or am I *guia*? Am I me or am I *orixá*?"—the preoccupation with Vinícius' questions, introduced earlier, becomes apparent in this very context.

How does one deal with one's sensory impressions and the sudden appearance of the perception of another entity in one's body? Which sensations "are one's own" or "are of the incorporated entity"? What is the difference between "my" perception and the entities' engagement? Accordingly, dealing with multiple sensory impressions is a challenging task, and many of my informants referred to moments at the beginning of their "career as a medium" where they felt lost, overwhelmed, or insecure:

> "It is a huge task, sometimes it's frightening! Mediumism is a big deal in your everyday life and often a really confusing exercise. If it wouldn't be for love, you couldn't sustain it! But it is worth it – for love it is worth it."[10]

It appears that emotions and feelings are a central means of contact with the world of spirits. By sensory perception, mediums enter an energetic exchange with "their" entities and thus into a state of communication "on another level." Feelings of trust and unconditioned love are, according to Beatriz and other interlocutors, fundamental for their devotion and the integration of the entities into their everyday lives. To fulfill their task to perform as a medium, they engage in a continuous process of (spiritual) learning and development. Throughout courses of "mediumistic development" (*desenvolvimento mediúnico*), or trainings to become a *mãe-* or *pai-de-santo*[11] (*sacerdócio*), mediums learn how to cope with their skills and how to handle their experiences and sensory impressions in the context of incorporation. They learn how to accept and how to use their "special tasks," and the responsibility of a consulting medium that comes along, as Antônio stresses:

> "We are in contact with a lot of entities! There are different cultures, which passed through different things—different experiences we went through in other appearances, you know? [...] and we learn a lot with this. This is really gratifying! It depends on our entities, on our communication with the consultants. [...] You learn to be more human, more humble. You learn to respect the other! [...] We learn that there is no right or wrong religion. There are various religions, so there are various ways!"[12]

He emphasizes the personal progress a medium experiences in his or her development. Accordingly, there is a spiritual part to be considered, including interaction with spiritual entities and with a personal "history" of (re-)incarnations. Antônio states that mediums share past life experiences with their spiritual counterparts and, therefore, develop intimate relationships with them. However, they do not only interact with those but also with arbitrary spirits who seek help and are addressed in the weekly consultations for the sake of providing spiritual support for humans and spirits apart from any religious denomination or belonging:

> "It's because I have the philosophy that God is in everybody. So, my religion isn't better or more perfect. It's perfect for me and for the people following me. It's the same with all the religions. I believe that God guides everybody to a certain place where everybody can be together, no matter who they are or which religion they follow."[13]

This philosophy is a cornerstone to the medium apprenticeship at TUCO. For Mãe Zuleide it is

necessary that the mediums of her *tenda* respect deviant persuasions and, accordingly, provide support to everybody who is seeking it. Further, by reflecting on their sensory perceptions, mediums learn to interact with other human beings as well as with their spiritual entities on the sensory level. Therefore, becoming a medium implies various individual motivations, expectations and different forms of personal engagement. For Antônio, it has been a "natural" process as he has been socialized within *Umbanda*. He explained that he had always liked the mediumistic work and that he was already expecting to become a medium of incorporation himself one day. So he was not surprised by the first approach of his *guia* in one of the weekly rituals (*gira*).

> "I was at the *gira*, doing a *trabalho* [work for the entities] and all of a sudden, I felt a presence close by my side… that I never, never felt before. So, this entity came very close and then there was a moment, when I didn't know anymore […] what was I and what was the entity. […] I was still conscious, but lost the control over my body. So, my body started doing things that I didn't understand. It's strange at the beginning, really strange."[14]

Many of my interlocutors share this initial confusion described by Antônio but state that afterward, the relationships with their *guias* were experienced as a remarkable bond of love and trust. This personal and direct bond to the spiritual world and the pantheon of *orixás* allows the mediums of *Umbanda* to experience the rituals in a certain "emotional regime" (cf. Reddy 2001). The social and emotional environment of the ritual context seems to offer to them a possibility to overcome everyday struggles and challenges, to integrate their selves into this "alternative" environment and to engage with this different agenda. The community of the *Umbanda tenda* thus acts as a *safe-space* (both for members and consultants) by providing confidential support regarding any questions, doubts and daily problems. Moreover, during the rituals, the mediums are able to embody personality and practice schemes deviant from their common *habitus*.

Turner (1967, 1968, 1969) states that rituals demonstrate important aspects of human experiences and values. His approach might be a generalizing one but for sure he touches an aspect of religious experience as relevant for the individual and its social relationships. In particular, his concept of *liminality* and the implied transformation of self throughout central phases of rituals, and the coherent idea of a developing *communitas* (the agents' sense of community during a ritual) is of importance in the context of *Umbandist* mediumship. Besides divergent personal aims and ideas, a common motivation to become a medium was the urge of charity and compassion for others as part of one's spiritual responsibility. Personal approaches, however, in one way or another applied to this idea and/or derived from opposing experiences: some of my interlocutors referred to their family connection with *Umbanda* and growing up within the faith. Others found their way to *Umbanda* after periods of personal physical or mental suffering, fundamental family problems or social marginalization, due to ethnic, gendered, or sexual oppression. Others described accessing *Umbanda* as a personal process of cosmological and spiritual "sense-making." My overall observation is the role *Umbanda* plays in the handling of emotional perceptions in their everyday lives, and that a mindful adaption of sensory and cognitive perception is seeked in the context of healing to develop some kind of "emotional balance." Another aspect is that financial issues, romantic advice, family disputes and other personal problems are integrated into the mediums' consultations concerning medical and psychological health issues.

Healing in *Umbanda*

Mediumship in *Umbanda* revolves around questions of health and healing. In the consultations, mediums prescribe teas, herbal baths or a special diet. They also provide guidance concerning the implementation of prayers, chants, or sacrifices as "ritualized" practices addressing an *orixá* or *guia*. Such can be a "shared" cup of coffee in the morning or the lighting of a specific colored candle. Mediums also provide a *passe* to their consultants, a kind of blessing and "energetic retracking" provided by the entities through the medium (Scharf da Silva 2004: 167ff). For major health problems, *cirurgia espiritual* (spiritual surgery) may be another option. In these spiritual surgeries, consultants lay down to be energetically treated by their *guia* in the privacy of their home. The

details of this "appointment" are organized in advance by the medium, so that the spiritual entities can make the home calls to perform spiritual surgeries on the patients. During these events, mediums are not physically present as the respective *guias* perform the treatment in a process which can last hours while patients are sleeping, unconscious and/or in a state of trance (cf. Espírito Santo 2018; Scharf da Silva 2004; Schmidt 2015; Hale 2009; Montero 1985). Throughout my fieldwork, these treatments and apparent resulting "medical miracles" have been a permanent topic of discussion. Lucas, who was undergoing spiritual surgery for his chronic back pain shared his narrative with me:

> "Well, one thing—an energy on the edge of common, right? I already feel knocked out, just from talking about it… and this derives from preoccupation. *Nossa* [my goodness], what was that what I saw? I don't know! What did I feel?' And then you start feeling good things, marvelous things—the smell of hospital, like I really would have been in a surgery. When you close the eyes, you feel that there is a bunch of people in the room. It was as if my back began to catch fire, a lot of fire […] like with a tattoo, you know? It doesn't hurt, but it burns! Now, I feel way better and I'm without pain."[15]

Lucas' narrative illustrates yet another level of the importance of sensory perception in the realm of mediumistic healing: in addition to the healers' engagement, it is also about the patients' experiences. He describes his perception of the presence of the spirits and the associated bodily sensations during surgery, in which he manifested a "realistic" treatment experience, right down to the scent of a hospital environment and the experience of being healed. Lucas discusses his orthopedic problems and the sensation of being treated, that he experienced during the spiritual surgery. But this also illustrates how the "healing cooperation" (cf. Kurz 2018) of *spiritual* and *biomedical* approaches can be thought of. Before undergoing this spiritual treatment, Lucas struggled with simple movements and experienced considerable pain when attempting everyday tasks. As a result, he was recommended surgery by his doctor. After his spiritual surgery, the pain disappeared. But Lucas still plans to stick to his next appointment with the medical doctor in order to verify the results and to receive a second opinion (cf. Pierini 2016: 29; Scharf da Silva 2004: 188ff; Montero 1985: 119ff). Lucas confirmed that he was not surprised by the success of the *Umbandist* healing therapy as he had already experienced similar success before: when he first "lay down" to a *preto velho*, he had suffered from liver cancer. The day after the spiritual surgery he went to the hospital for an examination and the cancer was not evident anymore. The doctor could not believe that the results had changed so dramatically in such a short time.

During my stay at the *tenda* I have witnessed many related narratives, and my interlocutors have always been very determined that while *Umbanda* can help and heal, the medical and therefore physical elements are equally important and require attention and care. According to Mãe Zuleide, *guias* would accordingly inform patients, that "[H]ere we can do something, here you need to see a doctor,"[16] stating that they never would advise a consultant to drop biomedical healthcare. "There are cases you HAVE to send to the doctor. There is no way! It's not just faith that will heal—it has to be seen as a whole."[17] Many of the people consulting *Umbanda* have already been passed from general practitioners to specialists, and, therefore from one treatment approach to another, without any experience of sustained cure. However, the spiritual treatment provided by the *guias* seems to be even capable of renewing a patient's motivation to pursue medical treatment simultaneously, at least according to Mãe Zuleide. Pierini (2016) confirms this line of thought when referring to her research on the *Vale do Amanhecer,* another mediumship-oriented Brazilian spiritual-religious practice. Mediums there likewise perceive healing as complementary to biomedical interventions. They treat spiritual causes of suffering, but refrain from dealing with physical aspects of disease. Therefore, mediums would advise their consultants to, alongside spiritual treatments and healing supplies, also seek biomedical healthcare, at least in certain situations (*ibid.* 29). This intersection of biomedical intervention and *Umbanda* healing practice is apparent in the above-mentioned case studies, and Antônio confirms this certain "balance":

> "I try to unite the two spheres, you know? I think that not everything is spiritual, but I also think that not everything is physical. I guess one has to find a balance between both things."[18]

The mediums of TUCO emphasized this understanding of health "as a whole"—as consisting of spiritual, emotional and physical elements. All these elements need to be treated in specific ways, which is why biomedical interventions are perceived as similarly important in *Umbandist* healthcare, and at least the mediums I met are very aware of a certain responsibility they oblige to:

> "You're dealing with lives in there! A lot of people stop going to the doctor to talk instead with a *guia*. […] They trust more in talking with a *Caboclo*, who gives you a tea and you're going to be better. So, it's a huge responsibility! If you take a person who is not prepared emotionally, mediumistically, spiritually to talk with others in this context [as a medium]—what damage can you do to someone's life?"[19]

Mari explains that as a medium of *Umbanda*, she tries to make a difference in the world, radiate some light and help wherever you can. However, she also states that one must nevertheless be aware of the limits, especially of one's own capabilities. She points out that the development and examination of one's sensory perception, emotional world and mediumistic skills is absolutely essential when confronted with the mental and physical health of others.[20]

Conclusion

The purpose of this article is to illustrate how my research data on *Umbanda* in Brazil intersects with different perspectives summarized as *aesthetics of healing* in this volume. I demonstrated in which ways sensory perception and experience is of importance within the realm of incorporation of spiritual agencies and their interaction with mediums and their consultants. Altered states of consciousness appear to intensify ways of multi-sensorial perception of the environment, as well as of self. In this context, I introduced the concept of *interoception*, addressing the perception of inner sensory stimuli and arguing for relating sensory impressions to, for instance, dynamics of self-awareness (cf. Kurz 2017). In this regard, I argue, relationships between mediums and their spiritual entities reflect unique, individual bonds permeated by complex feelings and emotional states. As for the healing processes in *Umbanda*, I have further illustrated how the senses impact healing processes by providing "real" experiences of being treated.

I suggest further anthropological and interdisciplinary research on mediumistic experiences in *Umbanda* and comparable healing practices to further explore the interplay of religion and medicine as two sides of the same coin, connected by the question of their sensory engagement with human existence and well-being. As a rather young and dynamic urban phenomenon, *Umbanda* sheds light on the personal handling of illness and well-being in the metropolises of Brazil. The academic examination of the multi-religious sphere is thus highly relevant, especially when further wanting to investigate *aesthetics of healing*. For *Umbanda* as an additional provider of mental and physical healthcare, there is potential for further research on spiritual healing, mediumistic experiences and related social tasks.

This example emphasizes the importance of the senses in the context of spiritual healing and practices of incorporation. However, it also addresses the urge for innovative and experiential approaches to explore personal level of experience in the scope of mediumship practice.

Clearly, the exploration and study of sensory aspects in relation to (individual) approaches of well-being frame our understanding of health and illness in divergent societies and are, therefore, highly relevant to medical anthropology and the related research area of the *aesthetics of healing*, that should be further studied on a larger scale.

Notes

1 *Umbandists* often refer to *Umbanda* as their "religion," like most of my interlocutors did. This is why I use this exact term to describe *Umbanda* here and elsewhere. Even if there is a widespread debate about the definition and the diffuseness of the term "religion," especially in the religious studies (cf. Strausberg 2012; Pollack 1995; Antes 1979), I use it in reference to the emic description and understanding of my contacts in the field.

2 All of my informants are referred to under pseudonyms here and elsewhere. The only exception is the Mãe Zuleide. She is the leader and priestess of TUCO and is thus inseparably linked to her group.

3 Interview Vinícius, Diadema, São Paulo, 2018-10-12. Original quote: "Eu falo que a mediunidade aparece na sua vida como uma pena, é muito leve. Começa na sua vida como uma coisa muito leve e passa a ser uma pedra. Ela cai sobre você, depois, com toda força. Então, os primeiros sentidos de minha mediunidade é muito aquela coisa. Sou eu – sou a entidade? Sou eu – sou *guia*? Sou eu – sou *orixá*? É muito sobre definir toda a energia!"

4 Literally "tent", it is the place of worship where *Umbandistas* unite for the weekly rituals and festive occasions. It also describes the community and thus can be find in the proper name of a spiritual community (*e.g.* Tenda de Umbanda Caboclo do Oriente).

5 I stayed in São Paulo from August to December 2018. During this time I did a student exchange connected to my masters program in *Social and Cultural Anthropology* at Freie Universität Berlin.

6 Interview Mãe Zuleide, Diadema, SP, 2018-11-26. Original quote: "A *Umbanda*, ela está em tudo – em todas as religiões. Se você for pegar uma bíblia, você vai ver que o nome de Deus e tudo que está lá dentro da bíblia é religião. Então, sim, a religião ela é – pra cada local ela tem um sincretismo. […] A única diferença entre uma religião e outra, é o humano."

7 In the humanities, especially in anthropology and religious sciences, the term "ritual" is questioned after a long period of debates about the definition and handling of the term (cf. Douglas 1970; Turner 1969; Durkheim 1912). In the context of this article, I refer to "rituals" as an emic description of my interlocutors. They use the term to describe their public and private meetings, taking place at their *tenda*. Further they have personal "rituals" that they accomplish at home, *e.g.* on a special day of the week at their private altar.

8 *Giras* are incorporation rituals of Umbanda, they are literally based on the Portuguese verb *girar*—"to turn."

9 Interview Beatriz, São Bernardo do Campo, SP, 2018-11-18. Original quote: "A gente estava numa festa da praia. A gente abriu uma gira na praia e eu comecei a passar muito mal – muito mal. Senti umas dores no corpo e estava enterrando um *orixá* em mim. […] As pessoas estavam incorporadas por Iemanjá. Uma das Iemanjás veio me abraçar. E aí, quando ela me abraçou, ela puxou a minha Iemanjá pessoal e começou a dançar. Eu comecei a perder o controle dos movimentos do meu corpo. Eu estava muito consciente, mas não conseguia abrir os olhos. Ela começou a dançar e foi isso!"

10 Interview Mari, Vila Mariana, SP, 2018-11-06. Original quote: "É uma tarefa muito grande, então, as vezes dá muito medo assim. A mediunidade é bem complexa na sua vida cotidiana e muitas vezes é um exercício bem confuso, complicado. Se não for por amor, você não consegue sustentar isso! Mas vale a pena – por amor, vale a pena."

11 *Mãe-de-santo* and *pai-de-santo* (*ialorixá/babalorixá*) can be translated as "mother/father of the Saint." They are the female and male leaders and priests in community's of *Umbanda* and other Afrobrazilian religions such as *Candomblé*.

12 Interview Antônio, Vila Mariana, SP, 2018-11-23. Original quote: "A gente tem contato com várias entidades! Tem culturas diferentes que passaram por coisas diferentes – o que a gente passou quando estivemos em outras vivências, sabe? (T.B.: Sei!) E a gente aprende muito com isso. Isso é muito gratificante. Depende das nossas entidades, da nossa comunicação com o consulente […]. Você aprende a ser mais humano, mais humilde. Você aprende a respeitar o outro. […] A gente aprende que não existe um religião certa, uma religião errada. Existem várias religiões e existem vários caminhos."

13 Interview Mãe Zuleide, Diadema, SP, 2018-11-26. Original quote: "É porque eu tenho a filosofia que Deus está em todo mundo. Então, a minha religião não é melhor ou mais perfeita. Ela é perfeita para mim e para as pessoas que me seguem, assim como em todas as outras religiões. Então, eu acredito que Deus conduz cada um para um determinado lugar aonde ele estará preparado para estar com todas as pessoas, não importa quem eles são ou que religião eles seguem."

14 Interview Antônio, Vila Mariana, SP, 2018-11-23, note by T.B. Original quote: "Eu estava na gira fazendo um trabalho e aí comecei a sentir uma presença perto de mim que eu nunca tive, nunca tinha sentido, e aí, aquela entidade foi se aproximando. E aí teve um momento onde eu não sabia mais aonde – o que era eu e o que era a entidade. […] estava ainda consciente, mas perdi o controle do meu corpo. Então o meu corpo começou a fazer coisas que eu não entendia o que estava acontecendo. É estranho, no começo, é bem estranho."

15 Interview Mãe Zuleide, sequence with Lucas, Diadema, SP, 2018-11-26. Original quote: "Bom, uma coisa – uma energia fora do comum, né? Já sinto k.o. só de falar já […] e isso vem da preocupação, né? 'Nossa, foi aquilo que eu vi, não sei aquilo – o que é que eu senti?' E se começa a sentir coisas boas, maravilhosas – cheiro de hospital, como se eu estivesse numa cirurgia mesmo. Você fecha os olhos e sente que tem um monte de gente no quarto. Era como se minhas costas começassem a pegar fogo, muito fogo […] como uma tatuagem, sabe? Uma tatuagem queima né? Não dói, queima e foi isso que eu senti. Aí eu estou bem melhor agora, estou sem dor! Mas ainda estou com este sentido nas costas."

16 Interview with Mãe Zuleide, Diadema, SP, 2018-11-26. Original quote: "Aqui a gente pode, mas aqui você precisa ir ao médico!"

17 Ibid. Original quote: "Porque tem casos que você tem que mandar pro médico. Não tem como! Não é só fé que vai curar. É todo um conjunto."

18 Interview Antônio, Vila Mariana, SP, 2018-11-23. Original quote: "Eu tento juntar as duas coisas sabe? Eu acho que nem tudo é espiritual, mas também acho que nem tudo é físico. Acho que tem que encontrar um equilíbrio entre as duas coisas."

19 Interview with Mari, Vila Mariana, SP, 2018-11-06, note by T. B. Original quote: "Você lida com vidas lá dentro! Muita gente deixa de ir ao médico para falar com o guia, entendeu? Muita gente deixa de ir [ao médico] porque confia mais para falar com o Caboclo que vai te dar um chá pra você melhorar. Então, é uma responsab-

ilidade muito grande! Se você pega uma pessoa que não está preparada emocionalmente, mediunicamente, espiritualmente para falar com outros dentro deste contexto – o que que você pode agregar na vida de alguém?" **20** Interview with Mari as well as in several personal conversations.

Acknowledgment

This article offered an insight into my research about healing and the senses in the Brazilian religion *Umbanda*. I would like to point out that all the findings of this article are taken from my master thesis, in which I analyzed the elaborated topics in more detail and with a special focus on the mediumistic experiences of my interlocutors and their senses in the context of psychological health and therapies.

References

Antes, Peter 1979. Die Religionswissenschaft als humanwissenschaftliche Disziplin. Zeitschrift für Missionswissenschaft und Religionswissenschaft 63, 4: 275–282.

Clifford, James & George E. Marcus 1986. *Writing Culture: The Poetics and Politics of Ethnography*. Berkley: University of California Press.

Csordas, Thomas J. 1994. Words from the Holy People: A Case Study in Cultural Phenomenology. In *ibid.* (ed) *Embodiment and Experience: The Existential Ground of Culture and Self.* Cambridge: University Press: 269–290.

———— 2002. *Body/Meaning/Healing.* Basingstoke: Palgrave Macmillan.

Desjarlais, Robert 1992. *Body and Emotion: The Aesthetics of Healing in the Nepal Himalayas.* Philadelphia: University of Pennsylvania.

Douglas, Mary 1970. *Natural Symbols: Explorations in Cosmology.* London: Barrie and Rockliff.

Durkheim, Emile 1912. *Les formes élémentaires de la vie religieuse.* Alcan: Paris.

Engler, Steven 2012. Umbanda and Africa. *Nova Religio* 15, 4: 13–35.

Engler, Steven 2017. Umbanda. In Bettina E. Schmidt & Steven Engler (eds) *Handbook of Contemporary Religions in Brazil.* Leiden: Brill: 204–224.

Espírito Santo, Diana 2018. *Fluid Spirits: Cosmology and Change in Contemporary Brazilian Umbanda.* Coconut Creek: Caribbean Studies.

Feld, Steven 1990. *Sound and Sentiment.* Philadelphia: University of Philadelphia Press.

Hale, Lindsay L. 2009. *Hearing the Mermaid's Song: The Umbanda Religion in Rio de Janeiro.* Albuquerque: University of New Mexico Press.

Halloy, Arnaud 2012. Gods in the Flesh: Learning Emotions in the Xangô Possession Cult (Brazil). *Ethnos* 77, 2: 177–202.

Howes, David 1991. *The Varieties of Sensory Experience: A Sourcebook in the Anthropology of the Senses*. Toronto: University of Toronto Press.

———— 2011. Sensation. *Material Religion* 7, 1: 92–98.

Ingold, Tim 2008 [2000]. *The Perception of the Environment: Essays on Livelihood, Dwelling and Skill.* London: Routledge.

Kurz, Helmar 2015. "Depression is not a Disease. It is a Spiritual Problem.": Performance and Hybridization of Religion and Science within Brazilian Spiritist Healing Practices. *Curare* 38, 3: 173–191.

———— 2017. Diversification of Mental Health Care: Brazilian Kardecist Psychiatry and the Aesthetics of Healing. *Curare* 40, 3: 195–206.

Macedo, Alice C. 2015. *Encruzilhadas da Interpretação: Cuidado e Significação na Umbanda.* Ribeirão Preto: FAPESP.

Mol, Annemarie 2002. *The Body Multiple. Ontology in Medical Practice*. Durham, London: Duke University Press.

Montero, Paula 1985. *Da Doença a Desordem: A Magia na Umbanda.* Rio de Janeiro: Graal.

Münster, Daniel 2001. *Religionsästhetik und Anthropologie der Sinne.* München: Akademischer Verlag.

Nichter, Mark 2008. Coming to our Senses: Appreciating the Sensorial in Medical Anthropology. *Transcultural Psychiatry* 45, 2: 163–197.

Pierini, Emily 2016. Embodied Encounters: Ethnographic Knowledge, Emotion and Senses in the Vale do Amanhecer's Spirit Mediumship. *Journal for the Study of Religious Experience* 2: 25–49.

Pink, Sarah 2015 [2009]. *Doing Sensory Ethnography.* London: SAGE.

Pollack, Detlef 1995. Was ist Religion? Probleme der Definition. *Zeitschrift für Religionswissenschaft* 3, 2: 163-190.

Prandi, Reginaldo 2004. Afro-Brazilian Identity and Memory. *Diogenes* 51, 1: 35–43.

Pressel, Esther 1974. Umbanda Trance and Possession in São Paulo, Brazil. In Felicitas D. Goodman *et al.* (eds) *Trance, Healing, and Hallucination. Three Field Studies in Religious Experience*. New York: Wiley: 113–225.

Reddy, William M. 2001. *The Navigation of Feeling: A Framework for the History of Emotions*. Cambridge: University Press.

Scharf da Silva, Inga 2004. *Umbanda. Eine Religion zwischen Candomblé und Kardezismus. Über Synkretismus im städtischen Alltag Brasiliens.* Hamburg: LIT.

Seligman, Rebecca 2010. The Unmaking and Making of Self: Embodied Suffering and Mind-Body Healing in Brazilian Candomblé. *Ethos* 38, 3: 297–320.

———— 2014. *Possessing Spirits and Healing Selves: Embodiment and Transformation in an Afro-Brazilian Religion*. New York: Palgrave Macmillan.

Selim, Nasima 2015. Sufi Body Practices and Therapeutic Politics in Berlin. In Gritt Klinkhammer & Eva Tolksdorf (eds) *Somatisierung des Religiösen: Empirische Studien zum rezenten religiösen Heilungs- und Therapiemarkt*. Bremen: Universität Bremen: 237–81.

Stewart, Charles & Rosalind Shaw 1994. *Syncretism/Anti-Syncretism. The Politics of Religious Synthesis.* London: Routledge.

Stodulka, Thomas 2015. Emotion Work, Ethnography, and Survival Strategies on the Streets of Yogyakarta. *Medical Anthropology* 34, 1: 84–97.
Stoller, Paul 1989. *The Taste of Ethnographic Things. The Senses in Ethnography.* Philadelphia: University of Philadelphia Press.
Stoller, Paul 1997. *Sensuous Scholarship.* Philadelphia: University of Pennsylvania Press.
Strausberg, Michael (ed) 2012. *Religionswissenschaft*. Berlin: De Gruyter.
Turner, Victor 1967. *The Forest of Symbols: Aspects of Ndembu Ritual.* Ithaca: Cornell University Press.
———— 1968. *The Drums of Affliction: A Study of Religious Processes among the Ndembu.* Oxford: Clarendon.
———— 1969. *The Ritual Process: Structure and Antistructure.* London: Routledge & Kegan Paul.

Manuscript received: 22.01.2020
Manuscript accepted: 30.12.2020

TESSA BODYNEK M.A., is a social and cultural anthropologist with a particular interest in the intertwining of the fields of religion, psychology and medicine in an anthropological framework. She completed her Bachelor's degree in Comparative Cultural and Religious Studies at Philipps-Universität Marburg. She then graduated with a Master's degree in Social and Cultural Anthropology at Freie Universität Berlin, specializing on medical and psychological anthropology. In this context, she conducted several months of fieldwork in the Brazilian metropolis of São Paulo to explore personal attitudes, feelings and sensory perceptions in the realm of religion and medicine.

Freie Universität Berlin
Institute of Social and Cultural Anthropology
e-mail: tessa-bodynek@gmx.net

Healing Efficacy and Subjectivity among Long-Term Residents in a Spiritist Asylum

SABRINA MELO DEL SARTO & ESTHER JEAN LANGDON

Abstract The article presents an ethnography of the social life of permanent residents interned in a Spiritist psychiatric hospital in the interior of the State of São Paulo (Brazil), focussing their participation in a "healing ritual" known as *passe*. It describes the ways of living and sociabilities that emerge in a compulsory daily routine, in order to identify agency and expressions of subjectivities and desires. Although they are in a hospital wing composed of individual residences, institutionalisation is a major characteristic of their lives, such that their histories often intertwine with a life in institutions. Their residential life is marked by a compulsory religious and medical routine that imposes a moral order on their actions. Through ethnographic research, we seek to understand their social practices that diverge from the normative order imposed by the hospital routine of enforced medications and participation in the Spiritist healing ritual of the *passe*. Rather than engaging in the ritual performance, these long-term residents resist through the enactment of alternative goals and desires. Long-term institutional experience and excessive medication contribute to other subjectivities and goals within the walls of the institution and its mandatory rituals.

Key Words mental affliction, institutional order, therapeutic practices, subjectivity, spiritism.

Introduction

Consideration of the status of "mental illness," "madness" or "insanity" in the contemporary world demands that we recognise Western civilisations' long history of imposed norms and marginalisation. As João Biehl (2005) has demonstrated in the case history of Catarina,[1] internment in a psychiatric institution is less influenced by medical diagnosis than by other factors, including life histories and social and economic resources. This article examines the social life of long-term patients interned in a Spiritist psychiatric hospital in Brazil who occupy a special residential annex called "Sheltered Home," a situation different in many respects from that of total abandonment described by João Biehl. However, like Catarina, they have been institutionalised for many years, some since childhood, for behaviour and/or social situations identified as abnormal. We are not examining in this article their expression of suffering or mental affliction, but rather how they, as subjects, engage in social action, constructing their lives within the limits of the institutional order. As part of the daily routine, patients are required to attend the Kardecist spiritual healing ceremony known as the *passe*, a ritual performance that is designed to heal the spiritual causes of their afflictions. Based upon ethnographic research of participant observation with the residents of Sheltered Home, we discuss the question of therapeutic efficacy as it relates to their life conditions and engagement in the ritual process.

The long-standing relation between Spiritism and health in Brazil has been examined by a variety of authors and several have examined the close historical relation between Spiritist doctrine, medicine and health seeking behaviour (Cavalcante 1983; Montero 1985). The relation is so much a part of Brazilian culture that the Spiritist healing practice known as the "hands-on healing" (Kurz 2017) or *passe* was officially authorised for use in primary health care by the *National Policy for Integrative and Complementary Health Practices* in 2006 (Nascimento *et al.* 2019). Sidney Greenfield's (1989, 1991, 2008) research examined the

healing efficacy of Spiritist surgeries, speculating that the success of such practices lies in the relation between Brazilian culture and the power of imagination, trance and suggestion. More recently, Helmar Kurz (2015, 2017, 2018a,b) has built upon anthropological models of healing and neuroscience, in order to examine the Spiritist *passe* as a component of the healing process of mental patients. Although he attributes part of the *passe*'s efficacy to the impact of the aesthetics of the performance on Brazilians, his research among Germans suggests that the *passe* sets in motion internal processes of healing independent of specific cultural frames. The aesthetics of healing stimulate internal processes ("interoception") that involve transformation and change in habits by drawing upon the patient's personal resources and engagement in the ritual process (Kurz 2017). His model of healing will be the focus of our discussion, given that he has conducted research among private patients of the same hospital as well as other comparable institutions in Brazil and Germany. However, our research points to different conclusions about the possibilities of the healing efficacy of the *passe* among long-term patients that are subject to the conditions of the public wards.

Recognising the social character related to long-term internments and the coercive aspects of institutionalisation (Goffman 1961; Foucault 1997), we examine the sociability and subjectivity of permanent residents of the psychiatric hospital in order to understand how their daily participation in the *passe* is lived and perceived. In order to examine their lived experience, we follow João Biehl (2007: 422) and his notion of subjectivity. For him, subjectivity is both an empirical reality as well as an analytical category that suggests a contrast with objectivity and connotes creativity, fluidity and the possibility of adopting a distinct symbolic relation with the world. Experience, as Arthur and Joan Kleinman (1995) observe, is that which mediates and transforms the relation between the context and the person. Through intensive ethnographic research, we found that long-term patients' experience and interpretation of the ritual diverge in several ways from both Spiritist explanations as well as anthropological models of healing efficacy.

Spiritism, Psychiatry and Institutionalization in Brazil

In Brazil, institutions for the internment of the "mentally ill" emerged with the industrial expansion during the final decades of the 19th century, and urban sprawl was a determining factor for the construction of what were called "hospices" at the time. Since the origin of Brazilian *alienism*, the country has remained attuned to European methods of treatment. Psychiatric institutions and treatments were introduced, and the principle focus of sanitary concern was on those subjects destabilized by rapid urbanization—the working class, the unemployed, freed slaves and foreign immigrants (Bastos 1997). During this period, hygienic or mental medicine of a scientific character gradually constructed the dominant discourse over all aspects of life, penetrating personal relations and moulding them to an idea of order and discipline (Cunha 1986). Following the *Proclamation of the Republic* (1889), those governing the country strove to create an educated society and to eradicate the "promiscuous places" that harboured disease and criminality; the "crazy" were included as examples of the diseased and criminal. Asylum institutions were thus created primarily as a public health intervention to cleanse society. They were conceived of as a necessity of society, and the pathological nature attributed to states of "madness" justified the exclusion of those considered "mentally ill" (Bastos 1997).

According to Angélica Aparecida Silva de Almeida (2007), psychiatry and Spiritism consolidated during the same period, both seeking social, scientific and institutional legitimation. For Spiritists, most mental illnesses have causes other than or in addition to the causes identified by psychiatry. Based on the idea that souls evolve over the course of many lives, many problems are attributed to spiritual debts accrued in previous incarnations. Insanity can be motivated by two factors: by unconscious feelings of guilt due to errors committed in past lives and by "obsession," or mental perturbation, in which one is tormented by an "unevolved spirit" (Ribero 2013: 119). Thus, Kardecist Spiritists founded psychiatric hospitals where they combined biomedical treatments with religious practices. Many of their practices are carried out by volunteers, since caring for the

ill is considered an act of charity, an important practice according to the Spiritist doctrine. Charity contributes to one's spiritual evolution, and thus these hospitals can always count on volunteers for fulfilling many of the tasks as well as on financial contributions from Spiritist followers.

The movement against internment of mental patients, known as the *Psychiatric Reform,* began in the late 1970s as health professionals and patients' relatives mobilized for the defence of human rights and restoration of citizenship for the interned (Delgado 1992). As a de-institutionalization process, it was based on the ideology of community psychiatry critical of psychiatric science and treatment administered in asylums (Camargo 2017). The movement proposed to decentralization treatment, substituting psychiatric hospitals with therapeutic communities. Concerned with the issue of human rights for the victims of the psychiatric violence of the autocratic state, it was part of the return to democracy and movement against the Brazilian dictatorship. It influenced the elaboration of public policies in health and other sectors, including culture, justice, human rights, work and social security. (Amarante & Nunes 2018)

Critical analyses of the *Brazilian Psychiatric Reform* proposal and its developments (Andrade 2010; Maluf & Andrade 2014) generally argue that the reform movement was responsible for the progressive attempts to extinguish psychiatric hospitals, which were overcrowded and costly institutions for the state. Psychiatric hospitals gradually saw a decrease in the number of beds: from 80,000 in 1970 to 25,988 in 2014 (Amarante & Nunes 2018: 2072). At the same time, pharmacological treatment expanded, spearheaded by the pharmaceutical industry that influenced the entire psychiatric community (Conrad 1992 *apud.* Camargo 2017). With the reform, psychiatry moved beyond the limits of the asylum model and into the public sphere of ambulatory care (Maluf 2010). The traditional model of hospital treatment was slowly substituted by the community care model and the rise of therapeutic communities, such as the "Psycho-Social Care Centres" (CAPS - *Centro de Atenção Psicossocial*) and "Psycho-Social Assistance Groups" (NAPS - *Núcleo de Assistência Psicossocial*).

Within this context, some psychiatric institutions closed down and others transformed in order to continue to exist. Some institutions altered their structures in order to become general hospitals with specialization in psychiatry and others became retirement homes. For a variety of reasons, certain psychiatric institutions did not fully comply with the process of de-institutionalization and continued with permanent residents. These institutions received additional patients who were coercively transferred from those that had been forced to close.

Those who have been interned in psychiatric hospitals for decades are labelled "chronic inhabitants." They reside permanently in institutions, regardless of the manifestation of symptoms of serious mental illness. They are those who have become estranged from interaction with social groups outside the institutional walls and are confined to relations maintained within the psychiatric hospital (Carneiro & Rocha 2004; Biehl 2005).

Psychiatric hospitals are usually subdivided into medical units or wards, and, in some of them, there is a specific residential unit that houses "chronic patients." According to Michelle Alcantara Camargo (2017), these wards, called "shelters" (abrigo), were designed to conform to the 1994 Ordinance (Portaria/SNAS nº 224 de 29/01/1994) that required the reformulation of the asylum policy and physical space in order to change the environment for long-term resident patients. These units are supported by the "Unified Health System" (*Sistema Único de Saúde,* SUS) and are composed of houses built within the hos-

Photo I: Sheltered Home Residences

pital walls, in order that the residents can live in a less asylum-like environment.

Sheltered Home: Institutional Routine

The *Spiritist Light Hospital* is one of these Brazilian institutions that, even with the process of psychiatric reform, has continued to maintain long-term residents in treatment. Beginning in 2015, the first author began research on the daily life of this hospital and its chronic inhabitants, hoping to comprehend the dynamics that transcend the coerciveness imposed by the institutional world. Initially she visited the institution staying with the residents for the day and participating in their activities (Del Sarto 2018). Then in 2019, she conducted intensive ethnographic field work for three months, sharing all moments of the daily institutional routine of the chronic inhabitants (Del Sarto 2020). Semi-structured interviews were conducted with the hospital staff. The issues raised in this article are primarily derived from this experience.

The hospital is situated in a city of 230.000 inhabitants located in the interior of the State of São Paulo. It is a Spiritist, psychiatric and asylum institution, created in the 1940s to provide care for people diagnosed with psychiatric disorders, and it houses both permanent and temporary patients from all parts of Brazil. In the 1990s, the hospital had 330 beds, 260 of which were commissioned by the *Unified Health System* and 40 for patients with private health plans. There were also 30 beds for underage patients with chemical dependence. The hospital has undergone significant changes in its composition and the treatments offered. It no longer accepts underage addicts; public beds were reduced to 142, and private beds for patients with superior economic resources or private health insurance were increased to 60. In spite of these changes, the Spiritist tradition of the hospital has been maintained and patients continue to be treated as biopsychosocial-spiritual beings. Treatment is carried out by a multidisciplinary team. Spiritists also are found among the administration staff and medical professionals, and they are present as volunteers who attend to the spiritual aspect of the patients through rituals and visits to the private wards.

It is important to recognize that the public wards, supported by the *Unified Health System* and donations, differ substantially from the private wards, resulting in very different patient experiences. The public wards are more crowded, with more patients per room. Private patients reside alone or share a room with only one other person. They have greater access to leisure areas and in general the environment of the private wards reflects more modern, well-cared conditions, in comparison with the visible deterioration of the public wards with structural problems and old furnishings. Private patients eat separately in their own dining hall, receiving meals of better quality and greater diversity. Finally, institutionalization for private patients is not as marked by the regimentation and coercive aspects that characterize the public wards. Internment is for the most part voluntary, and they are able to voice their complaints, have greater freedom of choice and benefit from a greater variety of psychotherapeutic treatments.

There are four public wards. These include a collective unit called the *patião* ("large yard") that houses in one large room the male patients without financial resources and who are incapacitated by critical states of mental or physical health. It was inhabited by both male and female permanent residents until 2018, when women were transferred to the female public ward that houses short term temporary patients. A third ward houses short term male patients for up to thirty days. Because of poor funding by SUS, the conditions of these wards and the situation of the long-term patients reflect abandonment and despair. The patients who live there have no contact with the external world and are considered incapable of returning to a social life.

The fourth public ward is the Sheltered Home annex, designed to conform to the 1994 ordinance calling for the humanization of psychiatric environments for chronic inhabitants. Although also supported by the *Unified Health System*, it contrasts in appearance and intention with the deplorable condition of the collective wards for long-term patients. It houses patients who have sufficient autonomy to care for themselves without the need for a full-time caretaker and has the appearance of a small village found within the walls of the institution. It consists of six separate residences with

a collective yard with cement seats. Although it has a capacity for a total of thirty-three people, at present there are only 21 residents, seven men and fourteen women. Four houses are exclusively for women, and two for men.

Each house has a living room, kitchen, bathroom and from two to three bedrooms. Kitchen facilities are strictly regulated; stoves are forbidden as well as knives and any other pointed objects. Behind each house there is a service area for washing clothes. Normally two to three people share a bedroom, and they decorate their houses according to their particular tastes, with pictures (mainly of Catholic saints), clocks and personal objects. Several residents own televisions and radios that can be heard throughout the day.

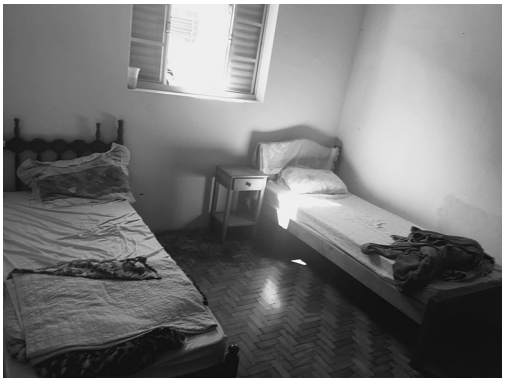


Photo II: Sheltered Home bedroom

The average age of the 21 residents is 66 years with an average of 22 years spent in institutional settings. Fourteen patients came directly from other institutions, where they had been interned as orphans or had no family support. All remain institutionalised because they are judged incapable of surviving independently and lack social support or resources outside the hospital to take responsibility for them. Because of their long-term institutional internment, their life histories intertwine with that of the hospital and other institutions where they have resided. Many have no clear understanding of why they are there or under what circumstances they would be able to leave. There is a running joke among them that the only way to leave is in a coffin.

The residents' lives are organised according to a daily routine established by the hospital. They awaken at 7 a.m. to a loud speaker barking out orders. After dressing, they go to the public canteen for breakfast. Immediately following, they file into a large hall located in the rear of the hospital where they participate in the "hour of the *passe"* consisting of a lecture on the Kardecist doctrine and the hands-on healing treatment (cf. Kurz 2018b). Following the *passe*, they return to the sheltered home and are administered the first medication of the day. Lunch is served at 11:30 in the canteen and immediately after they receive their second medication. There is a third medication at 2:30 p.m. and a mid-afternoon coffee. Dinner is served at 5 p.m. and the last medication of the day is administered at 8:30 p.m. Finally, a small snack is served at 9 p.m.

The loud-speaker installed in the hospital yard broadcasts orders and calls for assistance to the hospital staff throughout the day. Its presence not only coordinates the residents' activities but also is a constant reminder that they reside in an institution. Between the hours of the routine activities, the residents often gather in the collective yard to pass the time. Others sleep in their houses or listen to the radio or television. The female residents have the responsibility of cleaning their houses. Three of them also clean the men's residences and receive a monthly payment for their work. Nine of the patients are allowed to leave when authorized and can circulate in the neighbourhood around the hospital. Judged as incapacitated, the Federal government sends their disability payments directly to the hospital. Part of the payment is retained for the ward's maintenance, and each patient receives 60 Brazilian Reais (approximately $US 15.00) each week. This amount is controlled by the social worker who distributes it or saves it for the patients**.** Some go to the local shops by themselves, while others need someone to accompany them or must ask someone to make their purchases. Normally they spend their weekly allowance in the local food market, buying snacks and drinks that are not part of the Hospital's plain diet. In some cases, they save their money for weeks to buy clothing and other personal items or more expensive objects for their homes.

Photo III: Sheltered Home external area.

The *patião* and Sheltered Home are in constant relation. The resident of the Sheltered Home who demonstrates aggressive behaviour or fails to comply with the institutional regulations, will be sent to the *patião* (or female public ward) and remains there until the hospital psychiatrist authorises a return. Normally he or she spends two weeks interned in this ward but the period can extend to several weeks in case of more serious breaches of behaviour. Residents sent to the *patião* or female public ward do not receive their weekly allowance nor can they leave the hospital for short excursions. In addition, they are not allowed to have personal clothing or accessories. The probability of internment in these public wards is continually present in the daily institutional life in the form of threats from the hospital staff when they refuse to take their medicines or disobey in other ways. Also, these public wards are the destiny for residents who become permanently incapacitated because of age or health and no longer can care for themselves.

The hospital staff affirms that the sheltered home aims to progressively re-socialize and demedicalize patients. The therapeutic routine involves a complimentary relation between religious and pharmacological treatment. Both are obligatory - the hour of the *passe* as well as the daily medication. Four times a day at "medicine" time, they line up before the entrance of the nursing station to receive their pills. Each resident receives the pills with a small cup of water. Following that, they must open their mouths for the nurse in order to prove that they swallowed all the pills. They express resistance and dissatisfaction with the obligatory medication, complaining of the collateral effects and at times attempting not to swallow the pills (cf. Del Sarto 2020: 130). The only psychotherapeutic counselling that exists takes the form of a brief weekly visit from a psychologist who asks them how they are as she passes through the ward.[3]

The residents receive an average of 17 pills a day. A large part of them are antipsychotics and antidepressants; others are administered to counter the collateral effects of the first group. Most are familiar with the medications they take four times a day but dislike the heavy medication, associating it with punishment and control rather than with therapeutic goals. Medication is not seen as a cure for their problems, but rather as a cause of unwanted corporal or mental reactions and a manifestation of the coercive institutional force in their daily lives. Celia, a 50-year-old resident interned for 23 years, stated in March 2019:

> "We argue, and they administer remedies to punish us. Look at my mouth, it is always foaming. These remedies for depression do this to me. It's a remedy for the 'head.' Look at Marlene (another resident), she has a good head and we both have to take them. In order to lose weight, I drink green tea; for the head, Risperidone; I take Akineton for my deviated eyes caused by Risperidona. [...] There are times that my eye turns outward because of the remedy, and then I take another one to counter it. [...] If I had a house, I would want to live there just so not to take so much psychiatric medication. Here they fill me up. My mouth always foams. [...] I have to take medicine for the head, for depression. [...] At night I take two Amplictil of 25, Risperidone, green tea and Dogmatil. They give medicine to punish us."

Celia diagnoses her problem as one of the "head," a semantic category used among the group to speak of mental affliction. Although they dis-

tinguish between different degrees of affliction, problems of the "head" are not a central issue in the daily interaction between them. Many acknowledge that they were interned because of being "bad in the head," but they attribute their long-term permanence to social abandonment by their families or relatives.

Within the conditions and limits of the institution, the residents interact in ways that express their personal desires and capacities for sociability. They exchange reciprocal forms of assistance and small gifts and form special friendships and romantic relations.

Along with the threat of the *patião* and forced medication, they regard participation in the hour of the *passe* as another form of coercion by the hospital, although the Kardicist Spiritists consider it to be a necessary complement to the pharmacological treatment. Sheltered Home residents are the only patients in the hospital required to attend the *passe,* which occurs after breakfast Monday through Friday, although interested patients from other wards are present. It occurs in a large hall that is also used for other kinds of performances or events in the hospital. Rows of chairs are lined up in the hall before an elevated stage where the Spiritists leading the reunion are located. The volunteer Spiritists who perform the healing touch sit among the patients. Normally the men sit on the left side of a central corridor with the women on the right. The hall seats approximately 200 people, but generally only 40 to 50 patients are present, given that participation is not obligatory for those of other wards. Lighting in the hall is dimmed and soft instrumental music plays in the background during the entire ritual. The hour of the *passe* is divided into two parts. First, Sheltered Home residents, together with the other patients attending, receive a lecture on the Kardecist spiritual doctrine. The lecture is followed by the *passe,* described as a type of blessing and energetic healing which transfuses positive energy (Kurz 2017). During the performance of the *passe*, the patients sit with their eyes closed, and the Spiritist volunteers silently go before each individual, placing their hands above their heads without touching them. The volunteer stands with closed eyes, open chest and head lifted to the heavens while he or she briefly transmits the energies from the invisible realm.

The *passe*: Multiple Discourses and Ritual Goals

Different explanatory models of disease and healing circulate in the hospital, the most obvious of which are biomedical and Spiritist, although other religious perspectives are present in both the caretakers and patients. As in other Spiritist medical institutions in Brazil (cf. Ciello 2019; Aureliano 2013), treatments representing these perspectives co-exist and can be seen as complementary, in spite of differing explanatory models of disease and cure. In the Spiritist Light Hospital, medical treatment for mental illness is primarily guided by the biomedical paradigm, with emphasis on the use of medicines. In the case of Sheltered Home residents, psychotropic substances predominate as biomedical therapy, given that psychotherapy sessions are basically non-existent. In their case, rather than psychotherapy, biomedical treatment is complemented by obligatory participation in the *passe* ritual that seeks to restore spiritual as well as physical health.

At the end of the 19th century, both Spiritism and psychiatry in Brazil sought social and institutional legitimization for their concepts and treatment of mental illness. Both biomedicine and Kardecist Spiritism were seeking to be recognized as "scientific" at the time, and Spiritism was successfully expanding its therapeutic practices based on the writings of Allan Kardec (cf. Aubrée & Laplantine 1990). Based on its perspective that all illness, including madness, is be a result of both physical and spiritual problems, Kardecist Spiritism developed a complementary association with biomedicine in various medical institutions, particularly in those of mental health. Spiritist medical professionals and administrators work alongside those who do not hold the same beliefs. All Spiritist medical institutions also have a corresponding spiritual counsel in the invisible dimension that cares for patients.

Along with the Spiritist Light Hospital, other institutions are run by philanthropic Spiritist foundations in the State of São Paulo (Camargo, 2017) as well as many other parts of Brazil (for Paraná see Ciello 2019, for Santa Catarina see Aureliano 2013). According to Hannes Stubbe (1987 *apud.* Kurz 2017), the Brazilian health system does not provide sufficient therapeutic resources for the population, particularly for psychological

and psychiatric afflictions. The healing practices provided by the Kardecists, which are viewed as acts of charity, have come to replace those of the official health sector on some occasions and offer free treatment to the population (Kurz 2017: 197). As in the case of *Spiritual Light Hospital*, several receive funds from the national *Unified Health System* to care for patients who do not have private health insurance, but as recognised by Helmar Kurz (2017), resources received from the government are insufficient for adequate patient treatment.

As Waleska de Araujo Aureliano (2013) has demonstrated in her study of the therapeutic-religious institution, the Center for Cancer Patient Support (CAPC), Spiritist therapeutic institutions in many ways organizationally and symbolically mimic those of biomedicine, while addressing the spiritual dimension of the patient's affliction. However, Spiritist treatment goals are more comprehensive than those of biomedicine and encompass a broader concept of *healing*, rather than the more limited biomedical concept of curing, which aims at the elimination of observed symptoms (Langdon 2013; Frank 1961).

According to Spiritism, illness is caused by acts performed by the person in his or her present life which compromised the balance between body, mind and spirit, or they may be caused by disembodied spirits, motivated by karmic debt, which act on the embodied subject causing disequilibrium a spiritual and mental order. In other cases, karmic disease may also occur because of choices made by the spirit itself during reincarnation (Aureliano 2013).

The objective of the *passe* is to extend beyond the material physical body connecting to a network of social actors who are both material and immaterial participants in a "religious field" for the care of illness. Maria Laura Viveiros de Castro Cavalcanti's (1983) pioneer study of the cosmology and ritual of Kardecist Spiritism describes the *passe* as an important ritual practice that has the double objective of treating the body and spirit. Through the *passe,* energy flows from the invisible world (that of the spirits) to that of the visible, the world of humans, through a medium. Even in cases of karmic illnesses that do not have a cure, it aims to restore the spiritual dimension of the patient through the transmission of energy (Cavalcanti 1983: 75). The efficacy of the *passe* depends upon the presence of a superior spirit, the ritual preparation of the medium and the capacity of the patient to absorb the energy through an attitude of good will.

The *passe* is not the only Spiritist ritual performed in the Hospital, but it is the only one of which they are aware. Disobsession rituals, as described by Fernando Ciello (2019) in his thesis on Spiritist therapy for mental patients in the state of Paraná, are also performed at the *Spiritist Light Hospital*, but without the patients' awareness. However, as mentioned, only the residents of Sheltered Home ward are obligated to attend the *passe* and see it as one of the coercive measures they are subjected to. This is in contrast to the Spiritist volunteers' explanatory model about the purpose and efficacy of the ritual. The volunteers who perform the *passe* are trained as mediums and their perspective as to its purpose and efficacy follows that of the group's doctrine - the healing touch is important because mental illness results from the acts of disembodied spirits that influence the mental functions of embodied individuals. The performance of the healing touch is an act of charity that addresses the spiritual aspect of madness.

Carol, a 66 year-old volunteer at the Hospital, explained:

> "My responsibility is to organize the *passe,* because there used to be a lot of talking, walking about [...] and little by little I started to discipline things, precisely for this, to transmit trust to them so that when they are in there, they feel that we're all there to help them. They sit and wait to receive the healing touch, and we raise our thoughts and ask God for this energy to come so that we can be a faucet that will pass this energy on to them. With the patients, there are *perispirits* from other beings that are already disembodied, that are ignorant. They aren't evil - they don't know good, and they suck energy from the patients. Okay, they have very refined techniques for this. Those obsessing spirits that suck them are called "spiritual vampires" and they suck the energy of patients. But you can't disregard the biological aspect, because there are people who have the genetics for schizophrenia, the genetics to be addicted to alcohol, they have their fathers' metabolism for that. This is something that has been proven; there's no doubt about it. So the patient can overcome a good share of it, and then what happens is she dis-

> embodies, loses that connection with the obsessing spirits, because the good spirits will help and improve her, she's born again, sometimes with an easier test, and she starts to overcome it. That's the aim. The treatment needs to be together, the biological and the spiritual, so that it has an effect. If you only do the physical, it will take really long, with only the spiritual sometimes you won't even solve anything."

Marcia, a 71 year-old volunteer, made a similar statement:

> "The *passe* is this, you're physically ill, lacking energy, you go to the hospital and they take blood ok? That's the physical part. When you're psychically ill, you're psychically in disharmony, you can receive the *passe*. As you go, spiritually speaking, elevating your thoughts, the range of your vibrations, you start to connect to spiritual mentors who are entities that have left their physical bodies but exist and are up there, but we don't see them. They are pure energy, and you contact them and start to become an instrument for transmitting these energies."

According to the volunteers, the aesthetics of the environment of the *passe* is also fundamental to this process, and the atmosphere created in the hall where the meetings take place is a rupture from the daily noise and activity of a psychiatric hospital. In the words of Rosângela, a 68 year-old volunteer:

> "The preparation of the environment for the transmutation of cosmic energy for the benefit of those who receive it is very important, so, it can't occur in any environment, if there's noise, if it's dirty [...] you know this, I don't need to say it, the environment of the Earth that is not conducive only produces bad things... Now, when the environment is good, prepared, you go in and straight away you notice that there's something different there. You've seen that I cry? I'm so tuned in that emotion comes just like that, you feel that good sensation, you know, as if you were in an air conditioner, as if it were a cloud [...] that's a fantastic moment, the more you harmonize with an environment, the more you'll help someone."

However, the residents of Sheltered Home do not express the same sensations or expectations when participating in this daily ritual. They are not motivated to attend and often attempt to escape participation. Few say that the healing touch makes them feel good. Valdir, a resident who has been institutionalized for over thirty years, expresses this sentiment, "For me the *passe* is like an obligation. It's part of the rules for living here, but to be honest, if I could, I wouldn't go." Some say that when they go to the *passe*, they feel bad, their vision darkens, and they feel a kind of dizziness. Others also say that they do not understand what the speakers are saying, and that the dark ambience makes them sleepy.

Rosana, a 64 year-old resident who has been institutionalized for 17 years, described the healing touch as follows:

> "It's [located] beside the *patião*. I go there every day, but it didn't happen today because of the rains. [...] we go there to the yard, you enter via the *patião*, follow the path, there's a room full of benches,... chairs, you go in there, sit down. There are men and women who talk about a pile of things. At times I fall asleep and don't even understand what they're talking about. I look and I see nothing, because it's sort of dark and with my eyesight I can't see. I only hear the voices. [...] You have to go to the *passe*, you know, it's good to take away the evils of the body."

Conscious of their denials or resistance to the healing touch, the volunteers seem to think that both the residents and entities causing the disease, the spirits obsessing them, should be treated like children who must be taught to behave appropriately. They thus claim that even when residents deny that they understand or do not want to participate in the ritual, it is crucial that they go, because the *passe* will not only treat the patient, but also the obsessing spirits that surround him or her. As far as the volunteers are concerned, it does not matter if the patients rationally understand the healing touch, since its efficacy does not depend on understanding, but on the gradual transformation of the patient and the obsessing spirits. This transformation of the patient and of the obsessing spirits can occur in the current life span or in future lives. Therefore, an irrational misunderstanding of the healing touch does not inhibit evolution in another carnal life. In that environment, illness – particularly chronic and degenerative diseases – are seen to be a part of the individual, and thus cannot effectively be "cured."

In spite of the fact that the residents do not perceive the possible therapeutic value of the ritual and hold no expectations regarding healing, participation in the ritual allows them to expand their field of social interaction for both affective or economic reasons. It is one of the few chances that they have during the day to interact with patients that reside in other wards of the hospital as well as with outsiders who are not part of the medical team, such as the volunteers who perform the *passe*. These encounters make possible the creation of networks beyond the limits of their ward and different forms of relations emerge. For example, one resident maintains a romantic relation with a patient she met when sent temporarily to the collective ward (*patião*). Since returning to her residence in Sheltered Home, the couple meets only during the *passe*, when they talk and exchange small gifts, such as fruit, trinkets or clothing. The *passe* is also a chance for the residents to find out about their friends who were sent to the *patião*. During my research, they always sought to find out about a former resident of Sheltered Home who, because of health problems, was sent permanently to the collective ward. Not only are expressions of friendship and affection witnessed between patients of other wards, but also they demonstrate fondness with some of the volunteers. One volunteer who is particularly expressive and affectionate with the residents is surrounded by them during the *passe*. They fill the row of seats beside her, touching and holding hands during the lecture.

The extended network also fosters economic exchanges during the hour of the *passe*. Because of a recently established smoking prohibition in their ward, the residents take certain objects to the *passe* in order to exchange them for cigarettes. One resident told us that in the public collective ward there was a lack of soap, so that he was able to exchange soap for cigarettes.

Although it is the intention of the Spiritist volunteers to create a special sacramental space during the "hour of the *passe*" in which the ritual performance results in transformation of the spiritual condition of the patients, we found that the ceremony addresses other needs and objectives of the permanent residents. For them, the *passe* helps to reorganize the institutional order, permitting the expansion of social and economic relations beyond the small group of 21 people that inhabit their small community. It provides the opportunity for new manners of living a permanently institutionalized life. Thus, the *passe* gives the opportunity for expanding the residents' experience. Although in the eyes of the residents, it does not strengthen or contribute to a spiritual network, it contributes to the satisfaction of their material and emotional desires and needs.

Healing Efficacy and Consciousness of the Patient

Discussions of ritual efficacy have long been a focus in anthropology. Early analyses, such as those of Claude Levi-Strauss (1975), Clifford Geertz (1966) and Victor Turner (1964), concerned symbolic action and the dynamics of the ritual process resulting in modifications of the inner state or perspective of the patient (Langdon 2013). Subsequently, with the performative turn in anthropology, theorists began to suggest that ritual efficacy lay not in semantic manipulation, but in the heightened aesthetic and sensorial experience created by performance that engages participants in dynamic interaction in specific contexts to bring about the creation of reality and the reordering of experience (Laderman & Roseman 1996; Langdon 2013; Schieffelin 1985). Through the concept of embodiment, Thomas J. Csordas (1990) has focussed on the work of culture and ritual upon the body. More recently and building upon these theories, Mark Nichter (2008) has suggested that sensorial anthropology should also be considered in order to understand how sensations are experienced phenomenologically, interpreted culturally, and responded to socially in ritual healing.[4]

Drawing upon these discussions, Helmar Kurz (2015, 2017, 2018a, b) has investigated the efficacy of Kardecist Spiritist rituals in mental health institutions in Brazil, including the *Spiritist Light Hospital*, and has endeavoured to explain how the *passe* works sensorially within Brazilian culture to bring about personal transformation and reintegration in mental health patients. Based on narrative interviews made with patients who were temporary residents of the private ward of the hospital and with mediums and patients in other parts of Brazil, he presents case studies of

those who have had successful outcomes through participation in the Spiritist *passe* and have moved from patients suffering from mental afflictions to Spiritist mediums who participate in the *passe* in order to help others. Helmar Kurz is concerned with the relationship between corporeal engagement and sensation that result in healing experiences conceived of as self-transformation by learning and changing habits: "Patients integrate into a stable and caring group, learn to act self-responsibly and experience self-empowerment by developing capacities of healing self and others" (Kurz 2017: 203). For him, Spiritism de-stigmatises mental illness, promoting strategies in which the person learns how to love and forgive oneself and others and to live an ethical life.

For Helmar Kurz, the "work with the senses" in Kardecist ritual concerns an ongoing process of self-awareness brought about by a rupture in habitual sensorial environment. During the *passe* there is a reduction of stimuli to acoustic sensations in order to stimulate the practice of listening. This is in contrast to the noisy and highly interactive environment that characterises Brazilian culture and social relations. The reduction to few acoustic stimuli evokes sensitisation of (self) perception as attention focusses on hearing voices and results in a shift of self-perception. The silent sensory experience of the healing touch intensifies this experience and through repetition, a new form of self-experience will be learned. For Helmar Kurz, the silence and aesthetics of the *passe* establish a meditative environment that marks a rupture from everyday interaction and attentive listening for the voices contributes to inducing trance, the shifting of consciousness and stimulating inner processes. He adopts the neuroscientific concept of interoception (Dox 2016; Farb *et al.* 2015) to refer to these inner processes, and suggests that the concept forms the bridge between anthropological interest in processes of embodiment and neuroscience's focus on related inner processes: "While anthropologists develop a growing interest in processes of embodiment in terms of how social and cultural factors influence state, behaviour, and experience of the human body, neuroscience focuses related processes within the body" (Seligman & Brown 2009 *apud.* Kurz 2017: 203).

Helmar Kurz's investigations in Brazil demonstrate the complementary relation between local religious and psychiatric explanatory models that result in mutual inspiration and practices of cooperation. His research on the success of Kardecist Spiritist practices that have been transferred to Germany highlight the potential for their healing efficacy in other cultural settings, concluding that illness explanatory models and healing practices are not necessarily reducible and exclusively linked to social and cultural frames or contexts, but also entail personal expectations, individual resources and emotional aspects (Kurz 2018: 37) that are related to the quest for explanations, coping strategies, and solutions for human conditions and experiences.

In spite of Helmar Kurz's valuable contribution of an analytical model that contributes to the understanding of the role of the senses in Spiritist healing, our study did not yield similar results with regard to the healing efficacy for the chronic inhabitants of Sheltered Home. This does not represent a failure in his model that joins anthropological concerns with those of neuroscience in order to understand the process of healing, but due to the different life conditions and personal resources of the patients interviewed by Helmar Kurz and those whose daily lives were followed in this residential ward. The patients interviewed by him were temporary residents treated in the private ward and received various modalities of psychotherapy and spiritual counselling. Their personal narratives expressed consciousness of their affliction and a desire to reduce medication and restore their emotional and mental wellbeing. They were engaged in their healing processes.

Those of the sheltered home have experienced very different life conditions. Institutionalization is perhaps the single most important condition of their lives, since it has shaped, in fatal ways, the diagnosis of mental illness and incapacity to live in the outside world. Obviously one reason is the condition of having spent the greater part of their lives in coercive institutions, with little or no contact with the outside world and with little potential of perceiving other possibilities in life. A second, and one that most probably limits personal resources for consciousness of their afflictions or engagement in a healing process is the forced ingestion over decades of psychotropic medica-

tions that cloud thinking and create sluggish somnambulist or highly agitated responses. For them, there is no apparent reason for why they are there nor do they envision any possibility of leaving the hospital. They do not tell narratives about their afflictions, nor do they perceive mental illness as a determining factor in their lives.

They are wards of the state; they have the status of minors with limited rights in a public psychiatric hospital in which the possibility or hope of being released is almost non-existent. As chronic inhabitants of the institution, they remake their lives within its limits, creating micro political movements through social interaction. These movements, or forms of resistance, emerge as strategies of survival of living subjects whose subjective experience is constructed within the confines of the social reality of the hospital. During the *passe*, the residents comply with the daily obligation to attend the spiritual treatment and yet resist engagement with the ritual performance, finding other ways of experiencing the moment, be it in the expression of affection, small economic exchanges or simply sleeping through parts of the ritual.

Final Consideration

In this article we have followed the institutional life of "Sheltered Home" to examine the coercive mechanisms exercised upon the residents and their relation with one specific obligation: the ritual of the *passe*. As residents inserted within a structure of institutional power, their experience and interpretation of this ritual process differs from the interpretations and intentions of the Spiritist volunteers who administer the healing touch or *passe*. Given that they are individuals abandoned by the social logic, they are part of a system that determines the routines to which they should live. Failure to comply or acts of disobedience are met with punitive measures. One such measure is increased confinement through banishment to other public wards, such as the *patião*, where they lose the few rights that they have, including the right to personal clothing or participation in brief trips outside the hospital. Heavy medication is another form of coercion, one that can be further increased in certain cases of unapproved behaviour. Among the obligations and rules that they must obey is the required participation in the daily ritual of the *passe*, intended by the hospital to heal the spiritual causes of their mental afflictions. Negation to attend the *passe* can result in punitive measures.

In spite of their expressed resistance to the *passe*, the residents attend the ritual, appropriating the event for their own purposes and desires. In this sense, they do not engage in the ritual process, seeking a therapeutic resolution that would liberate them from affliction. Rather, the hour of the *passe* represents an opportunity to explore other possibilities and desires in their institutional lives. They are able to increase the social field, relating to persons who reside outside the walls of the hospital, such as the volunteers, or communicating and trading objects with patients from other wards and from whom they are separated during other periods of the day. Generally limited to the confines of the sheltered home, they remake their social world during the *passe*, by resisting engagement with the ritual and expressing their personal desires and affections.

By emphasising their capacity to express other objectives through participation in the obligatory ritual hour, we do not seek to minimize their objective situation as chronic inhabitants of a psychiatric institution. In turn, we seek to respect them as humans with volition and resilience, valuing their subjectivities and experiences. Our study has shown what João Biehl (2016: 418) affirms as

> "[...] how people struggle, make and live their lives in spite of, by means of, or along with macrostructural forces [...] recognising the real effects of these forces on the lives of people: violence, inequality, limits, possibilities or opportunities."

The residents of Sheltered Home find different ways or means to remake their lives within the limits of the institutional order.

Although the ruptures in social relations caused by long years of internment have left marks on the lives of the residents of *Spiritual Light Hospital*, their resilience has enabled them to reconfigure these ruptures, generating the subjectivity of belonging to the social group with which they live (cf. Camargo 2017). This capacity to generate social networks contributes to the restoration of some of the forms lost through prolonged institutional life. Although they do not engage in the ritual hour seeking relief from or healing of men-

tal affliction, the *passe* offers opportunities for the enactment of agency, subjectivity and desire that permits them to construct ways of living beyond the institutional moral order.

Notes

1 In his well-known monograph *Vita: Life in a Zone of Social Abandonment*, João Biehl (2005) analyses the total abandonment of Catarina, a woman who has been interned in mental institutions for much of her life due to misdiagnosis and total lack of family support. Years of institutional treatment have left her speechless and crippled.
2 All are from the State of São Paulo, but only one is from the city where the hospital is located.
3 Approximately every three months there is an "assembly" in which the medical professionals meet with the group of residents to discuss the living experience and any problems in the ward.
4 Although Sidney Greenfield's (1999, 2008) studies of Spiritist healing in Brazil did not work specifically with the sensorial concepts suggested by Mark Nichter, his works argue that Brazilian culture has a role in the individual's readiness to respond and be affected by Spiritist rituals.

References

Amarante P. & M. O. Nunes 2018. A reforma psiquiátrica no SUS e a luta por uma sociedade sem manicômios. *Ciência Saúde Coletiva* 23, 6: 2067–2074.

Almeida A. & A. S. Angélica 2007. *Uma fábrica de loucos: psiquiatria x espiritismo no Brasil (1900–1950)*. Dissertation. Universidade Estadual de Campinas, Instituto de Filosofia e Ciências Humanas, Campinas, SP, Brazil.

Andrade A. P. M. 2010. O gênero no movimento da reforma psiquiátrica brasileira. In: S. W Maluf & C. S. Tornquist (eds) *Gênero, saúde e aflição: abordagens antropológicas*. Florianópolis: Letras Contemporâneas. 273–293.

Andrade A. P. M. & S. W. Maluf 2014. Cotidianos e trajetórias de sujeitos no contexto da reforma psiquiátrica brasileira. In: J. Ferreira & S. Fleischer (eds) *Etnografias em serviços de saúde.* Rio de Janeiro: Garamond. 33–56.

Aubrée M. & F. Laplantine 1990. *La table, livre et les esprits: naissance, évolution et atualité du mouvement social spirite entre France et Brésil*. Paris: Lattès.

Aureliano W. A. 2013. Terapias espirituais e complementares no tratamento do câncer: a experiência de pacientes oncológicos em Florianópolis (SC). *Cadernos Saúde Coletiva* 21: 18–24.

Bastos, O. 1997. A história da psiquiatria e da saúde mental no Brasil. *Journal Brasileiro de Psiquiatria.* 9, 46: 473–475

Biehl, J. 2005. *Vita: life in a zone of social abandonment*. Photographs by Torben Eskerod. Berkeley: University of California Press.

———— J. 2007. Antropologia do devir: psicofármacos - abandono social - desejo. *Revista de Antropologia*, 51, 2: 413–449.

————2016. Antropologia entre o inesperado e o inacabado: entrevista com João Biehl, *Horizontes Antropológicos*, 22, 46: 389–423.

Camargo M. A. 2017. *Dentre muros: uma etnografia sobre um hospital psiquiátrico*. Dissertation in Social Sciences. Campinas: Unicamp.

Carneiro N. G. O. & L.C. Rocha 2004. O processo de desospitalização de pacientes asilares de uma instituição psiquiátrica da cidade de Curitiba. *Psicologia, Ciência e Profissão.* 24, 3: 66–75.

Cavalcanti M. L. V. C. 1983. *O Mundo invisível: cosmologia sistema ritual e noção da pessoa no Espiritismo*. Rio de Janeiro: Zahar.

Ciello F. 2019. *A vida do diagnóstico: práticas terapêuticas e movimentos em uma clínica-dia*. Dissertation in Anthropology. Universidade Federal de Santa Catarina. Florianópolis, SC, Brazil.

Csordas T. J. 1990. Embodiment as a paradigm for anthropology. *Ethos* 18, 1: 5–47.

Cunha M. C. 1986. *O espelho do mundo.* Rio de Janeiro: Paz e Terra.

Delgado P. G. G. 1992. *Psiquiatras, juízes e loucos: modelos de interação entre a psiquiatria e a justiça, na conjuntura da luta pela cidadania plena e reforma psiquiátrica no Brasil*. Dissertation in Preventive Medicine, Universidade de São Paulo (USP), Brazil.

Del Sarto S. M. 2018. *Além da loucura*: *um estudo etnográfico no interior de um hospital psiquiátrico, espírita e asilar*. Undergraduate Monograph. Universidade Estadual Paulista (UNESP). Marília, SP, Brazil.

Del Sarto S. M. 2020. *Institucionalizados: Uma etnografia da vida social de moradores de um hospital psiquiátrico e asilar.* Master's Thesis in Anthropology. Universidade Federal de Santa Catarina. Florianópolis, SC, Brazil.

Dox D. 2016. *Reckoning with the spirit in the paradigm of performance.* Ann Arbor: University of Michigan Press.

Farb N. *et al.* 2015. Interoception, contemplative practice, and health. *Frontiers in Psychology* 6: 1–26.

Foucault M. 1997. *A história da loucura na idade clássica.* São Paulo: Perspectiva.

Frank J. D. 1961. *Persuasion and healing: a comparative study of psychotherapy.* Baltimore: John Hopkins University Press.

Geertz C. 1966. Religion as a cultural system. In M. Banton (ed) *Anthropological approaches to the study of religion.* London: Tavistock. 1–46.

Goffman E. 1961. *Manicômios, prisões e conventos.* São Paulo: Perspectiva.

Greenfield S. 1989. Pilgrimage, therapy and the relationship between healing and imagination. *Discussion Paper* 82. University of Wisconsin: Center for Latin America.

———— 1991. Hypnoses and trance in the surgeries of Brazilian Spiritist healer-mediums. *Anthropology of Consciousness* 2, 3+4: 20–25.

———— 1999. *Cirugias do além: pesquisas antropológicas sobre curas espirituais*. Rio de Janeiro: Vozes.

———— 2008. *Spirits with scapels: the cultural biology of religious healing in Brazil*. Walnut Creek: Left Coast.

Kleinman A. & J. Kleinman 1995. Suffering and its Professional Transformation: Toward and Ethnography of Interpersonal Experience. In A. Kleinmann (ed) *Writing at the margin.* Berkeley: University of California Press. 95–119.

Kurz H. 2015. "Depression is not a disease: it is a spiritual problem." Performance and hybridization of religion and science within Brazilian Spiritist healing practices. *Curare* 38, 3: 173–191.

———— 2017. Diversification of mental health care: Brazilian Kardecist psychiatry and the aesthetics of healing. *Curare* 40, 3: 195–206.

———— 2018a. Transcultural and transnational transfer of therapeutic practice: healing cooperation of Spiritism, biomedicine, and psychiatry in Brazil and Germany. *Curare* 41, 1+2: 35–49.

———— 2018b. Affliction and consolation: mediumship and spirit obsession as explanatory models within Brazilian Kardecist mental health care. In M. Nunes & T. P. Marques (eds) *Legitimidades da loucura: sofrimento, luta, criatividade e pertença*. Salvador, EDUFBA. 129–155.

Laderman C. & R. Roseman (eds) 1996. *The performance of healing*. New York, Routledge.

Langdon E. J. 2013. La eficacia simbólica de los rituales: del ritual a la performance. In B. C. Labate & J. C. Bouso (eds) *Ayahuasca y salud.* Barcelona: Liebre de Marzo. 80–119.

Lévi-Strauss C. 1975. A eficácia simbólica: o feiticeiro e sua magia. In *ibid.* (ed) *Antropologia Estrutural I*. Rio de Janeiro: Tempo Brasileiro. 193–213.

Maluf, S. W. 2010. Gênero, saúde e aflição: políticas públicas, ativismo e experiências sociais. In: S. Maluf & C. Tornquist (eds) *Gênero, saúde e aflição: abordagens antropológicas*, Florianópolis: Letras Contemporâneas. 441–457.

Montero P. 1985. *De doença a desordem:* a magia na Umbanda. São Paulo: Graal.

Nascimento C. M., C. D. Tesser & M. C. Sousa 2019. Traditional, complementary and integrative medicines in the Brazilian health primary care. *International Journal of Complementary & Alternative Medicine* 12, 6: 246–248.

Nichter M. 2008. Coming to our senses: appreciating the sensorial in medical anthropology. *Transcultural Psychiatry* 45, 2: 163–197

Ribeiro R. A. 2013. Loucura e obsessão: entre psiquiatria e espiritismo no Sanatório Espírita de Uberaba-MG (1933–1970). Dissertation in History, Universidade Federal de Uberlândia, MG, Brazil.

Schieffelin E. L. 1985. Performance and the cultural construction of reality. *American Ethnologist* 12, 4: 707–724.

Turner V. 1974. *O processo ritual.* Petrópolis: Vozes.

———— 1964. A Ndembu doctor in practice. In: A. Kiev (ed) *Magic, faith and healing*. New York: Free Press. 230–262.

Manuscript received: 10.12.2019
Manuscript accepted: 07.02.2021

SABRINA MELO DEL SARTO studied Social Sciences at the Universidade Estadual Paulista (UNESP) between 2014 and 2017. In 2018 she entered the Graduate Program of Social Anthropology of the Universidade Federal de Santa Catarina (UFSC). She obtained a Master's degree in 2020 and is currently studying for her doctorate with emphasis on Mental Health, Institutionalization and Hospital Ethnography. Her research is funded by CAPES.

INCT Brasil Plural/UFSC
C.P. 5178
Florianópolis, SC 88040-970
e-mail: sabrinadelsarto@hotmail.com

ESTHER JEAN LANGDON (Ph.D. Tulane University 1974) is a CNPq researcher and coordinator of the National Institute of Research: Brazil Plural – IBP (CNPq/INCT). She retired as full professor from the Graduate Program in Social Anthropology of the Federal University of Santa Catarina in 2014 and continues as advisor and voluntary professor. Her primary research themes are shamanism, anthropology of health, oral literature and performance. She has published throughout the Americas and Europe; the most recent books include Cosmopolitics among the SIona: Shamanism, Medicine and Family on the Putumayo River; Saúde Indígena e Políticas Comparadas na América Latina (with M. D. Cardoso); and Políticas públicas: reflexões antropológicas (with M. Grisotti). Her curriculum is registered with CNPQ https://wwws.cnpq.br/curriculoweb/pkg_menu.menu?f_cod=94F11130168720DB71ABA8AC99C5B986.

INCT Brasil Plural/UFSC
C.P. 5178
Florianópolis, SC 88040-970
e-mail: jean.langdon@ufsc.br

The Significant Walks Project

Aesthetic Articulations of Walking, Data, and Place

SHIRLEY CHUBB, ANN MOORE, NEIL BRYANT & KAMBIZ SABER-SHEIKH

Abstract This paper discusses how the *Significant Walks* (2014) research project explored the impact of walking with chronic low back pain (CLBP).[1] The project involved an interdisciplinary research team working with participants to document how the familiarity of personal walks might be understood as a measure of physical and mental experience. The research methodology combined point of view video documentation of each walk, with simultaneously gathered biomechanical data recording the movement of the spine. Verbal data on pain levels experienced whilst walking was also collected. Additional layers of visualisation were added to the synthesized footage as the team worked with participants to explore how the interpretive aesthetics of visual effects applied to each walker's documentary film of their walk could further express their experience of walking with CLBP. Driven by the biomechanical data, the intensity of these effects captured interoceptive visual narratives that explored place, movement and sensory perception.

Focussing on the importance of real-world experience, the project took research out of the laboratory and clinic to investigate how personal walks might act as a measure of the changing physical experiences associated with chronic low back pain. By engaging directly with each participant's environment, these encounters revealed how individualised documentation can simultaneously express quantitative and qualitative responses to physical experiences. The research methodology reinstated each participant's aesthetic interpretation at the core of understanding and engaged with the arts and health agenda, phenomenology and aspects of new materialism. The resulting films act as a communicative interface, conveying the impact and lived experience of the prevalent, but often overlooked, condition of CLBP and exploring the connectivity of human, site, materials, technology and environment.

Keywords Arts & Health, Visual Art, Physiotherapy, Phenomenology, New Materialism

Introduction: From Drawn to Digital Realities

The rise in creative responses to illness has evolved as a defined area of practice that brings health professionals and patient groups together to create viable shared understandings of health conditions. The efficacy of creativity is increasingly recognised as a viable way to develop shared understanding communicated as visual or other outputs. In 1917 during World War 1, surgeon and artist Henry Tonks' drawn documentation of soldier's facial trauma began to address issues of disfigurement and identity. Initially producing drawings of pre and post-surgical procedures as a documentary aid, Tonks work raised "uncomfortable questions about the nature of subjectivity and the ethics of viewing" (Chambers 2009: 579), where his use of fragile pastels as a drawing medium adds personality, delicacy and a sense of empathy to the documentary process (*ibid.* 587). Tonks' additional insight as a trained surgeon provided the objective quantitative assessment of surgical training alongside the subjective qualitative eye of the artist, setting a model for future investigative work that has increasingly brought artists, medics and health professionals together in analysing the impact of health conditions. In recent years art has been recognised as an important means to extrapolate the experiential identity of patients as significant to the lived experience of health conditions, and therefore as a catalytic point of reference that, when enabled through cre-

ative processes, can begin to create an interface between patients and clinicians. Key to this process is engendering in patients and participants a sense of confidence that their voice is valued and that the process of communicating through art, when effectively managed, can contribute real understanding and therefore more constructive pain or life management processes for both clinicians and patient participants.

The transferability of visual practice that informs medical and public understanding has become a keystone of funding within the burgeoning arts and health environment, with significant investment by funders recognising the value of creativity as essential to public engagement with health and other sciences. The range of outputs has been wide and varied, from autobiographical approaches by artists such as Jo Spence (2020) to collaborative projects where artists such as Deborah Padfield explore the value of visual images in the diagnosis and management of chronic pain (*ibid.* 2020b; Macek: no date). The arts and health agenda has generated a range of participatory projects that include active collaboration with children and older adulthood groups in a variety of contexts. These have included, amongst others, initiatives involving dance, music and walking projects, confirming that arts engagement can contribute to wellbeing and improved mental health in a variety of clinical, applied health and community contexts (APPG 2017). These initiatives have shed light on the benefits of experiential sharing and have variously generated site or participant specific insight into a range of physical and mental health conditions.

The role of technology has been varied across these initiatives but has predominantly been employed as a documentary tool to record events and capture live or performative interventions on site. The transferability of digital forms of documentation has enabled the wide dissemination of outcomes alongside still imagery of research methods and the resulting creative outputs. However, there is less evidence of technologies being used as formative elements of research and although in some work the use of clinical data underpinned creative responses, the direct incorporation of data as visual form has been less well investigated. Within *Significant Walks* the innovative use of synchronised data was the fundamental underpinning of the research, with digital visual documentation providing a vehicle for the expression of biomechanical data. The two processes of collecting video documentation and movement data simultaneously whilst walking, were co-dependent and provided bespoke visual records of each participant's walk.

The Context of Aesthetics Within Contemporary Arts and Health Research

Practice-based research within the creative disciplines has evolved and widened in recent years,[2] and interdisciplinary approaches to research have recognised the value of arts practice as an interface that creates co-related understanding between research fields, via creative outputs that effectively interpret the sciences to their varied publics. In addition, the burgeoning growth of arts and health agendas recognises creative interchange as an effective conduit for shared understanding between medics, allied health practitioners, patients and service users (APPG 2017). Inter- and co-disciplinary research teams now affirm the communicative value of embodied approaches to knowledge that can reveal the co-dependent dynamic of symptoms that individuals experience within particular cultural, social and familial environments (Murray 2015; Carel 2016a; Padfield *et al.* 2018, 2020a). Mixed methods and qualitative approaches to research have widened to affirm creative processes and the production of arts outputs as viable research, where outcomes prioritise the experience of the patient or participant as the formative producer, rather than the recipient, of knowledge. In some cases the process of generating knowledge through active, participative actions replaces the product as the locus of enquiry (Johnson 2010), with the hapticity of making (Pallasmaa 2009; Biggs *et al.* 2010; Ingold 2010; McNiff 2013), or the embodied nature of movement (Sheets-Johnstone 2011), seen as viable transferable knowledge systems. The resulting blend of knowledge informs researchers, patients and participants, with the former providing a framework of enquiry and the latter an expression of lived, contextual experience that can avoid the "abstractive and generalising" objectivity of science (Johnson 2010: 147).

Aesthetics, a seminal preoccupation of visual arts discourse, has likewise evolved beyond what might be understood as an experience received through the visual stimuli of traditional media such as painting, sculpture, printmaking or photography, to more bodily forms of interchangeable contemporary practice that accept the whole producer (or artist) and the whole viewer (or participant, and vice versa) as experiential partners. Key to this development within the visual arts, is a recalibration of how and what we recognise as aesthetic experience. Moving beyond the received definition of form, surface, palette, composition (and multiple other visual qualities or analyses), arts practice now includes propositional forms of visual practice that engage more fully with the original, more transferable, definition of *aisthetikos,* which Buck-Morss (1992) describes as "perceptive by feeling" (*ibid.* 7)**.** This return to the ancient Greek origins of the term redresses the modernist approach,[3] where aesthetics was primarily applied to "cultural forms rather than sensible experience, to the imaginary rather than the empirical, to the illusory rather than the real" (*ibid*.). This modernist understanding of aesthetics continues to preoccupy the financially driven economy of the visual arts, although new seams of inclusive creativity have been redefined within the wider fields of socially engaged, performative and collaborative arts agendas (Bishop 2006; Thompson 2012).

Pre-empting these developments, Dewey's (134: 36) notion of situated aesthetic experience recognised that the basis of a non-hierarchical lived engagement with the production or experience of art, relied on the "interaction of live creature and environing conditions" (*ibid*.) where "every successive part flows freely, without seam and without unfilled blanks, into what ensues" (*ibid.* 37).

Dewey's thinking has evolved in to the interdisciplinary theories of new materialism (Bennett 2010; Van Der Tuin & Dolphijn 2010; Haraway 2016) and object oriented ontology (Harman 2017), where lived experience acknowledges the parity of human and non-human interactions, or 'intra-actions' as Barad (2007) calls them. The resynchronised worlds of new materialism and object-oriented ontology have been readily accepted into contemporary arts discourse and are already familiar within creative practice, where the process of making, haptic knowledge and engagement and exchange with materials and sites are familiar concepts to visual artists, musicians and performers.

Significant Walks reflected these new realms of experiential, lived, site based experience through the research team's mutual interest in the resonance of walking as an interpretive tool. The team came together in response to Chubb's (cf. Hilty *et al.* 1995; Patrizio *et al.* 1998; Chubb 2011), methodology of manifesting physical measurements of time and space within particular sites. This work had generated a number of site specific exhibitions, most pertinent here being her extensive work on the life and evolutionary legacy of Charles Darwin. Chubb's (2004) site-specific exhibition *Thinking Path,* took Darwin's daily ritual of walking the same path in the grounds of his family home as its inspiration, resulting in a composite work of 1400 images that considered his life and the expansive legacy of his theories. A second exhibition, *Pen Rest* (2014), further explored the empirical roots of Darwin's theories through ongoing engagement with UK sites of seminal relevance to his upbringing (Nicol 2014).

A Synthesized Qualitative and Quantitative Methodology

Initiated by the collaborative team of artist Dr. Shirley Chubb, musculoskeletal physiotherapy specialist Prof. Ann Moore, biomedical engineer Dr. Kambiz Saber-Sheikh and digital artist Neil Bryant, *Significant Walks* took place in two communities in Chichester and Brighton in the South East region of the U.K. The research generated an immersive digital artwork synthesizing eye level video documentation of participant's personal walks with simultaneously gathered biomechanical data. The research team worked with walkers to explore how the interpretive qualities of visual effects software could be applied to individually documented walks in order to express the nature and challenge of personal movement on regularly encountered walks. Open calls via the researcher's universities and via community magazines widely read in the urban centres of each city, recruited eight female and four male participants ranging in age from 26 to 64. The participants were variously part and full time employed or retired and rep-

resented a spectrum of socioeconomic profiles. Coming from a range of social and cultural backgrounds and taking a variety of work related and recreational walks, the participants often reported that their walk allowed space for reminiscence and reflection on past experience and ability. One participant had experienced a period of homelessness and returned to the rural environment that was his home during this time. One participant took an internal walk at a workplace, where the applied effects were extreme and reported as reflecting the anxiety and time pressure felt when managing CLBP in the work environment. By capturing real world experiences of this eclectic group of individuals within their chosen environments rather than laboratory-based simulations (Ingold 2007, 2010; Bunzli *et al.* 2013), the research manifested the raft of daily social, environmental and cognitive influences that impact on individual experiences of walking.

Fig 1: *Significant Walks* (2014). Exhibition, Otter Gallery, University of Chichester

The case for the research was underpinned by the authors' personal experience of the condition and the broader impact of CLBP which has been identified, globally, as one of the five leading causes of years lived with disability (Vos *et al.* 2017). As Maniadakis (2000) reported, the economic burden of low back pain has been known for some time and continues to be an area of particular economic and social concern, with an estimated 80% of people in the U.K. suffering with back pain at some stage in their lives. People with CLBP describe the problematic nature of legitimising their condition, feeling that people do not understand their experience and that, at times, they are not believed (Froud *et al.* 2014). The impact of chronic low back pain on sufferers can be profound with people describing a "loss of self" and the search to legitimise their pain for themselves, family and colleagues (Woby *et al.* 2007; Bunzli *et al.* 2013; Froud *et al.* 2014).

Collaboration between the artists, recruited walkers, a physiotherapy specialist and biomedical engineer provided the opportunity to realise onsite experiential accounts of the condition rather than relying on the constructed reality of laboratory-based simulations. Within this process the key research questions were:

How can art be used to explore the resonance of location, social context and life experience on the lived experience of CLBP?

How can synthesized digital technologies be used to document physiological and cognitive experiences of walking with CLBP?

How can the respective qualitative and quantitative research methods of each discipline be combined to manifest participants experience of CLBP and therefore develop enhanced insight, knowledge and greater understanding through creative enquiry and research methods?

The research methodology drew upon Solnit's (2001) insightful assessment that

> "Walking is usually about something else – about the walkers character or encounters, about nature or about achievement, sometimes so much so it ceases to be about walking" (*ibid.* 132).

The significance of walking challenged the research team to find a process that could encapsulate the interplay of experiential and contextual influences present within the act of walking with CLBP. A series of lab-based pilot studies tested the potential of coordinating the use of lightweight high definition video cameras to record eye level views of walks, with a simultaneous use of inertial sensors to monitor and collect posture and movement data. The twelve participants contributing to the project were invited to identify a familiar, regularly encountered walk of around ten to fifteen minutes duration and were accompanied by the research team recording video and biomechanical data throughout their walk. The use of video was important in capturing the individual

Fig 2: *Significant Walks* (2014): Subject 11 project walk

Fig 3: *Significant Walks* (2014): Subject 10 project walk

circumstance of each walker's lived experience and acknowledged Pink's (2007) and Skinner & Gormley's (2016) assertion that visual data can explore and represent the relationship between visual and other forms of knowledge about place, identity and status. In this context walking is seen as a physical challenge that can also act as a measure of memory, loss and achievement, becoming a metaphor for how participants, and consequently viewers, might understand our sense of engagement with the world as we consider how we internally and externally respond, interact and navigate through environments.

The simultaneous use of documentary and biomechanical technologies allowed the capture of movement and momentum within context, enacting Sheet-Johnstone's (2011) observation that

> "wherever there is animate movement, an individual of whatever order is not just doing something—'acting'—but is experiencing it kinaesthetically and/or proprioceptively" (*ibid.* 477).

The multifaceted nature of the research method captured intersecting data streams with its synchronisation enabling internal data to affect external documentation when adapted through the addition of visual effects by each participant. Most of the participants had minimal experience of using visual effects software although all had acquired IT skills and, with the support of the research team, responded well to the technology available. Two of the youngest participants (aged 24 and 36) were familiar and confident in the use of software and were able to develop their visual responses more independently once introduced to the process. As a whole the group produced variously nuanced responses as they developed visual adaptations of their synchronised footage.

Five stages of development brought the researchers and walkers together, with the initial session led by the author to provide an overview of the origins of the project and the processes and equipment that would be used. A schedule

Fig 4: *Significant Walks* (2014): Subject 12 project walk including research team monitoring data capture, Photo: Shirley Chubb

of walks was then agreed, with each individual taking their chosen walk accompanied by the research team who were collecting real time, onsite data throughout each walk. The second walk-site session required each walker to wear a small head mounted video camera alongside the use of miniature 3D inertial sensors taped across the participant's spine to collect kinematic data.

The resulting stream of continuous biomechanical data recorded the movement of the spine whilst one researcher prompted walkers to estimate their pain level on a scale of 1–10 at regular intervals during the walk. The walkers were also invited to comment on their reasons for choosing their walk with the memories and thoughts prompted by walking collected within the video documentation. This discursive element of data collection was crucial to encouraging each participant to discuss the significance of their walk, commenting on personal reminiscence or anecdote as well as the nature of the walker's physical experience at the time. The significance of each individual's walk was critical to this process as the synthesis of video documentation with kinematic pain data created tangible visual representations of the link between internal and external movement. Once each walk was completed the research team used rendering software to synthesize the documentary footage and kinematic data creating a blended film that could then be further adapted by each walker to represent their personal reflections and interpretation of pain whilst walking. At the third research session each participant was shown their synchronized film and was invited to consider how visual effects could be used to interpret the specific nature and challenge of their movement whilst walking their chosen route. Using laptops provided by the project, and with the help of the research team, each walker made choices from a menu of digital effects that could enhance the colour and saturation levels applied to their footage/data sets.

This key stage of the research process involved one to one interaction with each participant to introduce the range of available effects. Consequent support helped each participant to investigate how the use and duration of visual effects at different stages of their walk could communicate their individual experience of walking. Key to the process was how the kinematic data drove the effects applied to the video documentation, with the resulting films pulsating in direct correlation to each pace of a walk as the hybrid streams of video, data and visual effects became one seamless document of each walker's experience. Participants were then invited to a fourth meeting where, with the help of the research team, they could refine their choices and make any necessary changes to their footage.

These individual outcomes were then edited and combined to produce a cumulative video artwork featuring each participant's walk. A final fifth session provided the opportunity to discuss the edited composite film, with participants invited to reflect on how the process of monitored walking and the application of visual effects software to their individual films reflected their experience of walking with CLBP and helped them to understand, and potentially manage, their condition.

Case Studies

The case studies cited include comments on the project at the production stage and also at a post-production focus group, where only female participants responded to the invitation to discuss and reflect on the project. Their experiences are varied and show how some walkers focussed on effects to register discomfort or anxiety whilst others adopted more positivist approaches recording achievement and enjoyment and how this relieved stress.

Case Study 1: Participant 01

Participant 01 was a 51-year-old female working as a library resource assistant within a higher education campus library. At the time of the project, she had suffered with CLBP for 4 years and described "having to sit down and get up like an elderly person." (Interview 2013-04-13) Her back pain had significant impact on her quality of life, restricting her mobility and consuming much of her time in the careful management of physical activity. In a post-production discussion on living with CLBP she commented that "you're weary because you're [...] pushing through the pain barrier, you're not just occasionally having spikes of pain... I'm just tired, I'm mentally and physically tired." (Interview 2015-01-09)

Participant 01 was supported in her work environment where possible but found being in active external environments challenging, at times feeling vulnerable as her limited mobility made it difficult to respond to crowded or highly active environments (for example in one data collection session she was concerned by a cyclist passing close by her on the pavement). However, Participant 01 was also a resilient and determined individual who walks a significant distance (ca. four miles), to work and back on a daily basis. She saw her ability to maintain mobility as crucial to maintaining her professional life and took an active approach to managing her condition. She was interested in the research project as a means to understand her physical condition and also saw it as a way to show work colleagues that she was "taking the initiative to deal with a health problem that could be career-curtailing as worst and disruptive at best" (Interview 2013-07-19). Through habit and force of circumstance Participant 01 had developed an acute visual awareness of her environment and chose to use her daily journey to work as her subject walk. During data collection and the consequent manipulation of her synchronised documentation, she paid particular attention to street surfaces, carefully monitoring where pavement repairs resulted in uneven surfaces, and potential obstacles to her walk such as refuse bins. She also frequently glanced around her to make sure that faster walkers didn't force her to stop abruptly as this was a painful process for her. She had also developed other internalised methods to manage the discomfort of walking, most significantly her habit of playing out the rhythm of music in her head to pace and preoccupy her and to mitigate against the "ever-present ache and intermittent bolts of pain" whilst walking. (Interview 2013-07-19)

Participant 01 became every involved in the research process and appreciated the sense of engagement and community that it offered to her. She initially contributed her regular walk to work and followed this by taking a second recreational walk where the visual effects applied to her footage were in stark contrast to her daily walk to work. The former applied careful delineation of the walk, making specific changes in effects across the duration and terrain of the walk. For instance, from a tunnel effect whilst stationary at junctions, as pausing within a walk was uncomfortable, to an intense pulsating spherical interference in the video whilst walking uphill. For the second, recreational walk the effects used were softer, more positive in feel and included negotiating the inclusion of a key word at the start of the walk to reflect the sense of ease and positivity felt when walking in a less crowded or time limited setting.

In the post-production discussion Participant 01 contributed a range of commentaries including the sense of empathy and enlightenment she felt in response to the project and how reflecting on the relationship between the oscillation of her biomechanical data and the resulting intensity of visual effects had shown her

> "how one side was more obvious that than other side, I'd never known that before. And that was a revelation to me [...] That kind of knowledge helps you to deal with the thing, adding further that all these things are like building up knowledge about myself that no GP or specialist in the MRI clinic is going to tell me [...] It's very useful to understand

> the physical pain and help you mentally deal with it." (Interview 2015-01-09)

Case Study 2: Participant 03

Participant 03 was a 46-year-old female administrator who had been living with CLBP since injuring her back as a child during a sports activity. She described how her condition impacted on her work life where the sedentary nature of her job could cause stiffness and discomfort. She also reported that interaction with her young daughter was problematic at times as she could not move quickly or spontaneously. Participant 03 chose the daily walk to collect her daughter from school and described this regular walk as beneficial in loosening her up after a day at work with increased mechanical mobility meaning that painful twisting became less likely. She also commented that this walk provided relaxed time with her daughter during otherwise busy schedules.

Participant 03 developed a sensitive adaptation of her synchronised footage, bringing together both positive and negative aspects of walking by making use of a variety of visual effects. She made specific references to short passages of the walk as exemplary of particular issues when walking with her daughter. For instance, one passage of walking prompted an awareness of the flexibility she had lost and how in watching her daughter "jump and run around and [...] climb over the wall and not think twice about it", she would "always get to that bit and think, oh I wish I could do that." (Interview 2015-01-30)

Throughout the research it was clear that Participant 03 took an anticipatory approach to walking, recognising potential problems and adjusting to accommodate each change to the walking surface such as exposed tree roots, street furniture or inclines. She described this process as

> "like mild stress, that kind of how or where I'm walking what's going to happen, what if it's going to be uneven, where is it going to be uneven [...] because you can't actually always tell" (Interview 2015-01-30).

She found the research process thought provoking and enabling, enjoying the opportunity to talk and recognise the experience of others during social and focus group discussions. In reflecting on her adapted footage she enjoyed the opportunity of taking time to

> "think about the fact that it's just one part of the day, one little journey, but it's something I do regularly. [...] And that you don't often focus on how you are physically until you stop or something makes you stop" (Interview 2015-01-30).

Continuing to add that "doing this made me stop and think about the fact, oh this is what happens to my back, this is the effect it has [...] but I hadn't really stopped and thought about how much it affects what I chose to do" (Interview 2015-01-30). Participant 03 also noted that taking part in the project, and the visualisations of her condition that resulted "kind of drew a line for me [...] I realised what the impact [of CLBP] was and since then [...] I've been trying to do things to help myself a bit more." (Interview 2015-01-30)

Case Study 3: Participant 07

Participant 07 was a 41-year-old occupational therapist who has lived with CLBP for 20 years. Her condition was pervasive and all consuming (she reported a 10/10 when pain was at its worst), and affected her when moving or stationary, with working at a computer being particularly problematic at times. Her professional experience meant that she was familiar with some work-based issues relating to her condition and that her father's similar experience had given her some medical reference points.

She was also affected whilst walking outdoors and reported that CLBP meant that she was often anxious about being in unfamiliar places. She had experienced relatively pain free periods for a number of months but that these were "followed by periods of constant (though changing) pain for months [which] is depressing because I don't know why it suddenly comes back and whatever I do in terms of management (exercise, relaxation, hot/cold, daily stretches, pain relief), doesn't make it go away." (Interview 2013-04-13)

Participant 07 took a very contemplative approach to walking a familiar rural route close to her home as her walking subject and walked barefoot resulting in an enhanced symbiosis of pace and place that was delicately communicat-

ed as she carefully placed her feet to the ground throughout her walk. She used her walk as a measure of ability, reporting that she responded to her physical state during these regular walks grading "how bad things are by how much that I can do." (Interview 2015-01-30) Walking was an integral part of her schedule and she reported

> "even if I can just get out to that very first bit I feel like life's going to be alright, and I can still get outside, and you know just being in nature, will just cheer me up, but the further along that I manage to go the more I feel like, okay I'm not just going to be house bound or you know unable to walk and [...] so it's kind of like a therapy." (Interview 2015-01-30)

The effects Participant 07 chose were linked to positive feelings of being aware of and at times overcoming pain. Her film had a tangible sense of rhythmic pacing with the use of visually soft effects subtly animating her rural surroundings, producing a sense of her being in tune with the natural environments she enjoyed. Although perhaps one of the more subtle visual interventions, Participant 07's manipulation of data often held viewer's attention as she walked through a verdant edgeland landscape with gently rolling inclines and, at times, overgrown pathways. In reflecting on her adapted film Participant 07 commented that the effects used were depicting

> "an awareness of my back and they were sort of rhythmic things [...] like I would feel the muscle in my back or if there's a particular point [...] I would feel it rhythmically as I'm going along" (Interview 2015-01-30).

For Participant 07 the opportunity to reflect anew on her condition and, importantly, see the results of that reflection, were enabling. She pinpointed particular phases of her walk with real accuracy commenting that, when going uphill

> "I feel like I can achieve something, so psychologically even though there's more pain [...] I feel like maybe it's a way of thinking, I'm coping with this pain, it's still a way of getting up this hill, even though I can feel that point in my back quite clearly." (Interview 2015-01-30)

The Realisation of Phenomenology and New Materialism

The above case studies encapsulate how participants realised the experiential impact of the research when adapting their footage. The objectivization of each walking experience, externalised and viewed on screen, allowed them to recognise and animate cognitive aspects of their walking experience, indicating new levels of insight into the impact of CLBP for physiotherapists. In embracing visual outcomes as a means to reflect on their walking, the Case Studies indicate how participants were able to bridge the gap between the biomedical understanding of the lived experience of CLBP and the impact and significance of the biopsychosocial nature of living, functioning and managing the condition (Bunzli *et al.* 2013).

The recalibration of what and how data was gathered, with an emphasis on taking the research out of constructed laboratory conditions and into the real world, enabled a more immediate understanding of the impact of daily experiences of walking with CLBP within urban and rural environments. Although supported in her workplace, Participant 01 often found her external urban environment challenging, with street furniture, traffic and other road and pavement users at times impacting on her sense of progression and confidence. In contrast, her second recreational walk embraced the positivity of her whole environment, as vividly captured in her addition of the word "alive" to a seafront promenade (see Fig. 7), acknowledging an enabled mindset that was able to reflect on the positivity of her wider life experience and cultural heritage. Manifesting what Dewey (2005) recognises as the "dependence of the self for wholeness upon its surroundings" (*ibid.* 61), Participant 01 also reflects how the immediacy of visual representation can encompass a multiplicity of experience. In this way the personalised footage of her walking encounters reflect Bennett's (2010) consideration of new horizons of agency that move beyond the human, acknowledging Merleau-Ponty's awareness of "motor intentionality" and the "agentic contributions made by an intersubjective field" (*ibid.* 30). Likewise, Participant 01's reflective reengagement with familiar landscapes can be seen to manifest what Bennett advocates as a widen-

ing framework of experience that includes the non-human influence of other vital or "vibrant" materialities (*ibid.*).

The experience of Participant 03 also revealed how the significance of place and company (in this case the company of her daughter), can prompt enhanced understandings of past and present physical abilities. The lively, playful walking of her daughter allowed Participant 03 to meaningfully reflect on her own comparative experience, initially considering the impact of CLBP and her own compromised flexibility. However, the consequent process of reviewing and manipulating the documentation of her walk led to her realisation that an embodied engagement with place allowed a heightened sense of agency in how she might actively manage her condition. The lines of communication between her understanding of her own ability and that of her daughter, experienced across a repeatedly walked route between home and school, reflects Bennett's (2010) suggestion of a wider field of inclusion where, (revisioning Bruno Latour's term) the "actants" enmeshed within an environment, create a vital materialism "with more channels of communication between members" (*ibid.* 104).

Participant 07's choice of walking barefoot indicated an acute sense of connectivity and trust in a familiar landscape, reflecting Merleau-Ponty's (1996) consideration of being "thrown into nature, and that nature appears not only as outside me [...] but is also discernible at the centre of subjectivity" (*ibid.* 346). Her sense of connectivity when walking was felt rhythmically (a sensation echoed in Participant 01's account of matching the rhythm of music to her walking pace), indicating a kinaesthetic self-awareness that was further echoed in the process of footage manipulation where the use of shimmering visual effects animated her sense of moving through and "being in nature." This heightened sense of communication through visual rather than spoken or written accounts of walking experience, captures what Sheets-Johnstone (2011) describes as "an aliveness that language [...] can and often does fail to capture" (*ibid.* 435).

The case studies indicate how the methodology embraced walking as an arts practice that could act effectively as an interface for communicating biomedical knowledge (cf. Walking Artists Network). Situated within contemporary site specific arts practice (O'Rourke 2013; Fulton 2020; Long 2020; Prodger 2020), the research simultaneously created conceptual partnerships between artists and physiotherapists with the phenomenological basis of the work (Merleau-Ponty 1996; Moran 2000; Weiss 2008; Diprose & Reynolds 2009) providing a key element of connectivity for the interdisciplinary expertise that each researcher brought to the project. Importantly, the methodology also pushed at the boundaries of discourse surrounding patient-centred agendas, with the participants and researchers co-dependently creating new understandings that relate to the health sciences and health psychology (Murray 2015; Carel 2016a,b; VOS *et al.* 2017). The expanded process of active, site-specific interview and documentation additionally speaks to current debate in sociological, anthropological and ethnographic discourse (Coles 2000; Ingold 2004, 2011a,b; Pink 2007; Urry 2007).

Whilst phenomenology addressed the human within the research, as the project evolved and continued to be disseminated in a variety of contexts, the relevance of the new materialist agenda became apparent, acknowledging the permeable nature of the research. Participants, researchers, technologies, sites and the environmental context of each encounter constituted a whole, hybrid experience where no one element could be recognised without being seen through the visual conduit and agency of the other human and non-human partners in action. Haraway (2016) uses the term *sympoiesis* to encapsulate this thinking, seeing the term as "proper to complex, dynamic, responsive, situated, historical systems [...] for worlding-with, in company" (*ibid.* 58). These discussions (Bennett 2010; Van Der Tuin & Dolphijn 2010; Haraway 2016; Harman 2017; Ferraris & Terrone 2019) are defining new systems of thinking that move beyond the anthropocentric to conjoin objects, materials and environments with the human as co-dependent, co-affecting and co-responsive partners of experience.

Conclusion

Significant Walks was predicated on the "vision" of the participant to record highly individualised reflections on the compromised nature of walking with CLPB in a variety of rural and urban envi-

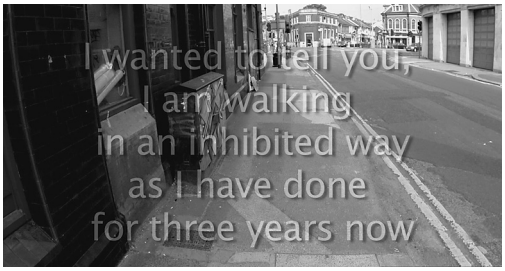


Fig 5: *Significant Walks* (2014): Subject 01 (walk #1), still of footage including digital effects and participant statement

Fig 6: *Significant Walks* (2014): Subject 03, still of footage including digital effects and participant statement

ronments. Each individualised account generated a unique, holistic account of walking through the incorporation of internal and external movement data. Quantitative biomechanical data recording the movement of the spine was synthesised with simultaneously recorded qualitative data capturing each walker's environment, with the consequent application of interpretive visual effects capturing individual responses to each walking experience. In this way the aesthetic of the research was multi-faceted, with each walker's documentary film enmeshed and unfolding from the internal source of the body. This process created an enhanced visual awareness of movement through particular environments as each walker sought ways to represent their cognitive sensory response to their body in motion and in context. These blended responses were intriguingly objective and subjective, realising Barad's (2007) notion of intra-activity, as each participant's internal biomechanical data rippled out to affect the perception of their chosen walk-site. Each walker, when presented with their footage saw their environment afresh and used their interaction with the embedded but "invisible" internal monologue of biomechnaical data recording their movement to affect their representation of walking through visually reconfigured external environments. Key to the realisation of the research, was the recognition of technology as an enabling, immersive and inclusive tool that democratises experience and the dissemination of outcomes (Hansen 2006; Alexenberg 2008; Stern 2013).

Significant Walks relied on a wholly collaborative approach reflecting aspects of the inclusivity of new materialism (Bennett 2010; Haraway 2016) alongside the formative use of technology to enable liberated, interactive, democratic understandings of self, site and circumstance. The research created knowledge that was "experientially exploratory" rather than "goal orientated" (Stern 2013: 48). By applying a new experiential rubric that relied on collaboration as the basis of shared knowledge, the research also challenged how contemporary visual practice often views the aesthetics of production through the lens of "lone" experience.

Significant Walks showed that collaborative interdisciplinary expertise and the use of emerging technologies to manifest quantitative and qualitative data can democratise the understanding of CLBP within lived environments. The research developed enhanced knowledge and understanding between health professionals, participants and the viewing public and the research was widely disseminated across subject disciplines promoting an increased understanding of a frequently misunderstood and misinterpreted condition within wider health-related and public communities. The innovative methodology, which to our knowledge has not be carried out before, indicates developing understanding, particularly in the field of Musculoskeletal problems. The visual and academic outcomes of the research addressed aspects of new materialism by remapping the body as a blended experience of internal movement permeated by a recalibrated awareness of surrounding environments. The participant walkers contributing to the project felt enabled by the research process, both in developing enhanced self-awareness and the consequent potential to manage their condition more effectively. The collaborative and co-dependent nature of the research relied on a synthesis of content as internal biomechanical data interacted

Fig 7: *Significant Walks* (2014): Subject 01 (walk #2) still of footage including digital effects participant statement

with the visual documentation of urban and rural sites. Bringing together researchers and participants as co-dependent producers responding to particular environments, the research recalibrated post-modern aesthetics through a return to the origins of the term *aisthetikos* as a rubric that understands sensory experience as legitimate, multifaceted knowledge.

Notes

1 *Significant Walks* was funded by the Wellcome Trust https://wellcome.org/
2 Here the creative disciplines include visual art, craft, design, film, dance and music.
3 The period of social and cultural "modernism" which we refer to, began in the early twentieth century and saw artists exploring new imagery, techniques and materials as they sought to reflect the "realities and hopes of modern societies" (cf. Tate 2021)

Acknowledgments

Significant Walks was funded by the Wellcome Trust and was disseminated internationally in a range of subject related conferences, symposia and publications. The *Significant Walks* research team would like to thank all of the project participants for their time, commitment and insight.

References

Alexenberg, Mel (ed) 2008. *Educating artists for the future: learning at the intersections of art, science, technology and culture*. Bristol: Intellect.
All Party Parliementary Group on Arts 2017. *The Inquiry Report, Creative Health: The Arts for Health and Wellbeing*. 2nd edition.
Barad, Karen 2007. *Meeting the universe halfway: quantum physics and the entanglement of matter and meaning.* Durham: Duke University Press.
Bennett, Jane 2010. *Vibrant matter: a political ecology of things*. Durham: Duke University Press.
Biggs Michael & Henrik Karlsson (eds) 2010. *The Routledge companion to research in the arts.* New York: Routledge.
Bishop, Claire 2006. *Participation*. London: Whitechapel.
Bourriaud, Nicolas 2002. *Relational aesthetics*. Dijon: Presses du Réel.
Buck-Morris, Susan 1992. Aesthetics and Anaesthetics: Walter Benjamin's Artwork Essay Reconsidered, *October* 62: 3–41. doi: 10.2307/778700.
Bunzli, Samantha *et al.* 2013. Lives on Hold: A Qualitative Synthesis Exploring the Experience of Chronic Low-back Pain. *The Clinical Journal of Pain*, 29, 10: 907–916.
Carel, Havi 2016a. *Illness: the cry of the flesh.* London: Routledge.
––––– 2016b. *Phenomenology of illness.* Oxford: University Press.

Chambers, Emma 2009. Fragmented identities: reading subjectivity in Henry Tonks' surgical portraits. *Art History* 32, 3: 578–607.
Chubb, Shirley 2004. *Thinking Path*. Shrewsbury: Museum Service.
———— 2011. Location and intervention: visual practice enabling a synchronic view of artefacts and sites. In S. Dudley *et al.* (eds), *The Thing about Museums: Objects and Experience, Representation and Contestation*. London: Routledge. 199–213.
Coles, Alex (ed) 2000. *Site-specificity: the ethnographic turn.* London: Black Dog.
Dewey, John 2005. *Art as Experience*. London: Penguin.
Diprose, Rosalyn & Jack Reynolds (eds) 2009. *Merleau-Ponty: key concepts*. Stocksfield: Acumen.
Ferraris, Maurizio & Enrico Terrone 2019. *Cinema and Ontology*. Milan: Mimesis.
Froud, Robert *et al.* 2014. A systematic review and meta-synthesis of the impact of low back pain on people's lives. *BMC Musculoskeletal Disorders* 15, 1: 1–15.
Hansen, Mark 2006. *New philosophy for new media*. Cambridge: MIT.
Haraway, Donna (2016) *Staying with the trouble: making kin in the Chthulucene*. Durham: Duke University Press.
Harman, Graham 2017. *Object-Oriented Ontology: A new theory of everything*. London: Penguin.
Hilty, Greg *et al.* 1995. *Hold: acquisition, representation, perception: work by Shirley Chubb*. Brighton: Green Centre for Non-Western Art and Culture at the Royal Pavilion, Art Gallery and Museums.
Ingold, Tim 2004. Culture on the Ground The World Perceived Through the Feet. *Journal of Material Culture* 9, 3: 315-340.
———— 2007. *Lines: a brief history*. London: Routledge.
———— 2010. *Making: archaeology, anthropology, art and architecture*. London: Routledge.
———— 2011a. *Being alive: essays on movement, knowledge and description*. London: Routledge.
———— 2011b. *The perception of the environment: essays on livelihood, dwelling and skill*. London: Routledge.
Johnson, Mark 2010. Embodied Knowing Through Art. In M. Biggs & H. Karlsson (eds). *The Routledge companion to research in the arts,* 1st ed. New York: Routledge: 143–151.
Mandiakis, N. & A Gray 2000. The economic burden of back pain in the UK. *Pain* 84, 1: 95–103.
McNiff, Shaun (ed) 2013. *Art as research: opportunities and challenges*. Bristol: Intellect.
Merleau-Ponty, Maurice 1996. *Phenomenology of perception* London: Routledge.
Moran, Dermot 2000. *Introduction to phenomenology*. New York: Routledge.
Murray, Michael 2015. *Critical health psychology.* Hampshire: Palgrave Macmillan.
Nicol, Gill 2014. *Inspired by: your guide to art and the museum*. Shrewsbury: Museum & Art Gallery.
O'Rourke, Karen 2013. *Walking and mapping: artists as cartographers*. Cambridge: MIT.
Padfield, Deborah *et al.* 2018. Images as catalysts for meaning-making in medical pain encounters: a multidisciplinary analysis. *Medical Humanities* 44, 2: 74–81.
Padfield, Deborah 2020a. Absence and presence: the potential for art to facilitate improved communication about pain. *The Lancet Haematology* 7, 2: 96–97.
Pallasmaa, Juhani 2009. *The thinking hand: existential and embodied wisdom in architecture*. Hoboken: Wiley.
Patrizio, Andrew *et al.* 1998. *New work: Polly Binns and Shirley Chubb*. King's Lynn: Arts Centre.
Pink, Sarah 2007. *Doing visual ethnography: images, media and representation in research.* London: Sage.
Sheets-Johnstone, Maxine 2011. *The primacy of movement.* Amsterdam: Benjamins.
Skinner, Jonathan & Gerard J. Gormley 2016. Point of view filming and the elicitation interview. *Perspectives on medical education*. 5, 4: 235–239.
Solnit, Rebecca 2001. *Wanderlust: a history of walking.* London: Verso.
Stern, Nathaniel 2013. *Interactive art and embodiment: the implicit body as performance*. Canterbury: Gylphi.
Thompson, Nato 2012. *Living as form: socially engaged art from 1991–2011*. Cambridge: MIT.
Urry, John 2007. *Mobilities.* Cambridge: Polity.
Van der Tuin, I. & R. Dolphijn 2010. The Transversality of New Materialism. *Women: A Cultural Review*. 21, 2: 153–171.
Vos, Theo *et al.* 2017. Global, regional, and national incidence, prevalence, and years lived with disability for 328 diseases and injuries for 195 countries, 1990-2016: A systematic analysis for the Global Burden of Disease Study 2016. *The Lancet* 390, 10100: 1211–1259.
Weiss, Gail 2008. *Intertwinings: interdisciplinary encounters with Merleau-Ponty*. Albany: State University of New York Press.
Woby, Steve *et al.* 2007. The relation between cognitive factors and levels of pain and disability in chronic low back pain patients presenting for physiotherapy. *European Journal of Pain*. 11, 8: 869–877.

Online Resources

Chubb, Shirley 2021. Artist website. https://www.shirley-chubb.co.uk/ [20.01.2021]
Fulton, Hamish 2020. Artist website. http://www.hamish-fulton.com/ [27.07.2020]
Long, Richard 2020. Artist Website. http://www.richardlong.org/ [27.07.2020]
Macek, Barbara (no year). Between Agony and Ecstasy: Investigations in to the meaning of pain. https://www.researchcatalogue.net/view/308804/470238 [27.07.2020]
Padfield, Deborah 2020b. Artist Website. https://deborahpadfield.com/About [20.07.2020]
Prodger, Charlotte 2020. Tate Website. https://www.tate.org.uk/whats-on/tate-britain/exhibition/turner-prize-2018/charlotte-prodger [21.07.2020]
Significant Walks 2014. Project Website. http://significantwalks.com/ [20.07.2020]
Spence, Jo 2020. Tate Website. https://www.tate.org.uk/art/artists/jo-spence-18272 [20.072020]
TATE 2021. https://www.tate.org.uk/art/art-terms/m/modernism [14.01.2021]

WALKING ARTISTS NETWORK (no year). Website. https://www.walkingartistsnetwork.org/ [21.07.2020]

Manuscript received: 30.07.2020
Manuscript accepted: 30.01.2021

SHIRLEY CHUBB Dr. phil., is Emerita Reader in Interdisciplinary Art at the University of Chichester and an Honorary Fellow in the School of Health Sciences, University of Brighton. Her research focuses on broadening the reach, impact and collaborative potential of the visual arts and involves the use of artefacts, film and digital technologies. Shirley's work is held in public and private collections and has been funded by Arts Council England, the Arts & Humanities Research Council and the Wellcome Trust. She currently supervises a range of interdisciplinary research projects and was awarded the 2021 Creative Physiotherapy Scholarship at Auckland University of Technology working within the Faculty of Health and Environmental Sciences.

University of Chichester, Department of Theatre and Fine Art
Bishop Otter Campus, College Lane, Chichester, PO19 6PE, UK
email: s.chubb@chi.ac.uk, http://significantwalks.com/, https://www.shirleychubb.co.uk/

ANN MOORE CBE, Dr. phil., is Professor Emerita of Physiotherapy in the School of Health Sciences at the University of Brighton. Her research interests have focused largely on Non-Specific Low Back Pain and she is particularly interested in the patient experience, increasing public awareness of the impact of LBP and developing new approaches to patient care, patient education, self-management and standardised data collection. Ann was Director of the Council for Allied Health Professions Research from 2012 to 2019 and has been Editor in Chief of Musculoskeletal Science and Practice journal (1995 to date). She has received several awards in recognition of her services and contributions to Physiotherapy including a CBE in 2016.

University of Brighton, School of Health Sciences
49 Darley Road, Eastbourne, BN20 7UR, UK
email: A.P.Moore@brighton.ac.uk, http://significantwalks.com/

KAMBIZ SABER-SHEIKH Dr. phil., graduated from the University of Sussex with a degree in Mechanical Engineering and was awarded his PhD in Biomedical Materials at the Interdisciplinary Research Centre (IRC) in Biomedical Materials, QMUL.

He has since worked in a range of settings and has varied experience of working in research, design, consultancy and teaching roles including: Finite Element modelling of total knee replacement prosthetics (University of Southampton), engineering analysis and design optimisation of an astronomical instrument (UCL), working on major infrastructure projects in an engineering consultancy (Mott Macdonald) and coordinating a biomechanics laboratory (University of Brighton). He is currently working as Staff Tutor and Associate Lecturer in the School of Engineering and Innovation within the Open University.

The Open University, Faculty of Science, Technology, Engineering & Mathematics
http://www.open.ac.uk/people/kss238, email: k.saber-sheikh@open.ac.uk,
http://significantwalks.com/

NEIL BRYANT works in the field of creative & digital technologies and is lecturer in 3D Animation and Visual Effects at the University of Chichester. He teaches modules in Film and Media and works with staff and students across subject disciplines to produce research related outcomes involving a range of digital technologies including video post-production, compositing and animation. Neil is a practicing artist and researcher and received an excellence award from the Japan Media Arts Festival. He shows work internationally, including The London Group Centenary Open and the NOW&AFTER Festival at the Moscow Museum of Modern Art.

University of Chichester, Department of Creative & Digital Technologies
Bognor Regis Campus, Upper Bognor Rd, Bognor Regis, PO21 1HR, UK
email: n.bryant@chi.ac.uk, http://significantwalks.com/

To the Bitter End

Affect, Experience, and Chemical Ecology

HANNAH DRAYSON

Abstract This article explores taste in its chemical, gustemological and affective senses, asking what we speak of when we talk about "bitter experience." Drawing lines of connection between human affect and chemical ecology, it suggests a way of thinking about taste as a chemical entanglement of affective qualities and ecological relations. Two observations underpin the argument. First, the ambiguous resonance of bitter-tasting compounds in human culture is grounded in their ambiguous medical meaning, the same drug may serve as poison or cure. Second, plants interact with many other life-forms by producing chemical compounds, many of which are bitter tasting, that have effects on the metabolisms of the organisms around them. These *secondary metabolites* have become entangled in human physiology and culture. The use of bitter-tasting plants in food and medicine requires specialised technical knowledge for identification, processing and dosing, a necessity that expresses itself in various yet comparable cultural responses to bitterness. A number of cultural traditions hold strong associations between embitterment, wisdom, healing, and remembrance. In these similar responses to bitterness, the article suggests that there is an ecological and affective resonance that might be located in the idea of bitter experience.

Keywords bitterness, medicine, taste, affect, experience

Introduction

This article draws lines of connection between personal and social affect and interspecies chemical communication. It takes the quality of bitterness tastes as its central motif. Using the mode of a reflective essay, it asks the speculative question; if there were such a thing as *bitter experience*, what would shape it? Developing this theme, it offers a thick account of taste and chemical ecology; drawing on insights and evidence from ethnography, ethnobotany, philosophy and herbal medicine. Bitter compounds and bitter emotions are characterised by toxicity and danger, the opening discussion presents an epistemology of experiential "taste knowledge" that stresses the danger and value of bitter experience. Thinking about the physiological action of bitter compounds on the human body draws further attention to taste as an immanent manifestation of chemical communication. In culinary practices that mix affect and healing, the value of practical knowledge of bitterness as well as responses to bitterness are embedded within the body. The final part of the article considers examples in the ethnographic literature and herbal medicine where skilled practical negotiations of bitterness are overlapped by affective narratives that stress themes of healing and remembrance. Taken together, these various treatments of bitterness offer an expanded sense of taste as a relational quality in both interpersonal and interspecies realms.

A narrative arc from the author's previous research (Drayson 2019) reflecting on how the affective and material dimensions of sugar connect sweetness, honesty, love, and healing is continued here. Responding to figures of speech in the English vernacular that commented on the use of sugar coatings to dupe patients and lovers, it connected "folk" knowledge of love and honesty to the aesthetic qualities of medicines. It followed a hunch that figures of speech might signpost forms of pre-reflective and embodied phenomenological "felt meaning" (Petitmengin 2013). In the case of

metaphors surrounding bitter medicine there is a pervading sense that what is healthful is not always pleasing to the senses. The English vernacular reflects on the problem of accepting or "swallowing" what is unpleasant: we "take our pills with jam," or a "spoonful of sugar;" some bad news or experience is a "bitter pill to swallow." As Highmore (2010) points out, the language of affect in common English usage tends to lace together the sensual and physical with the languages of emotion:

> "[W]ords designating affective experience sit awkwardly on the borders of the material and the immaterial, the physical and the metaphysical [and] makes it hard to imagine untangling them, allotting them to discrete categories in terms of their physicality or their ideational existence" (*ibid.* 120f).

Bearing this untidiness in mind, focussing specifically on bitterness might be seen to overlook calls in sensory anthropology to move away from the treatment of the senses as distinct modes, sight, touch, taste, etc. (Porchello 2010: 55). One reason to avoid this is that it carves up the sensorium according to physiological science, at the expense of the phenomenological, experiential accounts of individual experience. It also overlooks the synaesthetic nature of even the most everyday sensory experience and the capacity for "transcription and translation across the senses" (Seremetakis 2017: 249). It would seem that this failing is doubled in the current focus on a single taste when it is so clear that gustatory experiences result from the complex interplay of many sensory modalities including olfactory, chemical and haptic senses. Looking to a single sense, and a single taste modality can certainly seem excessively reductive. But the goal is to try to keep the narrow quality "bitterness" alive in as many senses as possible at the same time, to ask with Highmore (2010),

> "does the emotional condition of bitterness, for instance, release the same gastric response as the ingestion of bitter flavors? How do we make our way from one modality to another?" (*ibid.* 120)

The answer, he suggests, is not to try to disentangle these modes but to draw on the affect studies approach that understands these as a "nexus of finely interlaced force fields" and "build on the intuition that cultural experience is often a densely interwoven entanglement" (*ibid.*).

The trope of bitter experience is offered then as an entangling theme as we make our way between detailed disciplinary knowledge areas and varying ontological categories. In particular it makes space to consider bitterness' connection to interspecies relations. In recent decades a posthuman turn has led to a tendency in many fields to attempt to account for the human as emergent through its relations with other organisms. *Non-human* or *more than human others*—bacteria, viruses, plants, and animals and their entanglements now offer foci for works of "multispecies ethnography" which offer a

> "mode of attunement to the power of non-human subjects to shape the world and the ways in which the human becomes through relations with other beings" (Ogden *et al.* 2013: 12f).

A number of imperatives have inspired this shift of attention, many of which are political and environmental. Insights from the biosciences into the complex biological interdependencies between lifeforms has invited reconsideration of the fixity of both bodies and species (*ibid.* 14); a "rhizomatic zeitgeist inflects many branches of biology. And anthropology is infected too" (Kirksey & Helmreich 2010: 555). Specifically relating to plants, research in chemical ecology, including studies of plant-insect communication and allelopathy, biochemical communication between plants (Cheng & Cheng 2015) demonstrates a compelling relational world of chemical entanglements, raising questions of vegetal perception and agency (Myers 2015). In its concern with chemical ecology, and the chemical sense of tastes, this article follows in this turn of attention to the non-human, by speculating on the shaping of affect by the imperatives of interspecies and interpersonal relations. There is some resonance here with Hustack and Myers' (2012) coining of the term "affective ecology"(*ibid.* 79) to describe the affective entangling of orchids and bees (and researchers who seek to understand them). However the goals here are somewhat more modest in their attention to the human phenomenal world, seeking to consider where plant agency and plant "talk" might manifest in human cultural and affective tropes.

At its centre it seeks to think of the act of tasting as an engagement with a relational and ecological-chemical space that is shaped by an *embodiment* that emerges from a material, intentional and living world. Considering taste in this way can map a familiar sensory world with an evolutionary history of chemical and technical co-evolution that is the result of entangled non-human and human agencies.

Bitter Experience

In its colloquial English meaning, a "bitter experience" is one that we learn a hard lesson from. Bitterness' ambivalence leads us to consider arguments about experience and the senses as a source of knowledge. Historian of psychology Edward Reed (1997) has argued that modern life has become increasingly reliant on mediated experiences and theoretical knowledge. This is at the expense of "primary" experience—what we can see, feel, taste, hear, or smell for ourselves—a lack of which Reed suggests has serious implications for our mental abilities. Because the intellectual cultures of western philosophy and psychology "seriously underestimate the value of experience" (*ibid.* 158), primary experience has been increasingly thought of as an unreliable source of knowledge; a view that has had a pervasive influence on many aspects of life, work and education. Reed draws on John Dewey's arguments that theory has been elevated over practice partly for reasons of convenience: "practical activities are dirty, often dangerous, repetitious and impermanent" whereas the realm of ideas is "separate from the everyday world in which things rot or break" (*ibid.*) A hierarchy in which practical activities rank as lower, as earthy, bodily and material, justifies and allows those in power the ability to avoid (at least when it suits them) the unpleasantness and recalcitrance of a world that provides friction and disappointment, where things spoil or poison and create physical and bodily wear and tear. A world of danger that is, in the end, finite. While we can learn from what Reed calls "secondary experience," the potential information contained within a representation is extremely limited in comparison with the complexity of direct engagement with the entity or environment it is intended to represent – he compares a photograph of a person with an actual person. Taking an approach from ecological psychology, which considers the environment and experiences within it an inherent part of an organism's mental life, Reed suggests that the consequences of limited primary experience are stark. A lack of interaction with complex entities and environments is a lack of opportunity to develop the resources with which "to experience the world around us accurately and to use this experience to think carefully" (*ibid.* 158). They amount to an impoverishment of the ability to think with the materials of the physical world rather than representational structures.

Reed's thoughts point to two aspects of knowledge about or gained through taste. First, that of the dangers or difficulties of arriving at it, and second that it might offer something we could think with. As one of the three main chemical senses, taste is anchored in the body. Its corporeal immanence attaches it to risk. In their philosophy of taste and eating, Bosivert and Heldke (2016) cite the fearful English phrase "does this taste funny?"—a phrase which for them epitomizes taste's immanence and danger. It stresses the high stakes of tasting, and the close contact it requires us to have with its objects. As they point out, to know through tasting involves danger, intimacy, sustenance, and potentially, pleasure. Ingestion puts us into direct and necessary contact with the world; "stomachs keep us involved—invested—in our surroundings" we have to eat, even though it "calls us to risk; to be open and to learn to act with less certainty than we would like" (*ibid.* 108). They argue that an epistemology of taste demands radically different approaches to knowledge and exploration to that of sight. Unlike visual knowledge's privileged safe distance, what we ingest has consequences, an epistemology of taste leans toward an ethics that stresses pragmatic and embodied concerns; "eating reduces the gap between us and the rest of the world" (Bosivert & Heldke 2016: 107). In some sense it erases that gap; to eat something is to allow it to cross a boundary and enter the body. For better or worse, to know something through taste is to be changed by it.

Bitter Physiology, Bitter Culture

Even for sensory anthropologists, bitterness is a taste that "borders on the universal" (Sutton 2010: 216). Regarded as "the receptor system that guards the entry into the body," taste helps to avoid ingesting harmful or inedible substances and to consume what is nourishing (Rozin 1998: 28). Bitterness itself is particularly characterized by "rejection-withdrawal" and a "gape response;" a facial movement often observed in infants, where they open their mouths wide, and eject the objectionable material (*ibid.* 9). The ability to taste bitter substances is held across many species (cf. Muñoz *et al.* 2020 for a discussion of taste in blood sucking insects). Beyond the instinctive distaste response that protects against toxic substances, innate responses to bitterness give a limited sense of its complexity. As non-specialists, humans acquire knowledge about what to eat through cultural transmission and individual learning, allowing them to be flexible about what they eat, they have impressive systems that allow them to develop both tastes and aversions to different foods. Gustatory experience is shaped by a rich interplay of biology, culture and individual experience (Rozin 1998: 13; Howes 2003: 97; Sutton 2003: 225). Even on a physiological level, not all tastants that are toxic taste bitter and not all bitter tasting materials are toxic: when we taste bitterness it does not signal that we have come into contact with a specific material, thousands of "structurally diverse" molecules have a bitter taste (Korsmeyer 2002: 76; Kinnamon 2012: 1). However, the association between bitter taste and pharmacological activity is close enough that researchers now use machine learning to predict new drugs by exploring the chemical spaces of bitter tasting materials (Margulis *et al.* 2019). One of the goals of doing this is to identify promising molecules that are not so bitter tasting that patients will be unwilling to take them. Another is that the perceived bitterness of a substance also seems to correlate with how toxic it is to different bodily systems.

Different tastes are detected through taste receptor cells. While there are traditionally five tastes, bitter, sweet, salty, umami and sour, the detection of calcium, metallic tastes and oleogustus (fat) (Running *et al.* 2015) are more recent additions to what are officially considered to be distinct tastes. There are also a number of mechanical factors and chemoreceptors that contribute to the sense of an overall flavour; the hot pepper capsaicin spice and menthol from mint are both chemical senses. As proteins, bitter substances are detected through *T2R* cells, although "some bitterants are pharmacologically promiscuous," interacting with other receptors and metabolic systems (Bloxham *et al.* 2020: 56). Perhaps surprisingly, taste receptor cells are not only found in the mouth, tongue, and epiglottis. Emerging physiological research has identified them in many other bodily systems; gastrointestinal, respiratory, reproductive, urinary and cardiac. The functions of taste receptors in these systems are only partially understood (Di Pizio 2019: 57). In the gastrointestinal system the stimulation of chemo-receptors in the mouth and down into the gut releases a range of hormones, acids and enzymes essential to digesting food and to absorbing nutrients (McDonald 2010: 140). Researchers exploring the role of bitter detecting cells in the heart speculate as to their role, and even the source of the chemicals involved. The heart tissue may be responding to materials in food, toxins produced in the body by micro-organisms, or chemicals produced endogenously by the body itself (Bloxham *et al.* 2020).

Bitter Drugs

Despite the considerable medical properties of bitter compounds, the Western biomedical paradigm associates pharmaceutical taste with uncooperative patients reluctant to take bad tasting medicines (Menalla *et al.* 2013). When a discussion of how the sensory dimensions of medical treatment may influence its success, "placebo responses" are invoked, and attempts to harness these have mainly concentrated on visual design elements (a tablet's colour, packaging or marketing) rather than taste (de Craen *et al.* 1999; Moerman 2002). However, many medical traditions, including Traditional Chinese (Porter 1999: 153) and Tibetan Medicine (Gerke 2014), incorporate sophisticated approaches to taste as an element of their treatment practices. The correct balance of tastes in the diet can maintain the health of the body and food and medical knowledge and practices intersect. This model informs

the use of medical decoctions as well as culinary practices whereby "disharmonies can be corrected by adjusting the flavour of particular meals" (Ody 2000: 9). Here culinary and medical knowledge and practices intersect. At least as far back as the formative cuisines of the Chinese *Song* dynasty (960–1279) "good prescriptions" and "good recipes" have been in some ways interchangeable (Freeman 1979: 171). A correct balance of tastes in the diet can maintain the health of the body and "disharmonies can be corrected by adjusting the flavour of particular meals" (Ody 2000: 9). This same balance of taste qualities informs the use of medical decoctions and pharmacological classifications (Farquhar 2007: 294f). The five (or six) tastes—sweet, sour, bitter, salty and pungent/acrid—are connected with the elements, and a further two qualities, astringent and bland/neutral are also used (Ody 2008: 8). While they demonstrate a context in which taste is inseparable from the maintenance of bodily health, the sophistication of these medical systems in terms of their use of taste make bitterness as it is dealt with here seem a rather crude category. However, as Farquhar (2007) describes it, in Traditional Chinese herbal medicine's characteristic use of strong flavours, bitterness seems key;

> "[…] though patients often complain that herbal decoctions are 'too bitter' *(ku)*, […] a refined palate can no doubt also distinguish amidst the bitterness some tastes that are more sour, salty or pungent. Considering that individual drugs of diverse flavors are usually boiled together, it must be difficult to sort out all the tastes of a complex prescription. But there's no doubt, I think, that for a medicine to do anything very complicated it must assault the sufferer with a strong and complex flavor." (Farquhar 2007: 293)

This sensory "assault" is not only a matter of putting on a show for the patient. Chinese medical texts explain the functions of these medicines in terms of their flavour, a quality which is recognized as inherently and physiologically effective. Not separating the realm of "sensory input" from that of the known biological properties of the materia medica, raises a question; "what is the efficacy of a 'flavor'?" (*ibid.*) This question, of to what extent can a taste influence bodily healing, seems to be partly answered by recourse to the placebo response, that being aware of a treatment can increase the effects: "The rationally known efficacies of things cancel the relatively ephemeral experience of ingesting them, and our carnal tastes, when they are invoked, drift upward toward the cultural domain where subjective experience is stored." (*ibid.* 295) Bitter medicines then, seem to suggest that we might read through a lens that resists the relegation of sensory input to another realm. What might be the result if we resist the impulse to "drift upward" to a subjective domain, and instead like so many other medical systems, consider the "relatively ephemeral experience of ingesting" (*ibid.* 295) bitter tasting substances as inherently healing? Instead, let's dig down by broadening our contextual understanding of bitterness' relation to healing, tasting and chemical-ecological relations.

The Roots of Bitter Medicines in Chemical Ecology

In food and medicine, a sense of ambivalence about the meaning of bitter tastes is a result of the complex ecology of volatile chemicals that plants use to signal to one another and to communicate with and influence other species. In addition to the primary metabolites that function to control factors like growth in their own bodies, plants, fungi and bacteria produce compounds called secondary metabolites or *alleochemicals* which influence the growth, health or behavior of their own and other species (Johns 1990: 4f). Chemical co-evolution has produced many compelling inter-species interactions that the science of chemical ecology is still revealing in fascinating accounts of the chemical space within which highly complex inter-species communications take place. Hustak and Myers' (2012) curiosity about the extent to which these scientists are willing to ascribe agency to their objects of study leads them to suggest that;

> "[p]ullulating under the surface of chemical ecologists' neo-Darwinian accounts, we find the glimmerings of an affective ecology contoured by affinities and repulsions and teeming with articulate plants and other loquacious organisms" (*ibid.* 79).

A well-known and fairly straightforward example of plant-mammal communication would be the

fructose sugars in the fruit produced by the apple tree which attract animals to distribute their seeds. Indeed, the appeal of these fruit is so great that apples are even propagated by humans, who clone trees with desirable fruit and growth characteristics, spreading them worldwide (Pollan 2001). In distinction with its flesh, the apple seed is unpalatable, it contains a cyanogenic compound that when digested is metabolized into the poison cyanide. More impressive are examples of species using chemicals originally intended as deterrents for their own purposes. The milkweed butterflies, including the Monarch butterfly (*Danaus plexippus*), lay their eggs on milkweed plants (*Asclepias*). These plants produce cardenolides, steroidal toxins which affect the heart tissue of mammals. On hatching, the butterfly larvae eat the plant tissues and sequester toxic compounds produced by the plants into their own bodies, making themselves poisonous to predators (Johns 1990: 252). More impressive are examples of plant signaling predators of the caterpillars they detect feeding on them. Many chemicals have more than one function in their interactions with other species, which mean that it may be impossible to know which purpose they first evolved to serve (Rasugo *et al.* 2015).

Bitter compounds include a huge array of chemicals produced by plants; saponins, tannins, glycoalkaloids, cucurbitacins and alkaloids. Intended as they are to influence the physiology of other organisms, secondary metabolites offer a diverse array of pharmacologically active chemicals, with many potential medicinal uses; analgesics, psychoactives, emetics or antidotes for poisoning. Many bitter tasting chemicals have a defensive function and deterring those creatures that would engage in herbivory or protect against fungal and bacterial attack. It has been argued that here lie the first origins of human medicine;

> "in exploiting plant foods it is impossible to avoid their defensive chemicals [...] in adapting to them our species has made them an essential part of our internal ecology" (Johns 1990: xv).

As Johns explains it, the use of plant-derived toxins in human ecology is an inverted version of that used by the milkweed butterfly. Rather than poison larger animals that may eat us, it offers a way of dealing with predators that are smaller than us, with "parasitic micro-organisms and invertebrates that consume us from the inside out" (*ibid.* 252). The use of plants as medicine has its root in animal ancestry (Johns: 1990: xv). Since primatologists first observed chimpanzees eating carefully folded rough and toxic leaves to scour out intestinal parasites, many examples of *zoopharmacognosy*—the deliberate use of plants by animals for self-medication – have been recorded (Shurkin 2014: 17339ff).

Eating Bitterness

While bitter chemicals have become part of human internal ecology, they have also influenced technical and cultural practices. Processing techniques to remove toxins include heating, leeching, fermentation, grating, using lye, drying and mixing with clays (Johns 1990: 7). Domestication has resulted in plants that produce leaves and fruit that lack the toxic chemicals of their forebears. The *Cucurbitaceae* family, for example, which include pumpkins, squash, and cucumbers, produce toxic and very bitter tasting compounds called *cucurbitacins*. Selective breeding has made them more palatable, but less pest- and frost-resistant. Bitterness is not always an undesirable property. Herbs cultivated or gathered for their medical properties retain the bitter tastes associated with their pharmacological properties. Many other bitter plants inhabit the peripheries of agriculture. Semi domesticated plants, weeds and other seldom-used famine foods offer a stand-by for leaner times and hungry gaps, for example the seeds of bitter *hanza* berries that are eaten in Niger when drought destroys other crops (Kelley 201: 123).

The act of intentionally consuming bitter foods takes on symbolic resonance in a number of cultures. As Sutton (2010) points out; "[T]he metaphorical uses of this flavor are instantly recognisable: Ingesting bitter food as a representative of bitter experience can be found in many societies and rituals" (*ibid.* 169). He cites the *Passover* ceremony, which references Egyptian persecution through the consumption of bitter herbs, which map onto the bitter experience of persecution. The title of Johns' (1990) book on chemical ecology and human medicine *With Bitter Herbs They Shall Eat It* makes the same reference; its title a quotation from the *Hagadah*. There are other ex-

amples; in modern Chinese, the common term for suffering—*chiku*—translates as "eating bitterness," and often references the swallowing of difficulties (Farquhar 2007: 292). During the Cultural Revolution (1966–69) Chinese authorities encouraged people to eat a "recall bitterness meal" which combined wild vegetables and rice chaff in an unappetizing gruel, and was to be eaten while concentrating on memories of the bitterness of the society of the preliberation era (Oxfeld 2017: 79).

In their practical necessity for sustenance, knowledge of growing, preparing, serving, tasting and eating seem to offer more than metaphors, particularly given the danger and immanence of eating. Particularly when cooking and eating are social transactions, as is often the case, offending a palate, or worse, poisoning a guest with carelessly or ineptly prepared food is a legitimate concern. It is perhaps here that interspecies relations become particularly mixed up in interpersonal and intercommunal ones. Amy MacLachlan's (2011: 12) ethnography of the *Uitoto* diaspora in the borderlands of the Colombian Amazon offers an example for the immanence of taste knowledge. In *Uitoto* culture sweetness and bitterness feature heavily in daily emotional and practical life as mixed gustatory and affective experiences. A particular plant, bitter manioc (*Manihot esculenta*), is at the heart of this. Also known as *cassava* or *yuca*, manioc is a perennial plant native to the Amazon but extensively cultivated worldwide in both tropical and subtropical regions. Drought-resistant and able to grow on poor soil, in 2013 it was estimated to provide food to over 800 million people worldwide (Food and Agriculture Organisation of the United Nations 2013). The plant is cultivated in two main types, sweet, and bitter; both require processing before they are safe to consume. This is because the high starch tubers contain substances called *cyanogenic glycosides* that are turned into *hydrogen cyanide* when the plant is damaged.

Bitter manioc tubers are the basis of a wide variety of *Uitoto* recipes in daily and ritual use. MacLachlan (2011) shows that through the processing of manioc, sweetness and bitterness are embedded within *Uitoto* culture as technical culinary practices that shape how well-functioning relationships are understood. Preparing manioc by removing the toxins from the tubers is a multi-day process that is technically complex and physically exhausting. A lack of expertise and poor execution can result in the literal "poisoning" of relationships. "Bitter manioc is made 'sweet' by the expert labour of adult women, a capacity that is indexical of their status as well-made and knowing women" (*ibid.* 12). MacLachlan's hosts, while training her in manioc preparation would recount "nightmarish" cautionary tales whenever they observed her skills lacking. In one story, a young wife labors for days on a generous feast only to accidentally poison her husband's family. MacLachlan's observations of manioc preparation suggest that that the practices hold an affective resonance in a context in which there are substantial intercommunity and interpersonal conflicts. She describes a continuity in what is described as "sweetening" between culinary and social practices;

> "Uitoto women's skilled forgetting of memories and emotions they described as 'bitter' often appeared as the affective equivalent of leaching manioc, a deliberate rendering of the socially poisonous and debilitating into sweetened continuities in relations" (*ibid.* 170).

Sometimes acts of processing and consuming foodstuffs is accompanied by more direct references to healing. When the *Pomo* people of Northern California make acorn mush they describe "healing medicine" as well as an imperative to remember. For the *Pomo*, as in the recall bitterness meal, there is a connection to a violent history that must be preserved which, like bad tasting medicine, must be passed down to the children for their own good;

> "The old women whose words animate this recipe and its meaning argue over how bitter it must be, but they all call it medicine. They laugh at the children who want it sweeter, who do not understand the balance that Pomo people expect and value between sweet and bitter, comfort and pain, bounty and deprivation. The oldest leach the acorns of just enough tannin to avoid stomachaches, leaving enough 'toxin' to heal them of the legacy of settler violence. Bitter medicine heals in a bitter time." (Noel 2014: 155f)

The balancing act of "just enough" toxin to heal seems to go together with a recognition of the need for first-hand engagement with the experience of bitter taste. In contemporary herbal medicine the

digestive stimulation caused by bitter tasting compounds is considered to have a psychological effect of releasing individuals from negative emotions; "they help one let go of stuck energy – particularly anger and frustration – emotions often viewed in traditional medicine as being tied to stagnant/sluggish liver energy. Bitters, in addition to releasing bile, also help people let go of the emotional energies housed in different organs" (McDonald 2010: 147). Contemporary North-American herbalists have raised the idea of a "bitter deficiency syndrome" (McDonald 2010: 147) where Western-urbanized diets lacking in bitter tastes fail to stimulate the digestive system leading to sluggish energies and emotional problems. In cultures that retain diets that include a sizable proportion of leaf-based materia—a likely characteristic of ancestral human diets—there remains a lack of demarcation between the role of leaves understood as nourishing food and an awareness of their medicinal properties (Johns 1990). A reduction of the consumption of bitter leaves may have been influenced by shift from rural to urban living has reduced opportunities for people to forage wild growing leaves to use as salad or "pot herbs" and access to a smaller selection of less bitter commercially-grown leaves. While they argue that contemporary palates have a narrowed vocabulary of flavour provided by plant chemicals, bitterness is still prevalent in many forms. Beverages such as coffee and wine and foods like chocolate take their enjoyably bitter tastes from leaf *tannins*, a key flavour in leaf-based teas as well as many of spices. Bitter herbs are still connected to digestion and herbal "bitters"—originally alcohol-based tinctures combining bitter herbs such as yarrow, wormwood, and orange—have a history dating back to Hippocratic medicine and are still sold as a health supplement, although more often encountered in aperitifs, digestifs or mixed drinks that accompany a meal. Perhaps bitter herbs remain in plain sight.

The complexity of a herb

Using plants for healing is made complex by the way in which plants produce secondary metabolites. These are not single, simple compounds as they would be encountered in pharmaceutical chemistry. They are synthesized with other sometimes complimentary chemicals which are consumed together when consuming whole plant materials. They have their own interactions, as well as interactions with the systems of the body. Countless pharmaceutical medicines have been synthesized as copies of the active chemicals found in plants, resulting in the availability of pure substances with known strengths. However, Kaptchuk and Croucher (1986: 53) have argued that despite the apparent advantages of pure chemicals, isolating them fundamentally changes how they work;

> "the biochemical effect of a plant depends on the totality of the organic and inorganic substances in it. The same active ingredient within a plant has remarkably different effects when it is isolated from the plant" (*ibid.* 53).

For example, Chinese angelica (*Angelica sinensis*) effects the uterus in varying ways depending on its initial state, relaxing a tight uterus and contracting a loose one. Rather than being unpredictable, these effects stem from the regulation of bodily systems. As they argue, isolating substances risks a loss of knowledge: focusing on the known chemical qualities of a healing material rather than trying to understand the complex properties of a complete living being can lead to useful effects being overlooked.

In order to engage this complexity, they argue, those practicing in many traditions that use herbal medicine must recognize a feeling for each plants' character which has a

> "soul with its own texture and pulse, a way of interacting with other herbs and indeed with bodily sensations and feelings not measurable in the biochemist's lenses and scales. […] the feeling for their mixture, balance and synergetic effects constitutes the art of herbalist medicine" (*ibid.* 56).

A direct sensorial and synesthetic engagement with the plants that they use is required of practitioners of herbal medicine to discern their properties and proper use (cf. Gerke 2014: 27 for discussion of touch and taste as key in Tibetan medical practice). In an essay about the healing properties of bitterness, Jim McDonald (2010) describes how sensory observation of "scent," "color" and "flavour" informs the herbalists' awareness of plants' virtues: "Only by embracing bitterness can we learn what it has to offer—to teach us. In

this embrace we find it rich in medicine" (*ibid.* 152f). As he asks: "If plants' tongues speak to our tongues, then what do we not hear when we taste no bitterness?" (*ibid.* 141). In thinking about what this means for healing, we might ask then what is excluded from medicine in the move to pharmacy; if a relationship with plants originally medical tastes, what does it mean to encounter them out of their original context? To what extent do the aesthetics of the chemical senses inflect the meaning of medicine; could there be a *bitter deficiency syndrome* in the clinic?

The Bitter End

From chemical tastes registered in the inner tissues of the body's systems to the messages passed between organisms, bitterness has many resonances. It manifests in affect, taste, internal chemistry and external ecology. Rather than try to disentangle these different aspects, this article has drawn together evidence that suggests how bitter affects and bitter chemicals are connected. Taking literally the metaphorical connections between affect and taste and attending to connections between personal, affective embitterment and the actual consumption of bitter tasting compounds allows us to explore the ways in which *taste matters*. Framing the connection as homology rather than analogy offers taste and feeling as embodied engagements with human and more-than-human ecologies. That there are commonly held cultural traditions associated with emotional bitterness and healing is unsurprising given the chemical associations between bitter tasting materials and pharmacological action. Sharing the bitter experience needed to make use of bitter materials invites reminders of know-how, technical skill and experience, knowledge used in the complex negotiations of plant healing and the sweetening of interpersonal and interspecies relations. Riskily gained bitter experience holds resonance for remembering what can and has been weathered, it reminds us of what to do when tough times come around again. It offers a reminder that when we taste bitterness, it is because sometimes, plants tongues speak to our tongues.

References

Bitter Liebe 2020. *About Bitters*. https://bitterliebe.co.uk/pages/about-bitters. [2020-06-04].

Bloxham, Conor J., Simon R. Foster & Walter G. Thomas 2020. A bitter taste in your heart. *Frontiers in Physiology* 11: 431.

Bosivert, Raymond D. & Lisa Heldke 2016. *Philosophers at table: on food and being human.* London: Reaktion.

Carolan, Michael 2012. *Embodied food politics*. Farnham: Ashgate.

Eitan, Margulis, Ayana Dagan-Wiener, Robert S. Ives, Sara Jaffari, Karsten Siems & Masha Y. Niv 2019. Intense bitterness of molecules: machine learning for expediting drug discovery. *Computational & Structural Biotechnology Journal* 19: 568–576.

Freeman, Michael 1979 (1977). Sung. In K. C. Chang (ed) *Food in Chinese culture: anthropological and historical perspectives.* New Haven: Yale University Press.

Cheng, Fang & Zhihui Cheng 2015. Research progress on the use of plant allelopathy in agriculture and the physiological and ecological mechanisms of allelopathy. *Frontiers in Plant Science* 6: 1020.

Di Pizio, Antonella *et al.* 2019. Bitter and sweet tasting molecules: it's complicated. *Neuroscience Letters* 700: 56–63.

Farquhar, Judith 2002. *Appetites: food and seys in postsocialist China*. Durham: Duke University Press.

––––– 2007. Medicinal meals. In Margaret Lock & Judith Farquhar, Judith (ed) *Beyond the body proper: reading the anthropology of material life.* Durham: Duke University Press. 286–296.

Food and Agriculture Organisation of the United Nations 2013. *Save and grow: a guide to sustainable production intensification*. http://www.fao.org/3/a-i3278e.pdf/ [2020-06-12].

Gerke, Barbara 2014. The art of Tibetan medical practice. In Teresia Hofer (ed) *Bodies in balance: the art of Tibetan medicine.* New York: Rubin Museum of Art.

Highmore, Ben 2010. Bitter after taste: affect, food, and social aesthetics. In Melissa Gregg & Gregory J. Seigworth (eds) *The affect theory reader*. Durham: Duke University Press.

Howes, David 2003. *Sensual relations: engaging the senses in culture and social theory.* Ann Arbor: University of Michigan Press.

Hustak, Carla & Natasha Myers 2012. Involutionary momentum: affective ecologies and the sciences of plant/insect encounters. *Differences* 23, 3: 74–118.

Johns, Timothy 1990. *With bitter herbs they shall eat it: chemical ecology and the origins of human diet and medicine*. Tucson: University of Arizona Press.

Kaptchuck, Ted & Michael Croucher 1986. *The healing arts: a journey through the faces of medicine.* London: British Broadcasting Corporation.

Kelley, Lindsay 2014. Plumpiñon. In Eben Kirksey (ed) *The multispecies salon.* Durham: Duke University Press. 123–134.

Kinnamon, Sue C. 2012. Taste receptor signalling: from tongues to lungs. *Acta Physiologica* 204, 2: 158–168.

Kirksey, S. Eben, & Stefan Helmreich 2010. The emergence of multispecies ethnography. *Cultural Anthropology* 25, 4: 545–576.
Korsmeyer, Carolyn 1999. *Making sense of taste: food and philosophy*. New York: Ithaca.
McDonald, Jim 2010. Blessed bitters. In *Llewellyn's Herbal Almanack*. Woodbury: Llewellyn.
McLachlan, Amy L. 2011. Bittersweet: the moral economy of taste and intimacy in an Amazonian society. *Senses and Society* 6, 2: 156–176.
Mennella, Julie A.; Spector, Alan C.; Reed, Danielle R. & Coldwell, Susan E. 2013. The bad taste of medicines: overview of basic research on bitter taste. *Clinical Therapy* 35, 8: 1225–1246.
Muñoz, Ignacio J.; Pablo E. Schilman & Romina B. Barrozo 2020. Impact of alkaloids in food consumption, metabolism and survival in a blood-sucking insect. *Scientific Reports* 10: 9443.
Myers, Natasha 2015. Conversations on plant sensing: notes from the field. *Nature Culture* 3: 35–66.
Noel, Linda *et al.* 2014. Bitter medicine is stronger. In Eben Kirksey (ed) *The multispecies salon.* Durham: Duke University Press.
Ogden, Laura A., Billy Hall & Kimiko Tanita 2013. Animals, plants, people, and things: a review of multispecies ethnography. *Environment and Society* 4: 5–24.
Oxfeld, Ellen 2017. *Bitter and sweet food, meaning, and modernity in rural China*. Oakland: University of California Press.
Paxton, Heather 2008. Post-Pasteurian cultures, *Cultural Anthropology* 23, 1: 15–47.
Petitmengin, Claire 2007. Towards the source of thoughts: the gestural and transmodal dimension of lived experience. *Journal of Consciousness Studies* 14, 3: 54–82.
Pink, Sarah 2006. The future of visual anthropology: engaging the senses. London: Routledge.
Pollan, Michael 2001. *The botany of desire: a plant's-eye view of the world*. New York: Random House.
Porcello, Thomas *et al.* 2010. The reorganization of the sensory world. *Annual Review of Anthropology* 39: 51–66.
Porter, Roy 1999. *The greatest benefit to mankind: a medical history of humanity from antiquity to the present.* London: Fontana.
Reed, Edward S. 1997. *Encountering the world: toward an ecological psychology*. Oxford: University Press.
Rozin, Paul 1990. Getting to like the burn of chili pepper. In Barry G. Green *et al.* (eds) *Chemical senses. Volume 2: Irritation.* New York: Dekker.
––––– 1998. *Towards a psychology of food choice*. Bruxelles: Danone.
Running, Cordelia A., Craig A. Bruce, & Richard D. Mattes. 2015. Oleogustus: the unique taste of fat. *Chemical Senses* 40: 507–516.
Seremetakis, Nadia 2017. *An introduction to cultural anthropology*. Cambridge: Scholars.
Shurkin, Joel 2014. Animals that self-medicate: many animal species have created their own pharmacies from ingredients that commonly occur in nature. *Proceedings of the National Academy of Sciences of the United States of America* 111, 49: 17339–17341.
Stoller, Paul 1989. *The taste of ethnographic things: the senses in anthropology*. Philadelphia: University of Pennsylvania Press.
Sutton, David 2010. Food and the senses. *Annual Review of Anthropology* 39: 209–223.

Manuscript received: 19.06.2020
Manuscript accepted: 15.02.2021

HANNAH DRAYSON Dr. phil. is lecturer in digital art and technology and co-convenor of the Transtechnology Research Group in the School of Art, Design and Architecture at the University of Plymouth. An artist and designer, her work has explored the intersection of arts, science and medicine through a diverse range of media: web and digital design, interactive art, live coding, media archaeological reconstructions and guided dreaming. Her doctoral research explored the epistemological influences of scientific objectivity on the use of medical instrumentation in the arts. Her research interests focus on affect, embodiment and their intersection with scientific and medical technologies.

University of Plymouth; Transtechnology Research
Portland Square, Drake Circus, Plymouth PL4 8AA
e-mail: hannah.drayson@plymouth.ac.uk

Being Moved Together During Co-Creating Transitional Spaces

A Navigated Quest in the Borderlands of Pluralistic Healing and Therapeutic Contexts

DIRCK VAN BEKKUM

> "It is the attempt to separate intellect from emotion that is monstrous, and I suggest that it is equally monstrous—and dangerous—to attempt to separate the external mind from the internal" (Bateson 2000: 470).

Introduction

Bateson's quote mirrors a highly contested topic at the 2019 AGEM conference on the "Aethetics of Healing" which this volume reflects. It's aim was to contribute to the understanding of different forms of healing from an experiential, sensory, aesthetic perspective. The conceptual framework I am after needs to encompass both analytical and applicable knowledge and skills in clinical settings because I "fieldworked" as an anthropologist, a group therapist, an educator and an artisan in Dutch medical contexts. Tender skills in crafting artefacts with groups of psychiatric patients, in learning groups of students/therapists, I will argue, are indispensable too to my argument and validation of such a framework (Boas 1955; Bateson 2000: 128–152; Dissanayake 1982; Van Bekkum 2018).[1]

My arguments and concepts in this paper emerged from ten years (1983-1993) of clinical fieldwork in artisinal group therapeutic contexts in clinical psychiatry (Van Bekkum 1994, 2018; Van Bekkum *et al.* 1996) and from 25 years (1993–2018) of educational fieldwork in group training and co-educating groups of mental health and youth care professionals in the Netherlands and less frequent in Germany (De Voogt 1988; Van Bekkum 2006; Van Bekkum *et al.* 2010; Van Bekkum & Limahelu 2017).

Taking aesthetics of healing in anthropology and working with the senses seriously means for me sailing in deep epistemological waters.[2] To arrive at our anthropological destination, our cutlery making is, for some decades now, out of sync. We need three missing epistemological reference points to develop our navigation procedure.

1) bring ethnography from medical pluralism/indigenous rituals "home" to (Dutch) clinical contexts (Turner 1969; Turner 2012; Douglas 1996; Speck & Attneave 1973; Gone 2011; Van Bekkum *et al.* 2010),

2) integrating "the senses" in (Dutch) therapeutic contexts: an experiential (body-mind) shift from participant observation into total participation in collective settings (Turnbull 1990; Stroeken 2008; Van Bekkum 1994, 2018) and

3) an experiential (epistemological) shift to perceive living beings on earth, and thus ourselves, as "running on aesthetics." This means to understand the conception of "aesthetics of healing" as "learning to think how nature works" (Bateson 1979, 1990, 2000; Bateson & Bateson 2010).

This last point is rooted in a "sacred epistemology" (*ibid.* 1987). From these three reference points a conceptual clinical/educational framework is proposed.

Bateson suggested, leading by thinking example, "to learn to think as nature—humans and all other living being as a macro web of interacting ecosystems—works." Therefore, scientific thinking and human language needs to be complemented by humour/self-irony, art, play, dreaming, and ritual (cf. Bateson & Mead 1942; Bateson 1990, 2000: 128–152, 2017).

I argue in this paper, based on the fieldwork mentioned above and on the proposed conceptual framework, that anthropologists and prac-

titioners, among others, should open up to, and integrate all, their senses in their work (cf. Van Bekkum 2018). My interpretation of "aesthetics of healing" is a framework which integrates a) ecosystemic thinking (Bateson 1991), b) total participation in liminality (Turnbull 1990), and c) practicing plural reflexivity in transitional (liminal) spaces (Turner 1969, 1979, 2012; Van Bekkum *et al.* 2010). During these transitional moments transformation and healing, partly individually and partly collectively, may be facilitated for individual clients/professionals and their familial/social networks.

I present two cases from Dutch therapeutic contexts. Case 1 is about Wout (19) running into several psychotic episodes. He attended group therapy in clinical psychiatry in which I was therapist, artisan and anthropologist. Case 2 is about Annass (16) and Kareef (14), adolescent "troubling/troubled" sons in an extended Iraqi refugee family (ecosystem) diagnosed/treated within a (Dutch/Frisian) transcultural family therapy context.

Experiential Shifts: Ecosystemic Thinking, Total Participation, and Plural Reflexivity

During and after my graduate anthropology studies I worked as an artisinal group therapist. For ten years I was part of the Dutch medical mental health system studying about 500 drafted young men (and their families) who were being hospitalized in the clinical psychiatry department of a military hospital (Van Bekkum 1994, 2018). This placed me in a triple outsider position. An anthropologist and artisan in psychiatry, a therapist and artisan in anthropology and an artisan having no position in the art world. This quest suited my longing and ambition. Wanting to become a "clinical" anthropologist meant I was doing more than participant observation research. Turnbull's conception of "total participation" (1990), based on Turner's conception of liminality (1969), offered answers for this "going native at home."

It took decades of recurrent rethinking of Bateson's ecosystemic (ecology of mind) approach and twining it with Turner's ritual approach (communitas, liminality and plural reflexivity) to arrive at a cohesive "clinical' frame." I found support for my multiple outsider position with Koen Stroeken. He performed extensive fieldwork on healing rituals in *Sukuma* (Tanzania) divination (*ibid.* 2010, 2018). Becoming an apprentice in divinatory practice he needed, like me, "clinical" concepts to understand what he had been through during his education to become a healer (*ibid.* 2012). Stroeken found support in Bateson's "experiential—cognitive-sensory—frame" (Bateson 2000: 271ff) to understand how divinatory healing is aesthetically shaped (Stroeken 2008). The moments of healing and transformation in divination rituals resembles the practice of co-creating transitional spaces and *communitas* in therapeutic and educational contexts (Stroeken 2010: 50ff, 205ff, 2018: 174ff; Van Bekkum *et al.* 2010).

Only recently, in the year of our conference on the *Aesthetics of Healing* (2019), the above mentioned positional and epistemological muddle disentangled itself. First I had to realize that all my fieldwork was group focused; the group was the healing agency. To my understanding, in medical anthropology, research in this domain is scarce (cf. De Voogt *et al.* 1988; Braten 2007; Van Bekkum *et al.* 2010; Gone 2011; Seikkula *et al.* 2018). Most related literature on healing and psychotherapy focuses on individual healing in psychotherapy and within the group (Basu *et al.* 2017; Hinton & Kirmayer 2017; Kurz 2017). Another revelation to me was that I had to acknowledge that during my ten years of artisanal therapy fieldwork we, groups of young men and me, co-created numerous times "aesthetics of healing in working with the senses in therapeutic contexts" (cf. Van Bekkum 1994, 2018; Van Bekkum *et al.* 2010). This is demonstrated in the exemplary case of Wout. Further, during 25 years co-educating professionals in mental health and youth care practices we, students, co-therapists, co-educators, frequently had been co-creating transitional (deep learning) spaces in which "aesthetics of healing in working with the senses in therapeutic contexts" occurred (Van Bekkum *et al.* 2010; Van Bekkum & Limahelu 2017). This is demonstrated in the exemplary case of Annass and Kareef in the refugee family.

Ecosystemic Thinking How Nature Works

> "I hold to the presupposition that our loss of the sense of aesthetic unity was, quite simply, an epistemological mistake" (Bateson 1979: 18).

If we perceive that all living creatures—as parts of, and participating in, our universe—operate by aesthetics, as Bateson claims, we need to learn to think how nature works (Bateson 2010; cf. Dissanayake 1982; Hoffmeyer 2008; Charlton 2008; Harries-Jones 2016; Chaney 2017). Bateson developed his thinking practice and conception of ecosystemic thinking as a "sacred epistemology." This was posthumous published in a co-authored book with his daughter Mary Catherine from his marriage with Margaret Mead (Bateson & Bateson 1987). His starting point is: humans are out of sync with how nature works (*ibid.* 2010). To get back on track, according to Bateson, we have to learn to perceive our (individual) selves as parts of aggregates of organisms in permanent adaptive communication with our environments, as cybernetic ecosystems (Bateson 2000).

Cybernetic means: self-generating, self-organizing, and self-correcting (groupings of) organisms. Both individuals and collectives are, at the same time, highly autonomous and still deeply interdependent. These complex webs of interdependencies operate in a hierarchical order. Individual ecosystems are more determined by more comprehensive aggregates-organisms-environments (families, communities, populations, nations and species). A necessary (adaptive/systemic) change into more comprehensive ecosystems takes several generations and a lot of "clustering of changing" individual organisms. Cybernetic systems operate by endless fluxes (waves) of information exchange (cf. Eicher-Catt 2003). These extremely complex waves of floating information within and between (aggregates of) organisms are "patterned" [...] that is habituated. Adaptive communication processes are a "coupled" entity between organism and environment and, for Bateson, operate through the senses and for a large part outside of what we call "our cognition."

We are, as individual organisms and as aggregates of organisms, very fragile, cybernetic ecosystems. Double bindings (Bateson 2000: 271ff) and "runaway communication patterns" (Chaney 2016) do occur frequently in all organic ecosystems and nature has ways to prevent and eliminate these potentially damaging patterns (see case 2 of family Shakir). Bateson conceptualizes the integration of sensory messages into "beautiful wholes as "sacred" (non-conscious and incomprehensible) but also as a "pattern that connects patterns" which is, from a multi-generational perspective, easily to disrupt (*ibid.* 2000: 128–152, Brier 2008). Recent studies confirm the complexity and importance of Bateson's approach and of his conceptual framework as a way of learning/knowing how nature works (cf. Varela *et al.* 2001; Charlton 2008; Weber 2013; Harries-Jones 2016).

Total Participation: Working with the Senses

> "[...] without some method, the cross cultural comparison falls to the ground and with it the whole interest of this exercise. If we cannot bring the argument back from tribal ethnography to ourselves, there is little point in starting at all." (Douglas 1970: xxxvi)

Bateson's epistemological adagium of "learning to think how nature works" fits and fuels my quest for a number of years. Still it did not offer a way out of my "positional muddle" of being an artisan, a group therapist and a clinical anthropologist all in one. In my fieldwork in clinical psychiatry as artisinal group therapist I was doing something beyond participant observation (Van Bekkum 2018). What I learned to do was a kind of systematic trial and error to improve my efforts as a therapist by recurrently ploughing back my experiences and reflected observations into my daily practice (cf. Chavers 1972, 1980, 1984a,b). I took it as an endeavour to also theoretically question conceptions in mental health and youth care in Netherlands, especially regarding the context of migration.[3] To integrate anthropological and therapeutic approaches we, clinical anthropologists, created the conception of "migration as transition" (cf. Van Gennep 1960; Turner 1969; Van Bekkum *et al.* 1996). To grasp the complexity of young men's (and their families') group dynamics and avoid an individualistic—dominant psychological—approach we found the "systemic" conception to see social relations as "balancing of, sometimes conflicting, loyalties" (cf. Boszormenyi-Nagy & Spark 1984; Van Bekkum *et al.* 2010). This completed a compatable frame of "healing" (making whole again) found in borderlands of anthropology and psychiatry. As will become clear

later on this (therapeutic) making whole again is located in states of liminality within transitional spaces (cf. Winnicott 1953; Turner 1969). Only recently have I found an approach and a conception which fitted my long term "skill/knowledge producing" fieldworking in clinical and educational practices. It also encompasses working with the senses in therapeutic contexts.

Developing his concept of "total participation," ethnomusicologist and anthropologist Collin Turnbull (1990) refers to the importance of, and goes beyond, Turner's concept of liminality,criticizing the latter's approach of participant observation. He redefines "liminality" according to his experiences throughout healing rituals among the *Mbuti* people in Congo (Turnbull 1965). Based on his insights, Szakolczai and Thomassen (2019) develop their perspective of a shift from "fieldwork" as "participant observation" to field experience as "total participation," and, therefore, as a major breakthrough in social theory. It would be a "substantial renewal of anthropological methods" and an "intensive involvement" where the "experience of being present" includes that reasearchers are not only part of the activities but that these "fill [our] whole being" (*ibid.* 193). Turnbull (1990: 51), accordingly, states:

> "What we have lost is the awareness that our ability to participate fully, to become emotionally as well as intellectually involved in another culture, in no way detracts from our objective, rational, intellectual analytical ability. On the contrary it provides a wealth of data that could never be acquired by any other means, which of course is our very argument for entering the field in the first place." (*ibid.*)

Turnbull ends his seminal paper with the importance of working with the senses by total participating in fieldwork. This supports an individual and collective reflexive data collection in therapeutic and ritual healing contexts from an experiential, sensory, aesthetic perspective. *Total Participation*, during liminal states in healing rituals, according to him,

> "[...] provides the perfectly integrated point of view that enables those who can move freely in and out of the liminal state with the ability to make rational judgments that seem infinitely wise because they are so infinitely effective and functional. It is indeed well perceived as holy, as a timeless state of grace." (*ibid.* 80)

Plural Reflexivity

Victor Turner (1969) and Edith Turner (2012), with their conceptions of liminality and communitas emerging during rituals, illustrate dynamics of collective "mental" states in which temporarily several dualisms like individual-community, or mind-body dissolve. These mental states resemble Bateson's (2000: 128–152) ecology states of mind in frequently re-enacting the unities of organisms-environment and of mind-nature into states of grace. Campbell (1959) described similar liminal and ecosystemic takes on the communal transformations of *Aranta* boys' initiation rituals to get biologies in sync with nature:

> "The system of sentiments of the local group, however, has been constellated not primarily, or even secondarily, to gratify the crude wishes of the growing adolescent for sensual pleasure and manly power, but rather in the general interest of a group having certain specific local problems and limitations. The crude energies of the young human animal are to be cowed, broken, re-coordinated to a larger format, and thus at once domesticated and amplified. Hence, although the rites certainly have a psychological function and must be interpreted in terms of the general psychology of the human species, each local system itself has a long history behind it of a particular sort of social experience." (*ibid.* 90).

Adolescents' disruptive actions, both as individual and in peer-groups, could be taken as signals that a rite of passage is needed as Campbell (1959) outlines (cf. Van Bekkum 2017). Boys' initiation marks not only their transition into the adult male/female worlds. Their individual coming of age, like a wedding and a funeral, reshuffles all positions and ties in the webs of kinship of their families and bring about changes in inner (material/biological) and outer (minded/mental) worlds. For Turner this liminal state is a collective experience and these rituals heal affliction, loss, and trauma within the community. He also claims that during the experience of *communitas,* a plural—collective—reflexivity is developed. This perspective resembles Bateson's approach

regarding "feedbacking" self-generating, self-organizing, self-corrective abilities of ecosystems. Turner describes theses states of plural reflexivity as "occasions on which a society takes cognizance of itself" (*ibid.* 1969: 167). I will come back to this aspect when discussing Judith Limahelu's approach as a transcutural family therapist in Case Study 2 on the Shakir family below. At this point I just want to stress that Turner's descriptions of systemic changes during rites of passage resemble the practice of drawing genograms (kinship diagrams) in family therapy to explore and map disguised and neglected pain, traumata, and blocked or fractured patterns of interaction in families (cf. McGoldrick 1995).

These two key conceptions, total particiaption and plural reflexivity, constitute the backbone of our proposed sensory perspective on the aesthetics of healing. It complements the experiential frame of "co-creating transitional spaces" as initiated and developed between 1996-2018 from the idea of "migration as life-phase-transition" (cf. Van Bekkum *et al.* 1996). Let me briefly introduce this knowledge producing process.

Transitional Spaces in Therapies

The idea of transitional space, as a contextualized place of transition, transformation and healing, emerged during co-writing a chapter for a Dutch handbook on cultural psychiatry twenty-five years ago. Four clinical anthropologists, including myself, developed this conceptual frame of "migration as transition," from our experiences in working with clients/families with migration/refugee histories (Van Bekkum *et al.* 1996). It reframed the migration experience as a depathologizing narrative which created a shared context for both client and therapist. Migration and seeking refuge is troublesome for any ecosystem while it has to deal, personally and as a family, with (too) many changes in a relative short period of time. Most of our clients and students in our practices recognized this "systemic wisdom" fairly easy.

This idea formulated in the borderlands of anthropology and psychiatry became in limited use for the last two decades in Dutch mental health and youth care practices (Tjin A Djie & Zwaan 2019, 2021). It opened up a horizon of potentialities because it integrated Van Gennep's and Turner's ideas on rites of passage, transition and liminality in therapeutic contexts. And it turned out to be compatible with Bateson's ecosystemic thinking of ecologies of minds. By combining the anthropological idea of transition with concepts of transitional objects and transitional spaces, widely accepted in western child psychotherapies (Winnicott 1951) it became even more applicable in diagnosis and treatment. The child psychiatrist Donald Winnicott (1951) refers to transitional objects when it comes to bridging painful periods for the infant during the absence of the mother. The child copes with this absence by holding on to a "bridging – soothing – object," like for example a cuddle toy.

Winnicott observes that good parents-children relationships also foster *transitional spaces* which are full of potentialities and in which children build personal relationships with persons and objects beyond the nuclear family. For Winnicott (1967) transitional spaces are filled with sensory play, joy, imagination, longing and fantasy. They are spaces where cultural experiences are located and created. The conceptual frame summarized above made it possible to invite clients to share narratives on what kinds of rituals their families, their culture, their religion employ in order to deal with "too many changes in a short period of time" like birth, death and marriage. Ritual practice, therefore, became an asset in therapeutic contexts (Van Bekkum *et al.* 2010).

The following two case studies are selected as exemplary for a number of fieldwork contexts I/we worked in for over four decades. In these contexts I was not only practising participant observation but also intended to be an active changing agent in the contexts I studied. By doing so it fuelled my ambition to make sense of out of experiences in my own family and in the wider Dutch context. The case studies will serve as a base to illustrate my theoretical reflections and conclusions.

The first case is my "minded" sensory encounter as an artisinal group therapist with Wout, hospitalized in a clinical psychiatry during a series of psychotic episodes around 1987. The second one is a "composed" case of an Iraqi refugee family trying to create/make a home in the Netherlands.

Case study 1: Wout

Context

It was a regular artisinal group therapy (two hour) session as part of a diagnostic and treatment program in a psychiatry department of a Dutch military hospital. I was part of a multidisciplinary team of psychiatrists, psychologists (as psychotherapist), nurses, and three non-verbal therapists: a creative, a drama and an artisinal therapist (me). During the artisinal therapy session coffee breaks were held in which their designing/manufacturing processes were discussed. The initiating activity was designing and crafting an artefact in their personal program which I developed with them. My workshop was in a small separate building in the middle of a beautiful hospital garden with ancient trees. It had taken me two years to create both a material and mental space in which the clients could feel at ease away from the stressful open and closed wards. I used my "therapist authority" during intakes with every new member of the therapy to make clear that everybody in my workshop was rather vulnerable, including me. I made clear that making artefacts helps them to recover from their affliction and how being nice and respectful to each other is part of this. These were preconditions to enable co-creating transitional spaces.

The Therapy Session and Wout's Story

It was a Wednesday afternoon at three o'clock in the middle of the therapy session with six patients at work in my "smithy" workshop. I knew from staff meetings that Wout had been in psychosis for several days and was slowly recovering. Due to his anti-psychotic medication his fine motor skills were disturbed. It took Wout, therefore, much more energy to craft his artefact than in his normal bodily state. He liked coming to occupational therapy because of escaping confined space of the ward. Wout was a drafted soldier brought in our department several weeks ago with a psychosis. In one of the later therapy sessions, recovered from his psychosis, he told me what happened. With his platoon Wout was in a "bivak"—bush training—in his first two weeks in the army. He was exhausted and sleeping with his fellow soldiers in the open. The whole day they were fatigued in combat training in the field. It was dark with low temperatures and they had been awakened several times to exercise again. At one moment he started screaming, jumped up and started running around with his (not loaded) rifle in his hands. Within seconds everyone was up and the sergeant found him while hiding behind a tree, crying. The medics arrived, brought him back to the barracks and five hours later he was hospitalized at our ward in Utrecht. Diagnosed and strongly medicated he was edgy, mistrusting most of the (male) nurses. He was constantly moving around in the closed ward. He stayed by himself, and appeared to be deeply afraid of something. I will share here some of my observations and experiences from my notebooks of that afternoon to later on reflect on them:

> "Looking from the corner of my eye I saw Wout standing close to the window, his heavy metal file lifted up in the air directed to the glass. From his posture and appearance I saw he intended to break it. I was standing at the other side of the workshop and [...] terrified. Three big workbenches between me and him. No time to walk or talk to him. The situation was ridden with both anger and anxiety. I sensed that the other five soldiers present in the workshop were keenly aware of the emerging crisis. They stood still and watched us both. The safe therapeutic atmosphere in my workshop was threatened. Tension, even anger and aggression were alright for me as the therapist but I couldn't accept destruction. Wout was in a psychotic state. What to do? No time to think. Something within me, I do not know what, took over. I didn't look in his direction again. My fear became anger and I started mentally visualizing myself jumping over the benches at the same time calling to him: 'if you break that window I throw you out through that window'. No one moved. It seemed to take a lot of time (could only have been seconds) and I barely could stand the tension. I hadn't moved an inch after seeing his arm lifted high with the tool. I blinked, looked in his direction, catching him in the corner of my eye. His hand was back beside his body and slowly moving back to his bench. I carried on with my own activities. Then after twenty seconds I heard a noise added to the sound level in the workshop. I looked up and at Wout and saw him using the file reworking the piece of iron in the bench vise. And while his head bowed forward clearly a smile was

on his face. The tension in the room slowly disappeared. Not a word has been spoken throughout what happened."

No one present ever mentioned again what had happened that day but two months later in a conversation with Wout I returned to the event. His psychosis was cured and his medication discontinued. When I asked him if he could remember the incident he smiled. Here I quote his comment from my notes:

"Oh yes, I do exactly. At moments, even with those drugs, I had so much *Angst* (anxiety) that I had to do something. On the ward the atmosphere was so strict and tense that I didn't dare to scream, throw something or challenge the nurses in other ways. But with you in the workshop I felt more relaxed but then the *Angst* came and I had to do something. When you have psychotic moments you feel so open, so unprotected. You sense and feel everything what is and happens around you and all this is getting into your system. That's why I liked the crafting work with you. But at some moments it came back and I had to do something. And that's why I wanted to smash the window."

He stopped. I asked what he had felt or seen in those minutes. He smiled again and said:

"I felt and saw your anger; I saw it as a green light around you. And I knew that if I had broken the window you would have thrown me out. But I saw as well that you respected me and more important you saw my anxiety. That's what most nurses and doctors are afraid of. To feel my *Angst*."

Reflection

I was shocked, and touched, that he knew what I had thought and felt but also that he needed no confirmation from me as if he had correctly "read" my non-verbal message and body language. On a "deeper" level I was not surprised and told him that he had seen right through me. We shook hands, thanked each other and never mentioned the event again. This conversation was not shared with the other staff members in the department but Wout and other patients helped me to trust my communicative "instincts." By "being moved together," we co-created a transitional space in which a sensory (non-verbal) way of perception took place. The fear I felt was not only about smashing windows or how the other men would react. It was Wout's fear of mentally falling apart that I sensed and I could only know this by "doing total participation" (cf. Turnbull 1990). By voluntarily interconnecting our "minds" I partly decomposed mentally with him. This mitigated his *Angst* and he got back to his stabilizing and "sense-integrating" work.

In the years to come I felt much more confident to navigate on my inner compass in tricky or tense situations within therapy sessions. The feedback from Wout taught me that balancing between firmness (sometimes even anger) and tender skills ("resonating," cf. Wikan 2012) when"being moved together" (cf. Braten 2007) helped these young men and me to co-create transitional spaces. This is only possible by, temporarily, giving up your "potentially dominant" position and "individual ego" state in order to enter states of *communitas* in which all tensions, inequalities, animosities and differences temporarily disappear (cf. Turner 1969).

How transitional spaces are co-created is not easy to generally describe as it is very contextual and time/place bound. Every time and place require another "choreography" to facilitate participants, their intentions, issues and ambitions entering liminality. Based on numerous experiences we developed a preliminary cluster of active ingredients from the perspective of the facilitators:

"a) never start without a clear intention and purpose of the session
b) as facilitator you don't know what's going to happen. This means that the group process is leading us. Facilitators guard individual/collective intentions and the deep-safe character of transitional space.
c) create a circle and a centre to work in (offer food, drinks, humour, a few minutes of silence, etc.)
d) opening and closing transitional spaces in a collective mindful way is crucial for success.
e) prepare and facilitate participants to feel at ease to become more mindful on what's going to happen
f) invite participants to become emotional part of the purpose of the session by telling fitting stories (for example events of previous sessions)
g) invite participants to express and verbalize their expectations towards the session (if there is

reluctance in the group express your own aims for what to happen)
h) clarify that emotional surrender determines the longed for - individual and collective - outcomes
i) make clear that in transitional spaces feeling and communicating any emotion or thought is alright if done with a 'good heart'.
j) when sensed or needed 'mark' (put the group process on hold) transformative and epiphanal moments to help participants become aware what's happening."

Thomas Scheff (1979) developed a conceptual frame which resembles what we call transitional space. To understand dynamics of collective tension release in rituals demands a) an "emotional surrender to our senses," b) that emotions are aroused together by singing, joking, laughing, crying, dancing, drinking and eating "with all our senses." He conceptualizes the individual and collective key activity, which makes participating in the ritual effective, as "distancing, [...] the simultaneous and equal experience of being both participant and observer" (*ibid*. 60). This description recalls Turnbull's conception of "total participation."

Within the theoretical framework of this article, I conceptualize my encounter with Wout as follows: the making of artisinal objects in group (therapeutic) contexts reunites "mind and body" (and maybe other aspects of "self") on an individual level (cf. Van Bekkum 1994, 2018). All senses are involved and my "total participation" facilitates a potential "aesthetic healing environment." The setting (material/mental) of the workshop encourages Wout and me, within the group, to co-create a "minded" transitional space. This opens up to a "collective state" beyond words (cf. Wikan 2012) and beyond empathy (cf. Koss-Chioino 2006). We are all in a state of liminality. Our cognition lowers, our everyday thinking stops and the senses take over. We enter a level of "ecological minded" communication "living in each other's minds" (cf. Bateson 1979). In both the event and in our later encounter Wout and me practice plural reflexivity and "feed-backed" systemically: both individually as collectively.

Case Study 2: Refugee Family Shakir

Educating/Learning Context

This case study exemplifies a transcultural—system—therapy approach that has been put into practice for several decades and taught to many family therapists (cf. Van Bekkum *et al.* 2010), also by me for 15 years (2003–2018). We attend families and communities with children in (psychiatric/educational/behavioural) distress, focus on the as "self-healing systems" in order to cope with "too many changes in relative short periods of time" and with layered disruptive "unprocessed" events from the past like e.g., birth, death, migration, divorce, domestic/sexual violence etc. (cf. Van Bekkum *et al.* 1996). This specific case study developed from ten interview sessions (2016–2017) by me with my former student, and now colleague, Judith Limahelu, who "guided" the Shakir family. The case has been extensively described in Van Bekkum & Limahelu (2017).

However, the educational context of the case already begins with a three year education of Judith (2009–2011) as a transcultural system (family) therapist at the *Marjon Arends Institute* in Amsterdam. There were always two teachers/senior therapists present: one permanent and one specialized in the "topic of the day." The groups in these courses usually consisted of 90% women, and 50% of participants had a migratory background. All courses were designed and programmed as multilevel learning processes. During these years, a professional learning level was intertwined with a personal level learning process of retracing and rediscovering the students' own family and cultural history. This multilevel learning can be addressed as practising both total participation and plural reflexivity in which experiential shifts may occur on both individual and collective level. The basics of this kind of reflexive learning was already formulated in a "transcultural" feminist paper by (De Voogt *et al.* 1988). The "intersectional" influence of the therapist's - personal, family, gender, class, white, colonial, migration, ethnic and cultural - background had to be acknowledged and to be accounted for in the therapeutic process:

First, each training day has a "theme" integrated in the whole of the course. Second, we work in a circle of chairs with a "ritual centre" in the middle,

Fig. 1: Example setting of educational fieldwork student group

in shape of a coloured cloth with flowers, candles, food and several representational objects which interconnect learning days with the participating students (see fig. 1). Third, each day "opens" and "closes" with a "mindful ritual" by verbalising an intention/wish for this specific day/event and lighting and extinguishing a group candle. Individual students can light a candle with their own, verbal or non-verbal wish/story.

Every day the theoretical introduction is followed by the presentation of a case prepared by two students relating to their practical experiences. Teachers facilitate a learning space in which the group deals with and reflects on individual resonating/expressed emotions of participants, emerging from collectively discussing cases and theory. The aim of this educational process is synchronizing a) learning from clinical cases of troubled children within (ethnic/religious/national backgrounds of) their families with b) learning by reflecting on issues from our own families' histories. The ground work for this systemic teaching of transcultural family therapy is rooted in feminist family therapist supervision groups in the 1980s (cf. De Voogt *et al.* 1988; McGoldrick *et al.* 2005) and anthropological approaches regarding ritual practice (cf. Kluckhohn & Strodtbeck 1961; Turner 1969; Bateson 2000; Van Bekkum *et al.* 1996; Siddique 2011).

Treatment Context

The family Shakir consisted of two parents and eight children: four sons and four daughters. Two adolescent sons, Annass (16) and Kareef (14) of this extended Iraqi refugee family (1,5 years in the Netherlands at the time of the therapy) were both troubling in different contexts and firmly trou-

bled in their coming of age process. For months they "played truant" and committed minor criminal acts to finance their abundant "mind-blowing" marihuana and gaming addictions. All interventions from school, attendance officers, police, and numerous sessions with youth care professionals did not have the targeted effects. Different youth care workers were not able to establish a successful working-relation with the parents and perceived both parents and children as unmotivated to cope. Ultimately the responsible probation officer proposed to outplace the male adolescents from their family into state custody. As a last resort transcultural system therapist JUDITH LIMAHELU agreed to step in under the condition that 1) the outplacement procedure of the boys before would be interrupted until she would finish her therapy trajectory, and 2) she could work with the family in terms of home visits.

Judith started her home visits, interacting as an ordinary guest, with whoever was at home while chatting and drinking tea with the hospitable mother. The younger children and the girls slowly got interested once Judith appeared twice a week. With the children she played "family stories quartet game"—designed/published by herself—to initiate playful question/answer communications (cf. LIMAHELU 2010). Judith used the game to facilitate narrating family stories through which she could develop a contextual "picture" of this family. Her "instrumental method," sooner or later, touched the issues of the two sons in trouble. During one of her visits she saw an old lady on the sofa in the living room. Judith asked who she was and the children told her: "that's grandma (Oma), she lives with our oldest brother Abbas two blocks away." Involving the, before unseen, third generation changed the hierarchical and, thus, the parental and gendered contexts. With her visit Oma checked Judith's influence on the family. Her approval defrosted the stuck (double binded) situation between the family and the involved state care institutions: youth care, forensic psychiatry, police, and school. Oma's visit set a systemic process in motion which I interpret as a certain aesthetic configuration of healing.

Reflection

In our original extensive discussion of this case study (cf. VAN BEKKUM & LIMAHELU 2017) we demonstrated that every family member plays an indispensable role in keeping the "ecosystem" moving, and, therefore, also adapting to changed environments. By facilitating deep-safe moments, what she learned to call "co-creating transitional spaces," Judith patiently mapped - during a number of home visit sessions - afflictions, trauma's, kinship ties in the family's migration history and integration processes in Dutch contexts. She complemented her data collection by the family stories game with drawing "genograms" (kinship diagrams) together with the family which is a common procedure in family therapy (cf. MCGOLDRICK 1995). She used the experiential frame model of "migration/refuge as transition" (cf. VAN BEKKUM *et al.* 1996) to map the fragmenting/dividing effects on their life in the Netherlands. She carefully differentiated the effects of the migration process and experience from the trauma's due to the years of mass violence (war) in their home country. Both clusters of experiences - war traumas and migration/refuge - had destabilizing influences on the gender complementarity and transgenerational continuity.

The resulting recovery of this family also took place on a different level. The family had to synchronize their own cultural/religious/regional Iraqi/Islam bounded patterns "systemically" with a Dutch, regional Frisian, cultural environment. An important part of the intervention strategy was the co-creation (with families) of transitional (deep-safe/ritual) spaces facilitated by Judith as the transcultural system therapist. Judith repeatedly co-created "communitas" experiences (cf. TURNER 2012) and "plural reflexivity" (*ibid.* 1979) within the family by a) resonating with her own emotions with those of the client-system (total participation) and b) bringing in, at the right moments within the right mirroring content, her own family stories of migration, seeking refuge and creating a new home in the Netherlands (cf. PEUTZ 2012; WIKAN 2012). The Shakir family system reflected on herself and "feed-backed" on itself. This way, she initiated a self-correcting "wholing" process in which generational and gender issues were negotiated and resolved.

Important aspects of Judith's specific competences and interventions only became visible during our interview sessions. Most of her co-creating transitional spaces and the "fitting interventions" were outside of her "everyday awareness" (cf. Hall 1990: 24ff). These "tender - soft - skills" are somewhat common sense in many therapeutic professions but difficult to practice and communicate in terms of plural reflexivity among colleagues. Further, combining them intentionally, reflexively and applying them in collective setting during home visits is a rare practice (cf. Jude 2016). I argue that related dynamics of "being moved together" is comparable to ritual healing, no matter if located in medical pluralistic and/or (indigenous) community contexts (cf. Turner 1969, 2012; Steegstra 2004, 2009; Stroeken 2018).

From the perspective of a conceptual framework of "migration as transition" (cf. Van Bekkum *et al.* 1996) an ecosystem like the family Shakir from Iraq can be interpreted as temporarily "liminal vulnerable" in making a new home in a foreign country like the Netherlands and in which their children (born before and after the transition) can thrive. As I have learned in decades of clinical practice, migrant/refugee families may not only develop instabilities due to their transition from home to host culture. Another unseen burden are incongruences between subsystems (gender and generational worlds), exemplified here with the separation of Kareef and Annass from their original extended family setting. The formational "protective wrapping" (Tjin A Djie & Zwaan 2021) for the, liminal vulnerable, adolescent sons in a wider system of father (older brothers/uncles/grandfathers) and mother (older sisters/aunts/grandmothers) positions had been lost. This wholeness of the family was due to the loss of the extended family in their homeland and to both unseen massive changes throughout migration. The complementary and hierarchical levels of generations and gender relations in the Shakir family system are confused.

In the course of somewhat transitional/transformative ritualized practices and moments, parents, children and grandparents are facilitated to surrender and integrate ancestral systemic wisdom of patri- and matrilateral origin. Gaining this knowledge and integrating it into current contexts, provides this three/four generation family systems with the agency to reshape their collective lives and to resolve issues in raising their children and preparing them to move on. The family Shakir revitalizes and restores by reconnecting to their self-corrective ecosystemic capacities.

Concluding remarks

I have outlined—with the examples of a) Wout in a Dutch artisinal group therapeutic context, and b) Annass and Kareef in a family (systemic) therapeutic context—different modalities of "healing with the senses." They illustrate fluid, fleeting, (w)holistic healing instances in terms of "being moved together." These may turn out to develop systemic changes (e.g., of the ecosystem) in which a co-creation of transitional spaces reunites material (natured/organism) and immaterial (minded/mental) ingredients. My argument is that we need related aggregates of minds and tender skills to grasp what is needed to facilitate systemic changes in afflicted individuals and their (social) environments.

We started our navigated quest to "contribute to the understanding of different forms of healing from an experiential, sensory, aesthetic perspective" and proposed to add three epistemological reference points:

1) bring ethnography from medical pluralism/indigenous rituals "home" to (Dutch) clinical contexts.

2) integrate sensory aspects into (Dutch) therapeutic contexts to shift engagement on both perceptual and experiential (body & mind) levels from participant observation to total participation in collective settings.

3) "learn to think how nature works by using a sacred (experiential) epistemology" (Bateson & Bateson 1987) to "perceive our living earth and cosmos, as running on aesthetics."

By outlining key conceptions, we grasped processes of co-creating transitional spaces within the frame of our clinical and educational fieldwork. We thus composed a conceptual framework to contribute to the understanding of "aesthetics of healing" from the perspective of our therapeutic practices.

We facilitated total participation and plural reflexivity, and doing so, we co-create transitional

spaces in which experiential shifts occurred. Coping with these "systemic complexities," from my perspective, covers what YOUNG (1991) called "re-enacting the sacred."

These experiences are extremely difficult to verbalise, to put into words, let alone to put it into written language. Four millennia ago Lao Tzu stated: "The Tao that can be spoken is not the eternal Tao." This gap of communication and perception might be bridged by what we may coin as "tactile knowledge" (POLANYI 1958) and/or as "tender skills" (VAN BEKKUM 2017).

With this conclusion we stumbled upon a new question: how to express and communicate what can or cannot be said and written about the aesthetics of healing and the related "work with the senses?" In his sacred epistemology BATESON (1987) claims that rigorous science, self-irony and artistic imagination should go hand in hand. His texts are loaded with bitter, grace- and joyful irony and with poetic references to art.

Individually we live, communicate and learn through our senses in our daily lives. Still most of us need being moved together in transitional spaces to see how to find our ways "home" (cf. MCGOLDRICK 1995) in a navigated quest guided by the sacred (BATESON & BATESON 1987; BATESON 2017; VAN BEKKUM 2018).

Acknowledgements

Thanks Theresia Bernet and Marijke Steegstra for being there with me in Münster and during the writing/editing difficulties, Bert Keizer for improving my English and, of course, Helmar Kurz for saving my efforts/this text from oblivion.

Notes

1 "Tender skills" is a concept we developed together during our 30 years of running an intercultural consulting and training practice. Tender skills are utterly human and we all practice them in our fragile familial and social webs of relationships. How can we cherish our family relations and friendships as safe, loving and beautiful? How can we transfer/translate these tender skills to co- creating transitional spaces in clinical psychiatry and in co-educating family therapists turned out to be a long learning process. Approaches like "radical empathy" (cf. Koss-Chionio 2006), "open dialogue" (SEIKKULA *et al.* 2018), and "being moved together" (BRATEN 2007; BRUSCHWEILER-STERN *et al.* 2018) are validated therapeutic practices and examples of "operating tender skills."

2 The sailing metaphor is intentional while "learning to think how nature works" (central to our epistemological position) is a quest leading to the understanding of different forms of healing from an experiential, sensory, aesthetic perspective. The metaphor contextualizes my positionality in this paper and my clinical and educational research on which it builds.

3 "Doing theory" here denotes to a "fieldworking" practice in which "scholarly parsimony and artisinal aesthetics" are "done" at the same time. During and after my anthropological studies I started to make artifacts to express experiences in my fieldwork for which I could not find words/concepts. If anthropological theories, and those in other social sciences, are models to understand our worlds and aesthetics of healing it is a fruitful starting point in this special issue of Curare to walk a daring path into parsimony. BATESON's parsimony, also called the "Occam's razor," points to the "preference for the simplest assumptions that will fit the facts" (BATESON 1979: 30). Such parsimonious models of our worlds generate an aesthetic quality; they are beautiful and have grace. Manufacturing artifacts bring about aesthetic experiences which are both similar and different than parsimonious aesthetics by creating mental models in scholarly work, combining artisinal and scholarly approaches.

References

BASU H. *et al.* (eds) 2017. *Spirit and mind: mental health at the intersection of religion and psychiatry.* Berlin: LIT.

BATESON G. 1967. *Style grace and information in Primitive Art*. Reprinted in: BATESON 2000.

———— 2000 [orig. 1972]. *Steps to an ecology of mind*. Chicago: University of Chicago Press.

———— 1979. *Mind and nature: a necessary unity*. Toronto: Bantam.

BATESON G. & R. E. DONALDSON 1991. *A sacred unity: further steps to an ecology of the mind*. New York: Harper & Collins.

BATESON G. & M. CATHERINE BATESON 1987. *Angels fear: towards an epistemology of the Sacred*. New York: Macmillan.

BATESON G. & N. BATESON 2010. *An ecology of mind*. Documentary film. www.anecologyofmind.com (accessed 2020-07-28).

BATESON N. 2017. The era of emergency relocation: a transcontextual perspective. *Fokus På Familien* 2: 82–98.

BATESON G. & M. MEAD M. 1942. *Balinese character: a photographic analysis*. New York: Academy of Sciences.

BOAS F. 1955 [orig. 1927] *Primitive Art*. New York: Dover.

BOSZORMENYI-NAGY, I. & G.M. SPARK 1984. *Invisible loyalties: reciprocity in intergenerational family therapy*. New York: Brunner & Mazel.

BRATEN S. 2007. *On being moved: from mirror neurons to empathy*. Amsterdam: Benjamins.

BRIER S. 2008. Bateson and Peirce on the pattern that connects and the sacred. In HOFFMEYER J. (ed) *A Legacy for Living Systems.* Biosemiotics Vol 2. Springer: Dordrecht: 229–255.

BRUSCHWEILER-STERN N. *et al.* 2018. Moving through and being moved by: embodiment in development and in the

therapeutic relationship. *Contemporary Psychoanalysis* 54, 2: 299–321.

Campbell J. 1959. *Primitive Mythology*. London: Penguin.

Chaney A. 2017. *Runaway: Gregory Bateson, the double bind, and the rise of ecological consciousness*. Chapel Hill: University of North Carolina Press.

Charlton N. 2008. *Understanding Gregory Bateson: mind, beauty, and the sacred earth*. New York: State University of New York Press,

Chavers R. E. 1972. Dialektik als Wissenschaftsbegriff: *Eine Untersuchung über die Aspekte dialektischer Begriffsbildung im Hinblick auf den Methodenstreit der Wissenschaften unter erkenntnistheoretischen Voraussetzungen*. Dissertation. Berlin: FU.

Chavers R. E. [Black Horse] 1980. September moons Haiku in transition. Utrecht: Community for Development History.

———— 1984a. *Transversional psychology: a systematic and methodological study of psychotherapy*. Utrecht: DIES.

———— 1984b. *Kinematic conversion: a study guide in energy-transformations*. Utrecht: DIES.

De Voogt A. *et al.* 1988. *Integrating feminism & family therapy: a she-devil of a job*. Revised version of a lecture held on 29 April 1988 at the conference "Women's Perspective in Family Therapy."

Dissanayake E. 1982. Aesthetic experience and human evolution. *Journal of Aesthetics and Art Criticism* 41, 2: 145–155.

Douglas M. 1996 [orig. 1970]. *Natural symbols: explorations in cosmology.* London: Routledge.

Eicher-Catt D. 2003. The logic of the sacred in Bateson and Peirce. *American Journal of Semiotics* 19, 1: 95–126.

Gone J. P. 2011. The red road to wellness: cultural reclamation in a Native First Nations community treatment center. *American Journal of Community Psychology* 47: 187–202.

Hall E. T. 1990 [orig. 1959] *The silent language*. New York: Random House.

Harries-Jones P. 2016. *Upside-down gods: Gregory Bateson's world of difference*. New York: Fordham.

Hinton D. & L. Kirmayer 2017. The flexibility hypothesis of healing. *Culture, Medicine & Psychiatry* 41, 1: 3–34.

Hoffmeyer J. (ed) 2008. *A legacy for living systems: Gregory Bateson as a precursor for biosemiotic thinking*. London: Springer.

Jude J. 2016. Seselelame: feelings in the body - working alongside systemic ideas. *Journal of Family Therapy* 38: 555–571.

Kluckhohn F. R. & F. L. Strodtbeck 1961. *Variations in value orientations* Evanston: Row & Peterson.

Koss-Chioino J. D. 2006. Spiritual transformation, relation and radical empathy: core components of the ritual healing process. *Transcultural Psychiatry* 43, 4: 652–670.

Kurz H. 2017. Diversification of mental health care: Brazilian Kardecist psychiatry and the aesthetics of healing. *Curare* 40, 3: 195–206.

Limahelu J. 2010. *The family stories game*. https://www.familieverhalenspel.nl/familystories/ (accessed 2020-01-20).

McGoldrick M. 1995. *You can go home again: reconnecting with your family*. New York: Norton.

McGoldrick M. *et al.* 2005. *Ethnicity & family therapy* New York: Guilford.

Polanyi M. 1958. *Personal knowledge: towards a post-critical philosophy*. Chicago: Universitity of Chicago Press.

Peutz M. 2012. 'From some place deep in you': on personal connections between researcher and research in mental health. *Medische Antropologie* 24, 1: 179–193.

Scheff T. 1979. *Catharsis in healing, ritual and drama*. Berkeley: University of California Press.

Seikkula J. *et al.* 2018. The relational mind in couple therapy: a Bateson-inspired view of human life as an embodied stream. *Family Process* 57, 4: 855–866.

Siddique S. 2011. Being in-between: the relevance of ethnography and auto-ethnography for psychotherapy research. *Counseling & Psychotherapy Research* 11, 4: 310–316.

Speck R. & C. Attneave 1973. *Family networks*. New York: Pantheon.

Steegstra M. 2009. Krobo queen mothers: gender, power, and contemporary female traditional authority in Ghana. *Africa Today* 55, 3: 105–123.

Steegstra M. 2004. *Resilient rituals: Krobo initiation and the politics of culture in Ghana.* Münster: Lit.

Stroeken K. 2008. Sensory shifts and 'synaesthetics' in Sukuma healing. *Ethnos* 73, 4: 466–484.

———— 2010. *Moral power: the magic of witchcraft*. Oxford: Berghahn.

———— 2012. Health care decisions by Sukuma 'peasant intellectuals': a case of radical empiricism? *Anthropologial & Medicine* 19, 1: 119–28.

———— 2018. *Medicinal rule: a historical anthropology of kingship in east and central Africa* New York: Berghahn.

Szakolczai A. & B. Thomassen 2016. *From anthropology to social theory*. Cambridge: University Press.

Tjin-A-Djie K. & I. Zwaan 2021. *Protective wraps: transcultural aid for families*. Assen: Van Gorcum.

———— 2019. *Beschermjassen in de praktijk: professionals en families leren samen*. Assen: Van Gorcum.

Turnbull C. 1965. *The Mbuti Pygmies: an ethnographic survey*. New York: American Museum of Natural History.

———— 1990. Liminality: a synthesis of subjective and objective experience. In R. Schechner & W. Appel (eds) *By means of performance*. Cambridge: University Press. 50–81.

Turner E. 2012. *Communitas: the anthropology of collective joy*. New York: Palgrave Macmillan.

Turner V. 1969. *The ritual process: structure and anti-structure.* Ithaca: Cornell University.

———— 1979. *Frame, flow* and r*eflection: ritual* and d*rama* as p*ublic liminality. Japanese Journal* of *Religious Studies* 6, *4:* 465–499.

Van Bekkum D. 1994. Adolescence and ethnicity: an interdisciplinary model in occupational therapy and vocational training. *International Journal of Adolescence and Youth* 4, 3+4: 253–269.

———— 2006. Paradigmenwechsel und Kulturkritik: Transkulturelle Psychiatrie im 21. Jahrhundert. Zehn Handlungspunkte aus dem Manifest 2000 der IGGZ in den Niederlanden. In W. Machleidt & R. Salman (eds) *Sonnenberger Leitlinien: Integration von Migranten in Psychiatrie*

und Psychotherapie. Erfahrungen und Konzepte in Deutschland und Europa. Berlin: VWB. 45–54.

———— 2017. *Young men as whistleblowers: an anthropological gaze upon failing institutions and transitional spaces*. Soesterberg: Uitgeverij.

———— 2018. Beauty & grace in making artifacts: an anthropological gaze upon crafting in the world. In C. T. Burke & S. M. Spencer-Wood (eds), *Crafting in the world.* New York: Springer. 99–123.

Van Bekkum D. & J. Limahelu 2017. Families helpen zichzelf te helpen: cultureel zelfreflecteren en cultuursensitief-systemisch samenwerken in de jeugdzorg In *Jonge mannen als klokkenluiders: antropologisch leren kijken naar falende instituties en transitionele ruimtes*. Soesterberg: Uitgeverij Aspekt. 385–422.

Van Bekkum D. *et al.* 1996. Migratie als transitie: liminele kwetsbaarheid van migranten en implicaties voor de hulpverlening. In J. de Jong & M. V. D. Berg (eds) *Handboek Transculturele Psychiatrie & Psychotherapie*. Utrecht: de Tijdstroom. 15-59.

———— 2010. Rituelen en Beschermjassen. In J. de Jong en M. v. d. Berg (eds), *Handboek Transculturele Psychiatrie & Psychotherapie*. Utrecht: de Tijdstroom. 119–129.

Van Gennep A. 1960 [orig. 1909]. *The rites of passage.* London: Routledge & Kegan Paul.

Varela F. *et al.* 2001. The brainweb: phase synchronization and large-scale integration. *Nature Reviews Neuroscience* 2, 4: 229–239.

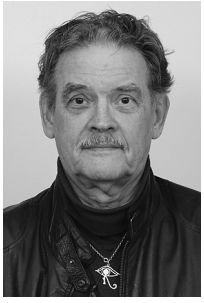
Weber A. 2013. *Enlivenment*: *towards* a *fundamental shift in the concepts* of *nature*, *culture and politic.* Bonn: Heinrich Böll Foundation.

Wikan U. 2012. *Resonance: beyond the words*. Chicago: University of Chicago Press.

Winnicott D. W. 1951. Transitional objects and transitional phenomena. *International Journal of Psychoanalysis* 34: 89–97.

———— 1967. The location of cultural experience. *International Journal of Psychoanalysis* 48: 368–372.

Young D. 1991. *Origins of the sacred: the ecstasies of love and war.* London: St. Martin's.



DIRCK VAN BEKKUM MSc. was born in artisinal blacksmithing families in 1947 in Amersfoort and studied social & cultural anthropology at the Radboud University, Nijmegen, The Netherlands between 1974–1988. From 1983–1993 he fieldworked as an anthropologist/artisinal group therapist with about 500 troubled/troubling drafted soldiers hospitalized in clinicial psychiatry. Between 1993–2019 he fieldworked in and co-educated, as a self-employed clinical anthropologist at Moira CTT (www.ctt.nl), numerous groups of mental health and youth care professionals in Dutch institutions. With hindsight 'being moved—healing—together in co-created transitional spaces' turned out to be what Dirck was after all those years. In this experiential quest of 35 years commuting between a) finding/performing language (conceptual frames) in communication with clients/students and b) crafting symbolic artifacts to express/perform (for what could not be expressed in language) was his core business.

Bureau Moira CTT (Cultural Transfer & Transformation)
Gocher Strasse 85, Kranenburg, 47559 Germany
e-mail: moira@ctt.nl, www.ctt.nl

Homeopathic Prescribing as an Apprehension of the Whole

NATALIE HARRIMAN

Introduction

Our way of apprehension as modern human beings[1] is characterised and defined by the realm of rationality (facts, rational analysis, quantification) which is often at odds with the less easily grasped realm of intuition (quality, value, experience). These opposing positions speak different and often irreconcilable languages. A key feature of rationality is reduction through material causation, whereas intuition uses metaphor, analogy or symbology and participative experience, which cannot be reduced. Healing by derivation (it comes from the Old English "haelan"—to restore to wholeness) is about the *whole* organism, something that science and by extension, biomedicine, has difficulty in grasping. In contrast, alternative and ethnomedical systems seem to be able to grasp wholes; they apprehend and experience the patient and what is to be cured on multiple levels. One of the tools they use is a form of knowing lost to us largely during the Enlightenment: gnosis, described by Gilles Quispel (1988), a modern scholar of gnostic and esoteric history, as the third strand of European culture where rationality and faith represented the other two strands. Homeopaths certainly use a form of inner knowing, which has striking similarities to gnosis, when apprehending the patient. The patient picture forms as a bounded, but fuzzy emergent metaphor and is the key tool in homeopathic diagnosis and prescribing and may present us with an indication of how we can grapple with the problem of seeing a patient as a whole. It may also open up the healing process to deeper exploration through alignments with gnostic and esoteric philosophical currents now being more closely explored by scholars.

In this essay I will approach healing by way of bringing together three concepts: the idea of (1) the whole through an analysis of (2) how homeopaths apprehend their patients using (3) what I think is a form of gnosis. This route will end with the positing of the use of imaginative, "non-intellective consciousness" (Roszak 1995),[2] alongside and integrated with the more familiar linear, rational consciousness and will be shown to be potentially the same as, but certainly akin to what is now viewed as gnosis in some circles. This will open up a Pandora's box of possibilities and introduce, through an alignment with gnostic and esoteric philosophical currents, an alternative way of conceiving of healing. It will also raise the prospect of a definition of healing which I will propose in my conclusion along with some ideas of how to investigate and augment it.

The dominant form of cognition in the West has been hugely influenced by the ancient Greeks, and more recently by the development and perceived success of the Enlightenment and its "children" science and technology. This has depended upon a number of fundamental philosophical assumptions which in turn rest on a deep split in the way that the world is apprehended. The split arose with the ancient Greeks and found its apotheosis in Descartes's mind/body separation with far-reaching consequences for how life is lived, certainly for the majority of people. It has affected medicine, a purely science-based pursuit in its dominant expression as biomedicine, which considers and treats human beings as machines, an approach based on a materialist-reductionist set of assumptions. This approach is now confronting some serious theoretical challenges largely in the fields of evolution and ecology (Kauffman 2007) where it is not effective at explaining certain phenomena, forcing scientists to think "outside the box" and test new theories. Driving this work is the challenge of how to deal with complex

systems and although the tools for implementing these new theories are not yet on the horizon, it will affect how we conceive of health and healing on a very fundamental level.

Complementary & alternative medical (CAM) approaches in the West do attempt to apprehend and treat people as wholes and biomedicine has been forced to respond to their challenge through a sort of syncretisation in the form of integrative medicine where CAM is acknowledged but does not alter the underpinning philosophy. A radical change in the underlying philosophy is critical for reform but will be a separate issue and will come from, in my opinion, the basic scientists and philosophers. It will still, however, leave us with the problem of therapeutic tools—if doctors are to apprehend the whole patient as the complexity it is, then how will this be achieved, what conceptual tools will be used? My argument is that we need to learn from those modalities and approaches that do indeed acknowledge a person as a whole—this will include CAM and traditional or indigenous healing practices. I am not going to address individual details of specific techniques but feel that an examination of the broader tools used and the philosophy underpinning the use of those tools might be more helpful in this quest.

The Split and its Limitations

The Axial Age, beginning around 500 B.C. in Greece, Persia, China and India gave birth to qualitatively different ways of thinking in religion and philosophy, which has been argued by some academics as the beginning of humankind's ability to self-reflect (Bellah & Joas 2012; Jaspers 1953) with a self-consciousness not previously seen (Baumard *et al.* 2015). From this point humankind loosened its ties to the mythological world, where life involved an intimate connection with *the divine* through society and the cosmos, and began the long journey to individuation and self-sufficiency. Charles Taylor sees this as the beginning of what he describes as the "great disembedding" (Taylor 2007, 2012) where mankind is sequentially separated from society, the cosmos and the divine finally resulting in a world where non belief in God is accepted. The ancient Greeks' definition of aesthetics reflects this incipient separation. They viewed perception through the senses and moral discernment as distinct from perception in the form of rational cognition showing us how the development of reason and the cognitive possibly necessitated, through its distillation out of the mythological, a separation from the sensorial and the moral. We would now call this the fact/value split or, post Descartes, as the mind/body split where the mind is perceived as separate from the body or the senses which are then considered inferior. This is nowhere more evident than in biomedicine which relies almost solely on scientific reductionism and materialist, rational interpretations of empirical observations. It is an approach which views the world as constructed of parts and explanations of the world as dependent on breaking the parts into ever smaller parts—as the celebrated physicist, Steven Weinberg, put it: "Explanatory arrows always point downward" (Weinberg 1994). This way of understanding phenomena relies on explanations of higher order phenomena, *e.g.* a cell, having their functions and to some extent their ontology rooted in lower order phenomena, *e.g.* organelles, which in turn are explained through sub-structures such as membranes which are rooted in molecules which themselves have explanations and origins in the fundamental chemical and physical laws. In other words, there is a single set of laws that underpin all higher order phenomena and to which scientists look for explanation (Kauffman 2007) as opposed to explanatory arrows that point upwards where higher order phenomena influence and explain the lower order laws. Reductionism holds that these lower order laws are eternal and universal and themselves can even be collapsed into one elegant equation governing all of physics and hence life. This philosophy essentially results in the perception and treatment of patients, living human organisms, as machines made of individual parts interacting mechanically with each other, all explained and underpinned by the mechanical laws of classical physics. It does not consider the more recent developments in quantum mechanics and complexity theory. It has, however, been extremely successful, particularly in acute medicine, but organisms are clearly not machines and researchers and medical practitioners are finding that this perspective is becoming limiting and might be curtailing our ability to effectively treat patients.

Contrary to this prevailing worldview, healing is about wholeness; the word itself derives from the Old English "haelan," in turn derived from the Proto-German "hailijana" which is associated with the idea of making whole again and feeling safe. This sort of narrative implies a perspective that views illness as a rupture in the wholeness of our being with a consequent loss in certainty, control, freedom and the familiar, something discussed in a seminal article by Kay Toombs (1987) and more recently by Havi Carel (2016) who both use "phenomenology"[3] to unpack the patient-physician experience. In other words, this rupture results in a loss of integrity in the person's being in the world, a feeling of being unsafe and therefore vulnerable which in turn engenders suffering and pain. The transcendence of suffering through a form of narrative and spiritual experience, as discussed by Thomas Egnew (2005) after interviewing some prominent physicians, may indeed be the beginning of a working definition of healing. In her later book, Toombs (1992) expands on her earlier thesis, discussing the pre-reflective experience of illness and its reflective or analytical reception by a physician who is often unable to bridge the gap between seeing the patient as an object exhibiting a collection of symptoms called disease and the individual's experience of their symptoms as an illness. She believes that if physicians could more deeply understand and enter into their patients' experience then they would make better physicians.

This perception of the patient as a whole is a welcome development arising out of a more postmodern, phenomenological approach and I think a more lived understanding of the patient's experience would make for better doctors. It does finally recognise that people are not machines, but how does a doctor schooled in reductionist biomedicine apprehend a person as a whole and then effectively intervene? Recent developments in integrative medicine have made a valiant attempt and are an improvement on an earlier era, but even so are a syncretistic blend of patient centered care with a whole systems approach where lifestyle, emotions and environment are considered and alternative medical modalities are often used (Manahan 2011). A method of this kind hinges on being able to identify all influences on the patient, a near impossible task, and the ability to compute the relations, effects and most critically, the relative value, that each element has individually and collectively. It fails to see the patient as a complex whole; it still views them as composed of separate elements, even if it now listens more carefully and embraces more parts.

The reality of wholeness is not only arising from work in the humanities. Developments in the scientific field of complexity theory are also informing us that the living organism is a complex, whole entity made up of many relational elements forming overlapping and hierarchical networks that together self-organise and produce what are called higher order or emergent properties which cannot be predicted from the initial conditions and elements. Researchers are beginning to advance ideas around life having irreducible higher order properties (Rosslenbroich 2016) directly contradicting the central scientific dogma that all phenomena follow the same set of laws and can be reduced to their fundamental constituents. Emergence is also opening up discussion on the value of vitalism again (Bognon-Küss *et al.* 2018)—the idea that the living organism may be animated by a dynamic vital force—and may indeed provide an explanation and the beginnings of a new philosophy to explore and develop tools to understand and work with life when viewed as more than the sum of its parts (Chen 2018; Sartenaer 2018). In other words, what is beginning to emerge is that living organisms are not machines and that perhaps when dealing with life, the explanatory arrows point upwards. Yet, the question still persists: How does a doctor apprehend and therapeutically intervene in a whole, living and situated organism, exhibiting unpredictable emergent properties that demands to be seen as a complex entity and can no longer be viewed as a machine?

Biomedicine, beyond integrative medicine, has very few answers to this question, but CAM and ethnomedicine may well provide us with an instructive and informative perspective. Having been consigned to the peripheries for many and various reasons and largely dismissed by the mainstream biomedical community as "snake oil" (Bausell 2007), alternative medicine not only is able to apprehend the organism as a whole, but also has the tools to diagnose, treat and interpret the outcome. Apprehending a whole is indeed quite a foreign concept to a biomedical practitio-

ner schooled in reductionist analysis which deals in material facts and universal laws. Its way of thinking—breaking down and compartmentalising—is not accustomed to building up, creating something different and novel. Creating involves a completely different way of acquiring and processing knowledge—the acquisition of facts, self-discovery, imagination, use of your intuition, courage and trust. It is not a whimsical or arbitrary process, it is structured and systematic, but we, as a Western society, seem to have lost our faith in it. It may involve a re-integration of the cognitive with the sensual or perhaps it is another way of knowing that may have been lost on the journey out of the mythological world-view. Either way, a closer analysis of exactly how it functions in a healing system that employs such techniques would not only be valuable in uncovering the tools necessary in treating our patients as whole, living organisms, but would facilitate our understanding of the concept and process of healing.

The Homeopathic Perspective and Method

Samuel Hahnemann conceived of and established Homeopathy as a medical practice in the eighteenth century, a time when the Enlightenment had not yet taken complete hold of medicine and philosophical influences were still quite fluid certainly in terms of not being dominated by scientism. He was certainly influenced by German Romanticism as well as the new empiricism, viewing his method as supremely scientific. It was indeed based on meticulous and extensive observations of his patients and so is soundly empirical, but did not square with the rational, materialist currents stirred up by the successes of the Enlightenment (Coulter 1977). Hahnemann posited a vital force, an idea quite current in the 1700s, but which became increasingly disparaged as the Enlightenment progressed, not being able to accommodate what it saw as mysterious, unexplainable forces. The idea of the vital force is absolutely central to homeopathy; diagnosis, therapeutics and the interpretation of outcomes depend on a thorough and deep apprehension and understanding of the patient's individual vital force by the homeopath.

The initial consultation involves extensive questioning where the patient's inner mental/emotional state, their general disposition along with the particular physical symptoms are clearly established. The homeopath is looking for specific, striking and characteristic symptoms that distinguish the patient's individual expression of their illness that then builds up into an integrated, homeopathically coherent picture composed of multiple symptoms and observations (tone of voice, emphasis, repetition, actions such as covering the mouth or crying) which gives the homeopath an overall impression of the *whole* patient at their time of distress. This impression that forms during the consultation is encapsulated in the mind of the homeopath as the patient picture which is matched to those pictures in the written homeopathic materia medica, recorded under what homeopaths call a remedy picture. A remedy is a substance (plant, mineral, animal, literally anything) whose properties have previously been elicited through "provings" where the extensively diluted substance is given to healthy volunteers who then record their experiences. These experiences are combined with homeopathic clinical knowledge in terms of cured symptoms and characteristics to form the remedy pictures. Matching of the received patient picture to the recorded remedy picture is achieved through a mix of linear symptom matching as well as the overall impression intuited by the homeopath of both the patient and the remedy.

This remedy picture which the homeopath has studied and meditated upon becomes embodied in the homeopath's consciousness and the matching to the patient picture occurs within as a type of certain knowing, a moment of what I believe is a form of inspired intuition. Both the remedy and the patient pictures are built up in similar ways—an accumulation of individual facts and observations—which reach a critical mass in their accrued complexity at the moment when the homeopath sees the match. The previously studied and embodied remedy pictures are activated by the emerging patient picture which, once it reaches a level of complexity and critical mass is matched in a moment of revelation or epiphany resulting in an intuition of the remedy for that particular patient at that time. This happens in a leap, not in the more familiar stepwise logical cause and effect manner (rational), and comes with a sense of surety and truth to the homeopath. They just

"know" in a more pre-reflective manner that this is the remedy. It is, however, critically dependent on doing the work of previously studying and understanding the remedy pictures and meticulously interviewing the patient, without which the critical mass is not reached, the complexity cannot form, the emergent pictures cannot be grasped and the whole cannot be intuited. The process reminds me of the adage: "the harder you work, the luckier you get."

So, what homeopaths are able to achieve is the missing link in integrative medicine. They use active listening to apprehend the patient as a whole through a whole systems approach (extensive questioning around all elements of the patient's *being*), but this is taken further through the patient picture which represents the patient initially in a linear manner and subsequently, in the match, analogically—it is essentially the emergent property of the consultation. The twin tools of intuition and analogy allow for an integration and a qualitative grasp of all the elements in terms of their relation to each other and their relative value and influence with the analogy or patient/remedy picture emerging as the concrete, although dynamic and fuzzy, manifestation of that knowing. It encapsulates the dynamic of relations with the remedy becoming the representative symbol, the metaphor for the patient's state at that time. It is a bounded, but breathing, moving conceptual structure that evolves over time, dense and rich with meaning and a tool compatible with the incorporation of a more experiential, pre-reflective perspective.

Gnosis

According to the Liddell-Scott Greek-English Lexicon, gnosis means higher, esoteric knowledge or awareness (Liddell *et al.* 2006); the Merriam Webster Dictionary (2020) defines it as "esoteric knowledge of spiritual truth held by the ancient Gnostics to be essential to salvation." It is associated with the esoteric and with the spiritual and since the discovery of the gnostic gospels at Nag Hammadi in 1945 has become increasingly studied by scholars of religion largely due to the landmark publication by Frances Yates on Giordano Bruno and the Hermetic Tradition (Yates 1964) in the mid-sixties. Since then interest in and discussion of gnosis and its relation to gnosticism, esotericism and mysticism has grown and certainly garnered some controversy along the way. A recent collection edited by April De Conick (2016b) has attempted to make sense of the current state of debate and is, in my opinion, a balanced and interesting compilation from a leader in the field. In her summary and introduction De Conick defines gnosis as

> "knowledge of God [...] (it) is not discursive or rational knowledge [...] It is knowing, as in becoming personally acquainted or even *becoming* what one knows" (De Conick 2016a);

in other words, it is experiential knowledge (of *the divine*) or perhaps what is referred to as the pre-reflective in phenomenology? An exponent of gnosis, gnosticism, was initially viewed as a collection of religions that seemed to challenge the status-quo and were consequently classed as heretical by the early Christian Church during the medieval and scholastic eras and certainly into the Renaissance when interest in them resurfaced with the revival of Plato's work by Marsilio Ficino.[4] In modern times, a definition of gnosis and gnosticism has eluded academics; it has been viewed as either the invention of heresiologists or a self-styled designation by a group differing in their spiritual outlook to the mainstream religions. A useful and broader definition has, however, been put forward by De Conick (2013) and discussed by Dillon (2016) that views gnosticism as a particular spiritual orientation or even more broadly as a "cognitive frame" with five defining characteristics: (1) gnostics are in *personal* possession of gnosis, (2) gnosis as knowledge of God is experienced through an individual encounter with *the divine* through an initiatory rite of some kind; (3) this inner divinity in the human is part of their essence, (4) this spiritual truth is hidden within the scriptures which (5) requires a transgressive interpretation. She essentially views gnosis and gnosticism as a frame of mind or orientation that has been expressed through the spiritual, but is effectively a disruptor, part of the counter-culture, something that has been evident most recently in the new age movement which has strong gnostic resonances (Hanegraaff 1998). So, by extension and removing any spiritual associations, gnosis can be seen as an opening to new knowledge (or truth) through a sort of personal revelation, through a direct indi-

vidual experience as opposed to an empirical one where phenomena are objectively observed; gnosis is purely subjective.

Gilles Quispel (1988), advanced a theory of gnosis as a kind of intuitive, non-discursive way of knowing and as the third dimension of the European cultural tradition alongside rationality and faith. This sort of categorisation is useful, argues Wouter Hanegraaff (2008) if applied in an analytical and not an historical capacity—gnostic ways of knowing can be found in both theology and philosophy and science as well as esotericism. In other words, gnosis is a tool alongside rationality and faith; possibly a tool that has been disparaged or ignored. Hanegraaff (2014) does view esoteric ideas and currents as having been "consigned to the wastebasket"—rejected—by mainstream philosophies in the West and may well be a window into the new and so potentially a disruptor. Hanegraaff (2008) further argues that gnosis differs from faith and rationality in that it can neither be communicated nor verified or falsified (reason can be communicated and verified, faith can be communicated) yet still consists of claims to knowledge that are deemed of real importance to the knower. Reason and faith are preliminary to gnosis which is seen as a gift from God and understood through something beyond the senses and rationality, a capacity described in the *Corpus Hermeticum,* a collection of Egyptian-Greek gnostic texts from the 2nd century AC. It is beyond words and requires the suppression of bodily senses, a sort of trance-like altered state of consciousness which Hanegraaff (*ibid.*) states cannot be understood with rational tools (in Philosophy and Philology), but will probably need the application of the less restrictive anthropological and psychological disciplines if we are to apprehend it in any way. He also advocates close reading of the texts, the *Corpus Hermeticum* and by extension, I think we could also turn to associated writings in the spiritual and alternative and ethnomedical worlds. From my experience, these have many common threads and are, at their fundaments, loosely based on what has been termed *The Perennial Philosophy* by many scholars (*e.g.*, Carl Jung, Frithjof Schuon, Gilles Quispel, Wolfgang Goethe, Aldous Huxley and many more).[5]

To return to our current discussion though, there are strong resonances and similarities in the way that homeopaths apprehend their patient and remedy pictures and the above description of gnosis. Knowledge of a patient/remedy match comes to a homeopath fully formed in a sort of revelation although there is much rational work done prior to the revelation; almost like a gift and so not always guaranteed.[6] This deeper, broader way of knowing that a homeopath uses to apprehend both the remedy and the patient pictures is a little more than intuition. It is a structured form of insight utilising imagination or creative thought that leads to a deep inner and personal apprehension of a truth that forms in the moment that the patient picture is matched with the remedy picture. A kind of gnosis, if you like, but also reflective of a wider and more fundamental set of alternative ideas which have been distilled as a set of four elements by Antoine Faivre (1994), the first "Chair of Western Esotericism at the University of Paris": (1) the language of correspondence or analogy where higher realms are reflected in lower realms (*e.g.* patient pictures having corresponding remedy pictures); (2) living nature (expressed in homeopathy as a vital force); (3) use of imagination as a tool of understanding (an essential aspect of homeopathic apprehension during diagnosis—gnosis); (4) experience of transformation. Perhaps homeopaths are able, by embodying some of these principles, to apprehend and intervene in wholes; perhaps, and this is purely my own speculation, by extension these principles might assist us in apprehending a patient as a whole, dynamic, living entity. Gnosis, through its use of both rational and intuitive modes, may indeed be a route into understanding and unifying the splits in the current apprehension of the world. The emergent revelation, a pre-reflective form of knowing that is granted once the analytical work reaches a critical mass, may be a way to hold the pre-reflective alongside or even integrated with the reflective. A closer study of it, using Faivre's four principles, as it operates through a modality such as homeopathy, may also provide a deeper insight into the healing process, not only in how to apprehend and intervene therapeutically, but also what to expect from the healing process as it unfolds.

Implications for the Concept of Healing—the Transformative Journey

Associating homeopathy, a therapeutic practice, with Western esotericism in terms of its use of one of the defining tools, gnosis, opens up a door to a philosophy largely ignored by the mainstream.[7] Although it has a history of suppression by the Christian Church as heresy and later by science as non-scientific, it has essentially run underneath western culture, having had some relatively recent flowerings—Renaissance, 1800's occult and German Romanticism, 1960's New Age—leaving behind a rich literature. Anton Faivre's descriptors, based on this body of literature, although still disputed, have stood the test of time and provide a useful conceptual framework for an alternative view of healing. This is providing we accept the assumption that healing is linked to wholes and the necessity of needing something other than the current reductionist-materialist paradigm to apprehend a whole. His first three elements, correspondence, living nature and imagination can be linked to how homeopaths apprehend, diagnose and treat their patients. The fourth element, transformation, is linked, in my opinion, to the unfolding healing process and is a common notion in many cultures (Nie *et al.* 2016) or as it is referred to—the journey. The concept of a journey incorporates the idea of travelling to another place, to somewhere different, perhaps new, but it implies a movement from one state of being to another state. If this is applied to someone who is travelling on a healing journey, the concept is internalised as the individual undertakes a personal journey of self-development, a change or transformation, triggered by a stimulus, an illness. The illness presents a challenge to the norm, rendering the current state uncomfortable forcing the individual to respond and journey to somewhere new, an unknown place. Many alternative medical practices speak of the journey into the unknown; homeopaths have often very little idea of what will happen to a patient once a remedy is administered. It is a voyage of mutual discovery which could result in positive or negative effects, but will most often constitute a movement onwards. It is referred to in some medical anthropological literature as the healing narrative (Kleinman 1988) with the idea of the narrative providing surrounding context to the trauma of the illness, context that often creates meaning for the individual.

Aspects of the healing journey are now being recognised in mainstream psychology circles as "post-traumatic growth" (PTG) (Tedeschi 1995). In a landmark article, Tedeschi and Calhoun describe PTG as: 'positive change that occurs as a result of the struggle with highly challenging life crises. It is manifested in a variety of ways, including an increased appreciation for life in general, more meaningful interpersonal relationships, an increased personal strength, changed priorities, and a richer existential and spiritual life.' (Tedeschi & Calhoun 2004). These two authors write extensively about the idea of great suffering bringing great good being an ancient concept present in all religions and Tzipi Weiss directly connects it to The Perennial Philosophy (Weiss 2013) which describes the process of spiritual transformation in detail. So, it appears that PTG may be the most recent manifestation of an idea that has been with human beings in some form or another for millennia. The idea that trauma often in the form of illness can trigger a change for the good, a development or transformation on a deeply personal level resulting in greater meaning in life and relief from suffering—would this not also align with greater personal integration, becoming (more) whole, and could we call this healing? If so, then people have been writing about it for millennia, in the spiritual texts, as a way of transcending suffering—is healing essentially this? If so, then how do we harness these ideas, how do we use them to help our patients?

The first step, to my mind, after accepting that people are whole entities in the understanding of which the materialist-reductionist approach is limited implying that we need a new approach, would be to understand the process of the journey—its landmarks. So, to follow Faivre and to turn to the spiritual/esoteric literature, Joseph Campbell's (1949) *Hero's Journey* offers a deep insight. The *Hero's Journey* describes a series of actions divided into roughly three main sections that are undertaken by the brave traveler and lead to "developmental growth, the promotion of healing, cultivation of social unity, advancing of society and deepening of cosmic understanding" (Allison *et al.* 2019). The actions required fall into (1) departure or separation which represents the

loss of one's usual safe environment; (2) initiation or suffering followed by personal growth and (3) return which represents the return of the transformed hero who is now able to give back what they have learned as a benefit to society. Allison & Goethals (2014; cf. Allison, Kocher & Goethals 2016) have written extensively about the hero's journey and leadership and as psychologists have closely examined the requirements for and consequences of a journey of this kind (Allison *et al.* 2019). In particular, they discuss what they call transformative arcs: (1) egocentricity to sociocentricity with consequences of thinking beyond yourself and fostering connection with the wider world; (2) dependency to autonomy which necessitates a willingness to deviate from the dominant cultural patterns, breaking the mould to create the new (which echoes April DeConick's ideas on gnosis being used as a disruptor) and (3) stagnation to growth where one strives to fulfil their highest potential (*ibid.*). Collectively, these arcs bring a richer, more fulfilled life and critically, greater meaning within a wider context allowing one to accept and understand the function of trauma or illness.

Spiritual and mythological literature is littered with references to great transformative journeys, most notable being that of St John of the Cross who endured a long, dark night of the soul. Greek mythology speaks of a descent into the Underworld—*katabasis* or breakdown—followed by a journey back to the light; Carl Jung uncovered the process of individuation, an often painful confrontation with and integration of one's shadow and more recently, Jordan Peterson (1999) writes about the necessity and function of chaos, the unknown, in our personal development. This body of literature provides a wealth of ideas and new avenues of exploration in terms of understanding healing. The use of gnosis in understanding wholes (organisms, people) unites the rational and the intuitive into one process, connecting often separately compartmentalized areas such as the physical body, psychology and spirituality and in its connection with the esoteric world opens up new areas of philosophy and process. It also hints at a more dynamic way of viewing life, as a journey or a constant progression from one state to another, never returning to a previously stated "norm." Perhaps then, healing is one of the mechanisms whereby human beings navigate specific gateways or transformations in their personal development; stages which are negotiated and transcended through a radical re-organisation of their whole being. These gateways can be identified and used as markers of progress along a defined and common process whose steps can be elucidated and that processes such as the *Hero's Journey* and others mentioned above will assist in greater understanding.

Conclusions

Biomedicine is highly effective in the treatment of acute disease, but fails when it comes to the chronic (Milani & Lavie 2015) which is more complex, multifactorial and now an increasing burden on our over-stretched health care systems, accounting for almost two-thirds of all disease (Brunner-La Rocca *et al.* 2016). It also has difficulty in dealing with co-morbidities, never mind whole organisms with their contradictory and overlapping properties and this is not due to a lack of trying or caring, it comes down to a limited and so failing philosophy. A philosophy that is underpinned by and depending on a materialist, reductionist approach to the living patient, an approach that is now being questioned in many fields, not only biology and medicine. The new thinking involves the acceptance of complex wholes with higher order, emergent properties that cannot be predicted from the initial set of conditions which does not fit with our current orthodox theoretical and practical diagnostic and therapeutic tools. In essence, we need a new philosophy, a new way of viewing the organism and divining and treating illness. This does not mean that we "throw the baby out with the bathwater;" I would not want a homeopath foisting an arnica tablet on me if I was lying in the road after a car accident, I would want emergency services to take me to hospital. It is a question of context and appropriateness and the widening of our perspective. But how do we merge these two approaches, how do we know which one is appropriate and when?

In this respect, Iain McGilchrist's (2019) work summarized in his book *The Master and his Emissary* may be quite informative. His research is focused on the right and left hemispheres of our brain and the type of thinking that each of them

undertake, but he crucially examines their relationship and relates this to the evolution of society over the past two millennia since the ancient Greeks. The right brain, left brain split evolved in vertebrates through an animal's need to focus on acquiring food in quite a narrow, practical way, but at the same time to keep one eye open for predators. As a result the left brain took on the role of focused attention while the right brain had open attention. In humans, who have large frontal lobes and particularly since the Axial Age when self-reflection, the ability to stand back, came about, this hemisphere division has been re-purposed. The right brain is now associated with the broadest view, the ability to grasp the interconnectedness of the elements of experience, the whole with its complexity and emotion where the left brain supplies the tools to grasp and manipulate that amorphous experience, it has denotative language, serial analysis, but is atomistic and reductive in its approach. Both functions are essential in apprehending and acting on our experience, but the relationship between the two is asymmetrical. The first experience of anything is through our right brain where the first thought also originates which is then passed to the left for serial analysis and expression through speech, but the meaning of it is then passed back to and integrated by the right brain. Essentially, the left deconstructs and manipulates what the right knows and then hands it back for integration into the larger context. Over the past few centuries, there has been an increasing overemphasis on the left brain as its way of knowing is simpler, more self-consistent, the 'greyness' or complexity has been removed and we have been left with a way of apprehension that mirrors our the new digital, binary age that because of the simplification alarmingly thinks it knows it all.

McGilchrist's description of this process is a startling reflection of how a homeopath apprehends the patient and chooses a remedy. The first encounter is through extensive questioning and observation of the patient forming an amorphous impression and experience that the homeopath presumably absorbs through their right brain. This impression is then processed and manipulated through left brain functions where individual symptoms are teased out and analysed which are then passed back to the right brain which puts the whole picture into context with existing knowledge and experience allowing for the remedy to make itself known. This synthesis is an integration of the senses, all of them, and the rational which is used as a fine tool to order and structure, but the final expression comes from the right brain, from the broader perspective, the one that is able to work with complex wholes. This last stage may well be a corollary to gnosis and certainly fits with the description from the *Corpus Hermeticum* of it being beyond the senses and rationality where the knower or apprehender enters an altered state in order to "receive" the knowledge which comes as an internal, personal truth. The asymmetry that McGilchrist proposes is indeed interesting—it appears that the right brain is dominant, it is primary and the final arbiter; the left brain is essentially a very fine and focused tool.

If we view biomedicine as aligned to this fine and focused tool then it is only part of the picture and should not dominate; context, interconnectness, relationships, relative values, wholes should dominate. By extension, the conclusion is that biomedicine is merely a tool in the box with intuition another tool and the integration of the two the final arbiter. But, the problem is that we do not currently trust our intuition and we do not have the formal structures to synthesise and integrate, allowing the answer to emerge. So, if orthodox Western medicine, biomedicine, is limited and not in keeping with how we as humans apprehend and process experience then we are truly failing our patients—we are not seeing their illnesses and trauma in context, we are not trusting our intuition, we are not engaging with them on the dominant level of experience. How do we remedy this? We broaden our perspective, we widen our context and we explore other areas.

Notes

1 My perspective throughout this essay is from that of the 21st Century western, post-Enlightenment where the materialist, reductive way of science predominates and where non-belief in *the divine* is possible. This is often contrasted to the pre-Enlightenment where subjective, participative and intuitive thinking along with belief in *the divine* is very much part of life. The latter is more akin to mythological apprehension.

2 In his book, *The Making of a Counter Culture*, Theodore Roszak describes the 1960's counter-cultural movements in terms of their opposition to what he terms the

technocracy—rapid industrialisation led by the universal acceptance of the authority of science, both natural and social. The counter culture stresses the importance of non-intellective factors particularly in terms of their opposition to the dominance of the rational; they promote quality over quantity and personal transformation over the social.

3 I have used the standard definition of phenomenology as appearing in the Stanford Encyclopedia of Philosophy (Woodruff Smith 2013):

"The discipline of phenomenology may be defined initially as the study of structures of experience, or consciousness. Literally, phenomenology is the study of "phenomena": appearances of things, or things as they appear in our experience, or the ways we experience things, thus the meanings things have in our experience. Phenomenology studies conscious experience as experienced from the subjective or first person point of view."

4 For the interested reader, Wouter Hanegraaff (2014), director of the "Center for the History of Hermetic Philosophy and Related Currents" at the University of Amsterdam, has a written a comprehensive history of esoteric and gnostic currents which will introduce the reader to other researchers in the emerging field of Western Esoteric.

5 The scope of this essay does not extend to a detailed discussion of "The Perennial Philosophy" which in essence claims that all the world's religions are at core based on the same set of spiritual truths. The interested reader can refer to any of the above-mentioned authors, particularly Huxley (1946) for a comprehensive introduction

6 I am a practicing homeopath and have discussed this at length with other practitioners who have similar experiences.

7 The "mainstream" in this context can be described by what it rejects, Hanegraaff (2016): "Esotericism can be understood as a general label for all those traditions in Western culture that had been rejected by rationalist and scientific thinkers since the eighteenth century, the period of the Enlightenment, as well as by dominant forms of Protestant Christianity since the sixteenth century, the age of the Reformation".

References

Allison, Scott T. & George R. Goethals 2014. *Heroes: What They Do and Why We Need Them*. New York: Oxford University Press.

Allison, Scott T., Craig T. Kocher & George R. Goethals (eds) 2016. *Frontiers in Spiritual Leadership: Discovering the Better Angels of our Nature*. London: Palgrave MacMillan.

Allison, Scott T. *et al.* 2019. The Metamorphosis of the Hero: Principles, Processes, and Purpose. *Frontiers in Psychology* 10, 606: 1–14.

Baumard, Nicolas, Alexandre Hyafil & Pascal Boyer 2015. What changed during the Axial Age: Cognitive Styles or Reward Systems? *Communicative & Integrative Biology* 8, 5: 1–3.

Bausell, R. Barker 2007. *Snake Oil Science: The Truth about Complementary and Alternative Medicine*. Oxford: University Press.

Bellah, Robert N. & Hans Joas 2012. *The Axial Age and its Consequences*. Cambridge: Belknap Press of Harvard University.

Bognon-Küss, Cécilia, Bohang Chen & Charles T. Wolfe 2018. Metaphysics, Function and the Engineering of Life: The Problem of Vitalism, *Kairos* 20, 1: 113–140.

Campbell, Joseph 1949. *The Hero with a Thousand Faces*. New York: Meridian.

Carel, Havi 2016. *Phenomenology of Illness*. Oxford: University Press.

Chen, Bohang 2018. A Non-Metaphysical Evaluation of Vitalism in the early Twentieth Century. *History & Philosophy of the Life Sciences* 40, 3: 50.

Coulter, Harris L. 1977. *Divided Legacy IV: History of the Schism in Medical Thought (1800–1914)*. Washington: Wehawken.

De Conick, April D. 2013. Crafting Gnosis: Gnostic Spirituality in the Ancient New Age. In Tuomas Rasimus *et al.* (eds) *Gnosticism, Platonism and the Late Ancient World: Essays in Honour of John D. Turner.* Leiden: Brill.

––––– 2016a. Introduction: Religion in the Margins. In *ibid.* (ed) *Religion: Secret Religion*. Farmington Hills: Gale: xv-xxxviii.

De Conick, April D. (ed) 2016b. *Religion: Secret Religion.* Farmington Hills: Gale.

Dillon, Matthew J. 2016. Gnosticism Theorized: Major Trends and Approaches to the Study of Gnosticism. In De Conick April D. (ed) *Religion: Secret Religion*. Farmington Hills: Gale.

Egnew, Thomas R. 2005. The Meaning of Healing: Transcending Suffering. *Annals of Family Medicine* 3, 3: 255–262.

Hanegraaff, Wouter J. 1998. *New Age Religion and Western Culture: Esotericism in the Mirror of Secular Thought*. Albany: State University of New York Press.

Hanegraaff, Wouter J. 2008. Reason, Faith, and Gnosis: Potentials and Problematics of a Typological Construct. In Peter Meusberger (ed) *Clashes of Knowledge: Orthodoxies and Heterodoxies in Science and Religion*. New York: Springer.

Hanegraaff, Wouter J. 2014. *Esotericism and the Academy: Rejected Knowledge in Western Culture*. Cambridge: University Press.

––––– 2016. Gnosticism Theorized: Major Trends and Approaches to the Study of Gnosticism. In April D. De Conick (ed) *Religion: Secret Religion*.

Huxley, Aldous 1946. *The Perennial Philosophy.* London: Chatto & Windus.

Jaspers, Karl 1953. *The Origin and Goal of History*. Oxon: Routledge &Kegan.

Kauffman, Stuart 2007. Beyond Reductionism: Reinventing the Sacred. *Zygon* 42, 4: 903–914.

Kleinman, Arthur 1988. *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York: Basic Books.

Liddell, Henry G. *et al.* 2006. *Greek-English Lexicon*. Oxford: Clarendon Press.

Manahan, Bill 2011. The Whole Systems Medicine of Tomorrow: A Half-Century Perspective. *Explore* 7, 4: 212–214.

McGilchrist, Iain 2019. *The Master and his Emissary: The Divided Brain and the Making of the Western world*. New Haven: Yale University Press.

Merriam-Webster. 2020. *Gnosis*. *Merriam-Webster dictionary*. Accessed 18 October 2020. https://www.merriam-webster.com/dictionary/gnosis

Milani, Richard V. & Carl J. Lavie 2015. Health Care 2020: Reengineering Health Care Delivery to Combat Chronic Disease. *The American Journal of Medicine* 128, 4: 337–343.

Nie, Jing-Bao *et al.* 2016. Healing Without Waging War: Beyond Military Metaphors in Medicine and HIV Cure Research. *The American Journal of Bioethics*, 16, 10: 3–11.

Peterson, Jordan B. 1999. *Maps of Meaning: The Architecture of Belief*. New York: Routledge.

Quispel, Gilles 1988. *Gnosis: De Derde Component van de Europese Cultuurtraditie*. Utrecht: Hes.

Rosslenbroich, Bernd 2016. Properties of Life: Toward a Coherent Understanding of the Organism. *Acta Biotheoretica* 64: 277–307.

Roszak, Theodore 1995. *The Making of a Counter Culture: Reflections on the Technocratic Society and its Youthful Opposition*. Berkeley: University of California Press.

Sartenaer, Olivier 2018. Disentangling the Vitalism–Emergentism Knot. *Journal for General Philosophy of Science* 49, 1: 73–88.

Taylor, Charles 2007. *A Secular Age*. Cambridge: Belknap Press of Harvard University Press.

––––– 2012. What Was the Axial Revolution? In Robert N. Bellah & Hans Joas (eds) *The Axial Age and Its Consequences*. Cambridge: Belknap Press of Harvard University Press.

Tedeschi, Richard G. & Lawrence G. Calhoun (eds) 1995. *Trauma & Transformation: Growing in the Aftermath of Suffering*. Thousand Oaks: SAGE.

Tedeschi, Richard G. & Lawrence G. Calhoun 2004. Posttraumatic Growth: Conceptual Foundations and Empirical Evidence. *Psychological Inquiry* 15, 1: 1–18.

Toombs, S. Kay 1987. The Meaning of Illness: A Phenomenological Approach to the Patient-Physician Relationship. *Journal of Medicine and Philosophy* 12, 3: 219–240.

––––– 1992. *The Meaning of Illness:A Phenomenological Account of the Different Perspectives of Physician and Patient*. Dordrecht: Springer.

Weinberg, Steven 1994. *Dreams of a Final Theory*. New York: Vintage.

Weiss, Tzipi 2013. Personal Transformation: Posttraumatic Growth and Gerotranscendence. *Journal of Humanistic Psychology* 54, 2: 203–226.

Woodruff Smith, David 2013. *Phenomenology.* Stanford Encyclopedia of Philosophy. Accessed 18 October 2020. https://plato.stanford.edu/entries/phenomenology/#pagetopright

Yates, Frances A. 1964. *Giordano Bruno and the Hermetic Tradition*. London: Routledge & Kegan.

NATALIE HARRIMAN is a scientist by training (PhD Developmental Neurobiology) and a homoeopath by vocation (Licentiate Homoeopathy) which she has attempted to integrate through her interests in philosophy (PG Dip Applied Ethics) and spirituality. She currently works at Brighton & Sussex Medical School in research management, practices homoeopathy from home and is developing a personal growth programme based on the Hero's Journey. Her academic research is focused on understanding how the new ideas on 'wholes' and emergence, arising out of complexity theory and studies in consciousness and brain functioning will challenge the dominance of our current reductionist, materialist world view. Data arising out of studies in ethnomedicine and western alternative medical practices as well as ancient, pre-Enlightenment philosophical ideas, emerging from the field of western esotericism will both assist and complement this work. Her homoeopathic practice is focused on helping people who have realised the need for paradigmatic change in their own lives and how serious traumatic life changes can be viewed as opportunities for life renewal, personal growth and eventually the giving back to society – essentially the search for meaning.

Brighton & Sussex Medical School, Brighton, UK
e-mail: n.harriman@bsms.ac.uk

The Need for Pluralism in Modern Healthcare

The Importance of Placebo Effects, the Environment, and Art in Facilitating Healing

PAUL DIEPPE

Introduction

All of us develop diseases and illnesses at times, and all societies develop strategies to help the sick amongst us. As medical anthropologists Arthur Kleinman (1980) and Cecil Helman (2001) have pointed out, there are three main approaches used to help alleviate health problems: 1) the popular sector: that includes self-treatment, advice from family and friends, help from other local people, and remedies based on religions; 2) the folk sector: which includes local healers, traditional medicine based in a particular culture or country, and the many forms of complementary and alternative medicine (CAM), such as homeopathy or kinesiology; 3) the professional sector, which comprises the legally sanctioned system in a country, and which, especially in Western and "Westernized" countries, is now exclusively based on biomedical science.

Over the last hundred years the biomedical sciences have enjoyed massive development, leading to a variety of new methods for diagnosing and treating diseases, particularly with drugs, devices and new surgical options; in addition to improved public health measures. These developments have been very successful, allowing us to treat many conditions effectively, and to completely cure some. For example, antibiotics can cure infections such as pneumonia, which previously killed many people, and cataract removal or hip replacement surgery can transform peoples' lives for the better. Therefore, it is not surprising that the medical profession now uses its scientific approaches exclusively, and tends to regard healers and CAM practitioners with suspicion and to undermine their work (Helman 2001; Jonas 2019). Similarly most "modern" patients seek state trained and legally sanctioned doctors, from whom they expect to receive "rational" insights on, and solutions to, their health problems.

However, other "unscientific" approaches to healthcare are still present in our "enlightened" societies. Popular remedies, such as wearing copper bracelets for arthritis, are widely used, and a huge variety of CAM and other healing practices are increasingly available and also widely utilised (Posadzki *et al.* 2013). Most biomedical practitioners dismiss such practices as "quackery," and in most "modern" hospitals it is unusual to encounter anything other than scientific biomedical practices.

Although a "Western" trained doctor myself, I now believe that we should be more pluralistic in our approach to health issues, and that we should consider the need to help people heal themselves, as well as trying to cure their diseases, and that we should not be dismissive of healers or CAM approaches. I am particularly concerned about those "modern" hospitals, which have become the cathedrals of biomedical science practice, dominated by complex machines driven by "the white-coated priests of biomedicine."

I believe the issue to be urgent and important, as chronic diseases are becoming increasingly prevalent in the West, in spite of its biomedicine. The World Health Organisation and others have lamented the problem they call the "silent global epidemic of chronic disease" (Meetoo 2008). In addition mental health problems are practically endemic in Western societies, with our doctors apparently powerless to help many of the people who suffer from them.

In this essay, I argue that we need to combine the healing arts with scientific medicine within our Western hospitals, and to be more pluralistic in our thinking about disease and illness. First

I provide definitions for my use of terms. Then I outline several different projects that colleagues and I have been involved in, which explore the power of the so-called "placebo effect" and its relationship to healing, and examine the potential role of space and art in changing the nature of hospitals and creating "healing spaces" within them.

Definitions/Semantics

Words and definitions are important, as usage and interpretations vary in different countries and cultures. Many of the words used here are potentially problematic, none more so than "healing," a word used as a noun, an adjective or a verb (Levin 2017). In this section I explain how I use some of the common words related to health problems. My usage is based on literature sources (Kleinman 1980; Helman 2001; Sontag 2003), but has also been moulded by my training and experience as a doctor. My medical training took place in London in the 1960s, and I practiced as a doctor in the UK from 1970 until 2010.

1) Disease, Illness and Sickness

Diseases are pathological processes or states within our bodies. Diseases are the province of scientists and health care practitioners: they are constructs within the science-based biomedical paradigm used to classify and describe things that "go wrong" with us. They are seen as essentially physical problems: abnormalities of the structure or function of the body or mind that can only be understood by reductionist, materialistic science, within which the whole person does not need to be considered, and the soul does not exist.

Illness is the experience of something abnormal going on within our body or mind. Illness is about symptoms, such as pain, that are often difficult to describe and a very personal issue for whoever has them (Sontag 2003). Illness is internal, experiential and the concern of the individual. Illness may or may not be caused by disease, and illness may or may not lead to sickness.

Sickness is the outward manifestation of a disease or illness. It is about an individual's interpretation of the meaning of their problem, and the behaviours that accompany that understanding (Kleinman 1980; Kaufman 1993). So if an individual is forced to reveal their disease or illness to others, or if they choose to behave in a way that indicates that they have health problems, sickness is apparent. Different people either try to hide their illness from others, or exaggerate it, leading to a huge variety of sickness behaviours in society that can be difficult to interpret. Very rarely sickness can occur in the absence of disease or illness (in other words an individual may choose to fabricate health problems for personal gain).

In general, biomedicine, with its conviction that we live in a purely materialistic reality which can be explained by science and science alone (Le Fanu 1999; Sheldrake 2012), is good at diagnosing and treating many diseases, less good at understanding or treating illness, and makes little or no attempt to deal with sickness, holism or the soul. In contrast, healing approaches the whole individual—mind, body and soul—and can potentially help with all dimensions of our health and wellbeing.

2) Treating, Comforting, Curing and Healing

Just as disease, illness and sickness have different meanings, so do comforting, treating, curing and healing.

Comforting others comes naturally to us. Humans are sympathetic, altruistic beings who want to help others who are in distress or not healthy. For the unskilled or uncertain person this will generally mean limiting their help to offering comfort to another. This is best achieved by providing a "gentle presence"—being there for the other person, listening, perhaps touching or hugging, and maybe sharing their problems, but above all else, just "being there" (Rogers 2003), and, as outlined below, ideally involving engendering a sense of safety.

Treating another person implies the use of a specific intervention designed to change the situation. A hug, as a part of the provision of comfort, might be seen as a treatment, but in general the word is used for more specific interventions aimed at a particular problem. It is an all-encompassing term that can be used for any sort of conventional or unconventional, professional or lay, approach to ill-health.

Curing is a term used to indicate the eradication of a disease or illness. It is what the modern

medical professional strives to achieve, and she sometimes succeeds: for example we can "cure" peptic ulcers and pneumonia by the use of antibiotics that rid the body of the agents that causes them. The grip of "scientism" (the blind belief in the power of science) (Sheldrake 2012) and of the makers of drugs and devices used in medicine is now so great that we have come to believe that with more research we can find cures for everything. But we cannot. Take the example of a hip replacement for an arthritic hip, rightly championed above as one of the successes of biomedicine. This is indeed a wonderful operation which results in lasting pain relief for many people and might be seen as a cure. But it is not; it relieves symptoms in some but not all who undergo it, and it removes some damaged tissues from the body, but it does not remove the underlying arthritis or its causes, which often go on to affect other joints. Joint replacement does not allow you to do all the things you could before you had hip disease, and the surgery can be dangerous, sometimes resulting in long term physical and psychological problems that doctors find difficult to "treat" and impossible to "cure."

Healing is the most difficult term of all, one that cannot easily be defined and perhaps should not be, as it is a dynamic, experiential issue for many of us, and not a "thing" (Scott *et al.* 2017). The current English word is derived from the word "haelan," used in older English in Saxon times, and meaning "to restore to good health." But the term is now used very differently by many people. It can describe a state (I have had healing, I am healed), a process (I am being healed), or a practice (I am healing another). In general it refers to a holistic notion of wholeness or integrity of mind, body and soul. It implies that there is more to life than a machine called the physical mind/body, and that we are continually changing, recovering, moving forward, and seeking integrity and wholeness. Healing is often more about allowing us to flourish in the face of illness and suffering, rather than curing a disease (Kaufman 1993; Greaves 2004). As already mentioned, biomedicine is largely about treating and curing, and not comforting or healing. We should remember the aphorism sometimes attributed to William Osler, (whilst others say it is a 15th century folk saying, cf. Shaw 2009). It says that the aims of medicine should be: *"To cure sometimes, to relieve often, to comfort always."*

The Placebo Effect

My academic journey into the world of healing began with research on the placebo effect and the placebo and nocebo responses (Dieppe *et al.* 2016; Dieppe & Rhatz 2017). The term "placebo" (from the Latin, meaning "I please") refers to the fact that people can get better from illnesses and diseases when given a treatment that should not have any effect. It is often thought of as "mind over matter" (Marchant 2016)—illustrating the Cartesian dualism inherent in our current narratives about our physical bodies and brains. Today, the term "placebo effect" is generally used to describe the improvement that can result from giving people "sham" or "dummy" treatments used in clinical trials (Finniss *et al.* 2011; Kirsch 2018). The randomised controlled clinical trial (RCT) is seen as the gold-standard technique for finding out if a medical intervention is effective or not; it involves comparing the "real" drug, operation or device, with a sham or dummy version, to find out the value of the "real" treatment. But when this is done, people given the sham treatment usually improve. Many of those who run such trials, as well as those who make the drugs and devices being tested, have seen this effect as a nuisance—an inexplicable phenomenon that dilutes the response to their active agent. Many attempts have been made to explain away the placebo response, it has been said, for example, that it is all about natural improvement, or artefacts resulting from the experimental nature of the RCT. However, as shown in the figure below, when trials have been done to compare the effects of a real treatment to a dummy treatment, or to no treatment at all, we still see that giving the dummy treatment produces much more improvement than doing nothing.[1]

It is apparent from data of the sort illustrated in the figure, that much of the beneficial effect of drugs used for common symptoms such as pain and depression, can be attributed to the placebo effect alone. For example, our own work suggests that about 70% of the pain reduction produced by drugs given to people with osteoarthritis can be explained by the placebo effect (Zhang *et al.* 2008; Dieppe *et al.* 2016). Furthermore, there are now a

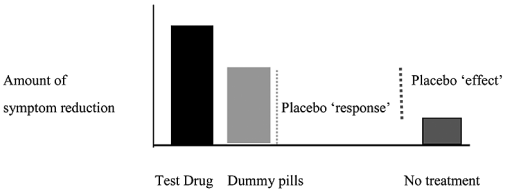


Fig. 1: This illustration is a rough generalisation of what happens when drugs for pain in osteoarthritis (Zhang *et al.* 2008), or for depression (Kirsch 2014) are tested in randomised controlled trials. Groups of consenting patients are allocated to take either the active drug, a dummy tablet that looks identical but contains no drug (the placebo treatment), or to take no tablets at all. Those people who take the active drug respond well, but those taking the dummy treatment improve nearly as much. That is called the placebo "response." If we then compare the amount of improvement in pain or depression in people not treated at all they improve much less. The difference between the amount of improvement with a dummy (placebo) treatment and no treatment at all, is called the placebo "effect."

number of studies to suggest that some surgical treatments are only effective because of the placebo effect. A well-known example is the use of arthroscopic surgery for osteoarthritis of the knee joint (looking inside the knee, washing it out and removing "debris"): people undergoing a sham surgical operation do as well or better than those who have the full procedure (Mosley *et al.* 2002). A further intriguing twist to the placebo story has been added by recent work showing that people respond to placebo drugs even if they are told that the pills are dummies (Carvalho *et al.* 2016).

How can this be? How can giving a pill without an active ingredient, or pretending to do an operation but not doing the full procedure (just cutting the skin to make it look real, for example) result in huge symptomatic benefit? We do not know all the answers to that question, in spite of intensive research by psychologists (Kirsch 2014, 2018) and neuroscientists (Benedetti 2013). Two theories dominate the thinking: that placebo effects are the result of expectation/suggestion, or that they depend on conditioning (Finniss *et al.* 2010). There is no doubt that such factors can contribute: if we expect something to happen (because it has been suggested to us) it is more likely to occur, and we can become conditioned to respond in certain ways to taking a drug. But I, like many others, do not think this is the whole story.

We (Kaptchuk 2002; Moerman 2011; Dieppe *et al.* 2016; Dieppe & Rhatz 2017) believe that is also about context and human interaction—that the placebo effect depends on the interactions between the person giving the "drug" and the person receiving it, and on the whole context in which such interactions take place, including the spaces in which clinical encounters occur, and the "rituals" that surround them. We all know that "giving" to another, comforting them and being there for them, can help; this we believe is an important part of the placebo effect, as well as being a part of what happens in a lot of healing encounters. So the placebo effect teaches us that the comfort and good intention that accompanies any attempt to treat someone can, of itself, be beneficial to disease and illness. My synthesis of the arguments outlined above is that giving another person "nothing" (a hug, or a dummy tablet with no active ingredient for example) helps their health and wellbeing a lot more than doing nothing – so it is about the '"giving" of something to another with good intention.

The Importance of Safety

Placebo effects have been difficult to research, in part because we have not had good theories to apply to aid our understanding (other than expectation and conditioning). But in the 2000s, Dr. Steven Porges (2009) developed his "polyvagal theory," and subsequently Dr. Maddy Greville-Harris and I explored its relevance to placebo effects (Greville-Harris & Dieppe 2015; Dieppe *et al.* 2016). The polyvagal theory, put simply, describes the two extreme states of the human autonomic nervous system—the "fight or flight" response at one end, and the "nurturing response" at the other. The fight or flight response—our innate, automatic response to threat—resulting in heightened anxiety, is something that most people have experienced, it is a part of life. Less is known about the nurturing response, which is the opposite—the relaxation we feel when, for example, we see a young baby smile. Porges (2009) explained the physiology of these responses (which involve the same parts of the nervous system, notably the vagal nerve—hence "polyvagal theory"),

and pointed out that they are linked to our ability to communicate with each other, with our hearing, our voice production, and our facial expressions. If we feel threatened and anxious we are not able to hear another person properly, or to communicate well, our face is expressionless and the voice becomes flat. In contrast, a feeling of safety results in improved ability to listen to and understand what another person is saying, as well as normal facial expressions and vocalisation. Greville-Harris and I showed that placebo effects are probably dependent on feeling safe (being in the nurturing state), whilst a state of anxiety (fight or flight) could activate the opposite—the nocebo effect—making symptoms worse in the absence of being given anything (other than words) that should affect us (Greville-Harris & Dieppe 2015).

Finding New Meaning

American anthropologist Dan Moerman (2011) describes the placebo effect as the "meaning response." He points out that the search for meaning is a key part of the human condition, and that ill health disrupts our normal narratives. The interaction of the ill person with a compassionate practitioner, and the provision of some intervention that might help (even if there is no active ingredient in it) can facilitate the reframing of the problem.

What then is the relationship between placebo effects and healing? We have postulated that the placebo effect is an important component of healing, activated largely by kindness, a comforting presence, and by making others feel safe through the power of human interaction. But we also believe that there is more to healing and the work of healers than just inducing a placebo effect (Dieppe & Rahtz 2017). Our qualitative research with healers (Rahtz *et al.* 2017, 2019 a/b) suggests that healers can activate remarkable changes within their clients through focussed attention with good intention. However, the mechanisms behind such effects are not understood. Healers often talk of "energy," a concept conceived of as "prana" in ancient Indian medical practice, and "chi" in Traditional Chinese Medicine (Kaptchuk & Croucher 1986). Most "modern" scientists dismiss the idea that there is some form of universal energy that can affect human health, but new findings from Parapsychology and Quantum mechanics suggests that such "energy" may be a fundamental part of the universe (Sheldrake 2012; Currivan 2017). And, as Ted Katpchuk (2002) puts it, ritual and the environment matter and help us develop new meanings, and heal. Recognising that most hospital and clinic environments are not likely to make you feel safe, to activate a placebo effect, help you find new meaning, or to heal, I have also turned my attention to the environments in our hospitals.

The Environment and Art in Hospitals

Until relatively recently little attention was paid to the appearance and "feel" of the spaces in which people are treated in hospitals or clinics. Hospitals have been seen as very functional places in which operations can be undertaken, wounds can be dressed, and people can be provided with a chance to recover, or to die. Many hospital spaces were austere and unfriendly, and no attention was paid to creating a sense of safety. Indeed hospitals and their staff have been excellent at creating fear and anxiety rather than relaxation.

Roger Ulrich (1991) undertook a study on the effect of a good view from a hospital bed on recovery rates and complications after surgery. He and his colleagues showed that patients in a ward with a good view recovered better from surgery, with less post-operative complications than those recovering in a ward with no view. Since then many primary research studies have shown that hospital design and hospital art make a big positive difference to patient outcomes and well-being, as reviewed by Lankston *et al.* (2010) and Anaker *et al.* (2017). As a result hospital design has changed, and the use of art and other ways of "softening" the appearance of clinics and waiting rooms have blossomed. In addition, other research has shown that being in natural environments, such as woodlands, can facilitate healing (Irvine & Warber 2002). All this work has helped us realise that we need to pay attention to the environments in which we try to treat people in hospitals.

Lots of hospitals now have an artist on the staff—someone whose role it is to make sure that there are artworks for people to see and respond

to, such as pictures on the walls, sculptures, good colour schemes in wards, and nice garden spaces for patients and visitors. The aim is to improve the experience of being in or visiting a hospital, for staff, patients, relatives and visitors, and it clearly achieves this.

Clinic Design as Placebo

A few years ago Ewa Roos[2] and I decided to test the "placebo effect" of being treated in a nice space in a hospital. Working in collaboration with Roger Ulrich,[3] we designed a trial to test out the hypothesis that physiotherapy treatment for knee pain would work better if it was done in a "nice" room than in a "nasty" space. We found two spaces which seemed to us to be appropriate—an old gymnasium room in the basement of the hospital, with no windows, a bad smell and bad acoustics, and a lovely first floor modern space looking out over the surrounding countryside, and with soft, pleasant furnishings and colours, and good acoustics. The trial "worked," we found a difference. However, the difference favoured the basement "nasty" room! Fortunately, Louise Sandal (*et al.* 2018), who was in charge of the study, had undertaken some nested qualitative research with participants, so was able to explore why they might have experienced more improvement when treated in what we thought was the "nasty" space. Most of the subjects were older adults with longstanding knee arthritis, and many of them told the trials team that the problem with what we thought of as the "nice" room was that it felt like an exercise room/gymnasium for young people and not for the likes of them, and that the view was distracting. In contrast, they felt "at home" in the basement room—this was the sort of space they expected to be treated in at the hospital; it felt "right" and they felt safe in it. So space does make a difference, but we need to understand the needs and contexts of the individuals we are trying to help in order to be able to design spaces that help people heal.

Rehn & Schuster (2017) from Germany have reported the results of a large survey on the effect of the environment on the perception of patients as to whether they were likely to get better or not in hospital. They found that the overall look of the spaces had a huge effect and titled their paper "Clinic Design as Placebo." More studies are needed to examine the power of architecture, design and hospital art on clinical outcomes.

Using Art and Design to create Healing Spaces in Hospitals

I have had the privilege of working with a small team of academics interested in the nature of healing and the work of healers. We are funded, in part, by *The Institute for Integrative Health in Baltimore.*[4] We have been trying to understand what health care professionals and the public think about healing (Rahtz *et al.* 2017, 2019a/b). As people often find that hard to describe using words alone, we use a variety of other techniques, including asking people to draw pictures in response to the phrase "what does the word healing mean to you?"

We use these materials to try to open up conversations about healing within the medical profession. One approach we have taken is to set up exhibitions about healing in hospitals, using some of the pictures that people have drawn in response to our question, as well as quotations about the nature of healing, objects and stories. We have exhibited in several places, using large panels designed by artist Deborah Weinreb working in collaboration with the whole team. Examples of the sorts of panels used in our hospital exhibitions are shown below.

We have sought feedback about the responses of people viewing these exhibitions in hospital spaces. Generalisations are difficult, but based on observational work, interviews and workshops held around the exhibits we think that patients and visitors are more likely to take note of it,

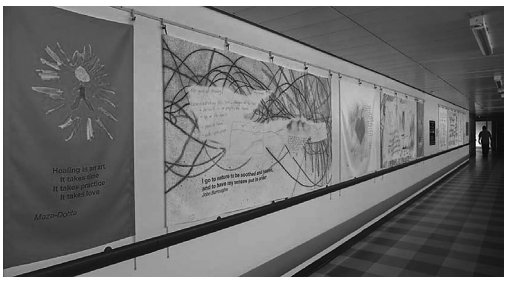


Fig. 2: A photograph of a part of the hospital exhibition along the wall of a corridor

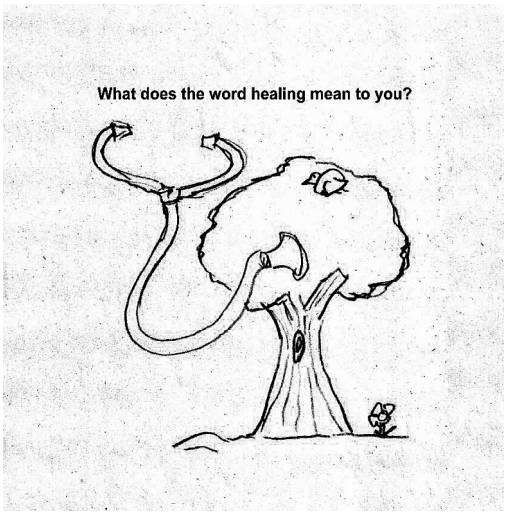


Fig. 3: An example of a panel shown in the exhibition showing an art-work done by a member of the public in response to the question 'what does the word healing mean to you?

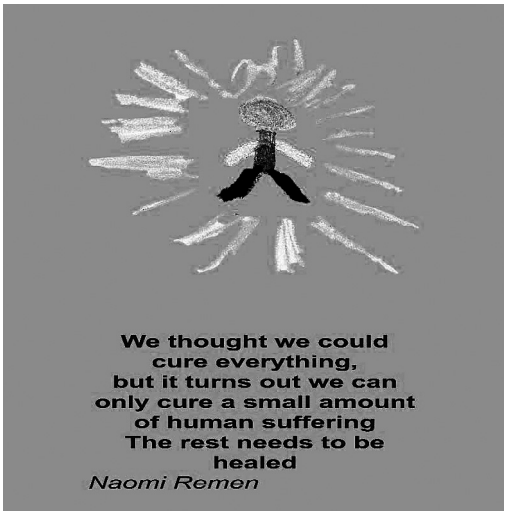


Fig. 4: A panel combining a drawing from a member of the public with a quotation about healing

and respond, than healthcare professionals. That said, many nurses have responded positively to the work, noting for example that "it is wonderful to see something about healing in the hospital" (arguably a strange thing to say, but indicative of the fact that "healing" is a subject largely ignored by medicine today). Doctors rarely took the time to look at the work, perhaps because they have no time, but perhaps because it is too challenging? What we have been most encouraged by is the number of patients and visitors who have used it as some sort of a "healing space" for them to go to whilst in the hospital; several people told us that they kept returning to the space the exhibition was in to help them find peace.

We provided people with the opportunity to comment anonymously on the exhibition by writing on feedback cards. The following quotes taken from these cards, completed by hospital patients or visitors provide us with some evidence for the possible value of this approach (we asked for age and sex but no other identification, age and sex are shown in brackets after each quote).

Some people particularly liked the quotation banners (there were 7 in all):

- "Some quotes will stay with me for a long time" (33 F)
- "Reading the quotes on healing helped me understand my own emotions" (47 M)

Others commented on the artwork:

- "Art is so healing, especially in a hospital" (58 F)
- "Lovely bright art works. The banners are great, a lovely idea" (46 M)
- "I am finding art very healing" (61 F)

Many commented on specific value of the exhibition to them in a time of need:

- "I am a broken man who cannot be fixed. I sit here crying, and hoping for some healing. [...] This exhibition has given me hope. [...] Maybe I will heal one day." (61 M)
- "Your exhibition lifted my spirits today, and it is the little lifts that help me to keep going" (40 F)
- "This exhibition has had a profound effect on me .... it has been a comfort often as I walked through. It is bringing tears to my eyes and touching a level deeper that I can easily share with those I know at present. Thank you." (60 F)
- "Having an elderly relative very ill in hospital, it has given me much to think about. I walk past the exhibition every day when visiting and stop to read every day." (62 F)
- "Wonderful, inspirational. I am finding healing in this hospital." (56 F)
- "I saw it first when I had just received a cancer diagnosis and it gave me hope and confi-

dence to see such a holistic approach being expressed." (47 F)

Outside of the hospital environment we were able to exhibit some of the panels in the Institute for Integrative Health in Baltimore.[5] Feedback from each of these events was very positive. In Rovaniemi we supplemented visual material with sound: there was atmospheric sound in the room, and people were able to listen to stories of healing on headphones. In addition, lighting was used to optimise the atmosphere we were trying to create, that of a healing environment. We do not know what long term impact exhibitions of this sort, and creating healing spaces in hospitals and elsewhere might have, but hope that these will be subjects of our research in the future.

Conclusions

The development of scientific medicine over the last hundred years, combined with its success in dealing with many diseases, has led to a culture of exclusivity in health care provision within "the West" in which the approach of medical science is seen as the only legitimate one for people to pursue and believe in. Other healing practices and forms of Complementary and Alternative medicine (CAM) are ridiculed by the so called "modern" medical profession. However, scientific medicine does not have all the answers. Chronic illness and mental health problems are rising in prevalence, and are often resistant to biomedical treatment. There are other ways of helping people with these problems.

In this review I outline the extraordinary power of "placebo" in the relief of symptoms such as pain and depression. I show why feelings of safety and positive human interactions are key facilitators of a placebo response. The placebo response is a major element of healing, but does not fully explain the healing often achieved by CAM practitioners and healing rituals.

I then discuss context, and in particular the importance of environmental factors. Evidence for the ability of different spaces to facilitate healing is presented. Finally I outline the work of my colleagues and I on the development of artworks that strive to create healing environments in hospitals. The exclusivity of medical science needs to be challenged, and healers and other CAM practitioners should be given the opportunity to work alongside doctors and nurses in our clinics and hospitals.

Acknowledgements

I would like to thank all my collaborators for their help, particularly Professor Sara Warber, Dr. Sarah Goldingay and Dr. Emmylou Rahtz. I would also like to thank the Institute for Integrative Health in Baltimore (TIIH.org) for generous help and financial support.

Notes

1 Trials of this sort are difficult to do for ethical and logistic reasons, and can involve deception, but an approach that has often been used is to randomise people to start treatment immediately, or after a few weeks. Then you can compare the outcomes at the end of the period in which those randomised to a late start were having no treatment.
2 Professor of physiotherapy in Aarhus, Denmark
3 Professor of architecture at the Center for Healthcare Building Research at Chalmers University of Technology in Sweden
4 (TIIH.org). The multidisciplinary core team includes Sarah Goldingay (a humanities scholar), Sara Warber (a doctor who has also trained in Native American Healing) and Emmylou Rhatz (who has degrees in both English literature and psychology) as well as myself.
5 Our funders for this work (TIIH.org), at a meeting of the International Congress on Integrative Medicine and Health in Baltimore (USA), and in the University of Lapland in Rovaniemi, thanks to a collaboration I have with Professor Jaana Erkilla-Hill.

References

Anaker A. *et al.* 2017. Design Quality in the Context of Healthcare Environments: A Scoping Review. *Health Environments Research and Design Journal* 10: 136–140.

Benedetti F. 2013. Placebo and the New Physiology of Doctor-Patient Relationship. *Physiological Reviews* 93: 1207–1246.

Carvalho C. *et al.* 2016. Open-label Placebo Treatment in Chronic Low Back Pain: A Randomized Controlled Trial. *Pain* 157: 2766–2772.

Currivan J. 2017. *The Cosmic Hologram: In-formation at the Centre of Creation*. Rochester: Inner Traditions.

Dieppe P., S. Goldingay & M. Greville-Harris 2016. The Power and Value of Placebo and Nocebo in Painful Osteoarthritis. *Osteoarthritis & Cartilage* 24: 1850–1857.

Dieppe P. & E. Rhatz 2017. Placebos, CAM and Healing: P + X + Y. *Complementary & Alternative Medicine* 4, 2: 1–3.

Ferrucci P. 2006. *The Power of Kindness*. New York: Penguin Random House.

Finniss D. *et al.* 2010. Placebo Effects: Biological, Clinical and Ethical Advances. *Lancet* 375: 686–695.
Greaves D. 2004. *The Healing Tradition*. Abingdon: Radcliffe.
Greville-Harris M. & P. Dieppe 2015. Bad is more Powerful than Good: The Nocebo Response in Medical Consultations. *American Journal of Medicine* 128: 126–129.
Helman C. G. 2001. *Culture Health and Illness*. 4th Edition. London: Arnold.
Irvine K. & S. Warber 2002. Greening Healthcare: Practicing as if the Natural Environment Really Mattered. *Alternative Therapies in Health & Medicine* 8: 76–83.
Jonas W. B. 2019. The Myth of the Placebo Response. *Frontiers in Psychiatry* 10, 577: 1–6.
Kaufman S. R. 1993. *The Healers Tale*. Madison: University of Wisconsin Press.
Kirsch I. 2014. Antidepressants and the Placebo Effect. *Zeitschrift für Psychologie* 222, 3: 128–134.
Kirsch I. 2018. The Clinical Significance of Drug-Placebo Differences. *Epidemiology & Psychiatric Sciences* 27: 240–241.
Kaptchuk T. 2002. The Placebo Effect in Alternative Medicine: Can the Performance of a Healing Ritual have Clinical Significance? *Annals of Internal Medicine* 136: 817–825.
Kaptchuk T. & M. Croucher 1986. *The Healing Arts: A Journey through the Faces of Medicine*. London: BBC Publications.
Kleinman A. 1980. Patients and Healers in the Context of Culture. London: University of California Press.
Lankston L. *et al.* 2010. Visual Art in Hospitals: Case Studies and Review of the Evidence. *Journal of the Royal Society of Medicine* 103: 490–499.
Le Fanu J. 1999. *The Rise and Fall of Modern Medicine*. London: Little Brown.
Levin J. 2017. What is Healing? Reflections on Diagnostic Criteria, Nosology and Etiology. *Explore* 13: 244–256.
Marchant J. 2016. *Cure: A Journey into the Science of Mind over Body*. London: Canongate.
Meetoo D. 2008. Chronic Disease: The Silent Global Epidemic. *British Journal of Nursing* 17: 1320–1325.
Moerman D. 2011. *Meaning, Medicine and the Placebo Effect*. Cambridge: Cambridge University Press.
Mosely J. *et al.* 2002. A Controlled Trial of Arthroscopic Surgery for Osteoarthritis of the Knee. *New England Journal of Medicine* 347: 81–88.
Porges S. W. 2009. The Polyvagal Theory: New Insights into Adaptive Reactions of the Autonomic Nervous System. *Cleveland Clinic Journal of Medicine* 76: 86–90.
Posadzki P. *et al.* 2013. Prevalence of Use of Complementary and Alternative Medicine (CAM) by Patients/Consumers in the UK: Systematic Review of Surveys. *Clinical Medicine* 13: 126–131.
Rahtz E. *et al.* 2017. Transformational Changes in Health Status: A Qualitative Exploration of Healing Moments. *Explore* 13: 298-305.
Rahtz E. *et al.* 2019a. Understanding Public Perceptions of Healing: An Arts-based Qualitative Study. *Complementary Therapies in Medicine* 45: 25–32
––––– *et al.* 2019b. Clients of UK Healers: A Mixed methods Survey of their Demography, Health Problems and Experiences of Healing. *Complementary Therapies in Clinical Practice* 35: 72–77.
Rehn J. & K. Schuster 2017. Clinic Design as Placebo: Using Design to Promote Healing and Support Treatments. *Behavioural Sciences* 7, 4: 77–84.
Rogers C. R. 2003. *Client Centred Therapy*. London: Little Brown Publishing Group.
Sandal L. F. *et al.* 2019. Room for Improvement: A Randomised Controlled Trial with Nested Qualitative Interviews on Space, Place and Treatment Delivery. *British Journal of Sports Medicine* 53: 359–367.
Scott J. G. 2017. Healing Journey: A Qualitative Analysis of the Healing Experiences of Americans suffering from Trauma and Illness. *BMJ Open* 7, 8: e016771.
Shaw Q. 2009. On Aphorisms. *British Journal of General Practice* 59: 954–955.
Sheldrake R. 2012. *The Science Delusion*. London: Hodder & Staughton.
Sontag S. 2003. Regarding the Pain of Others. London: Penguin Books.
Ulrich R. S. 1991. Effects of Interior Design on Wellness: Theory and Recent Scientific Research. *International Journal of Healthcare Management* 3: 97–109.
Zhang W. *et al.* 2008. The Placebo Effect and its Determinants in Osteoarthritis: Meta-Analysis of Randomised Controlled Trials. *Annals of the Rheumatic Diseases* 67, 12:1716–1723.

PAUL DIEPPE qualified as a doctor in London in 1970. He went to Bristol University in 1978, where he first became Professor of Rheumatology (1986) and then Dean of the Faculty of Medicine (1995). He was then served as Director of the Medical Research Council's Health Services Research Collaboration (1998-2008) before moving to Exeter in 2010 to become Professor of Health and Wellbeing and start his research on healing.

76 Hill View, Henleaze,
Bristol, BS94PU, UK
e-mail: p.dieppe@exeter.ac.uk

Aesthetic Embodied Imagination in the Tamalpa Life/Art Process®

ANJA LÜPKEN

Introduction

The Tamalpa Life/Art Process is a movement-based Expressive Arts Therapy approach. It fosters the integration of body, sensory perception, somatic movement awareness, movement improvisation, imagination, and artful expression with psychological content. Expressive Arts Therapy speaks to a person's emotional and creative capability and provides new options for personal development, insight, and healing. Daria Halprin, one of the founders, summarizes the main principle:

> "Expressive arts therapy proposes a radical approach, joining art and psychology to facilitate embodied learning and expressiveness. Based on the use of intermodal arts, expressive arts therapy sees the relationship between imagination and sensory expressiveness as the pathway for drawing forth awareness, creativity, and change. The interplay between psychological and artistic processes is the ground from which disturbance and new options for insight, change, and health are explored." (Halprin 2003: 74)

The article attempts to present the Tamalpa Life/Art Process as a practice of aesthetic embodied imagination that facilitates change and healing. After an exemplary description of a beginner's session, a short portrayal of the development, and rough localization in the field of Body, Movement, and (Expressive) Arts Therapies, the Tamalpa Life/Art Process is presented as an aesthetic embodied practice that facilitates metaphor and imagination for healing.[1]

In the studio—description of an introductory workshop

The following section will describe an open, two-hour introductory workshop held on a Sunday afternoon for people interested in taking part in the Tamalpa Life/Art Process. Participants usually liked to dance and were interested in self-awareness methods, but had no special training. The workshop took place in a small center for coaching and counseling, which lends its room to movement classes like Yoga or Tamalpa. The intentions for this session were to provide a first experience of the Tamalpa Life/Art Process that was simple enough for everyone and to create a welcoming atmosphere. The resources for this particular workshop were: the body (arms and hands); the *Movement Metaphor*[2] "letting go;" movement awareness; movement improvisation; drawing with oil pastels; partner exchange; *Aesthetic Feedback*;[3] *Life Art Questions*;[4] the *Three Levels of Awareness and Response*;[5] music.

After the individual welcome at arrival and a group welcome at the beginning of the session with a short explanation about Tamalpa, we began with the "name game:" one person says their name while making a gesture, then the group simultaneously repeats both name and gesture three times, then the next person says their name with a gesture, and so on. The playfulness continued throughout the warm-up and the music inspired lively movement and dance. We started with moving the joints from fingers, to wrists, to arms, to shoulders until the whole body was moving, and progressed to movement games that facilitated contact, thereby fostering further group integration.

When the warm-up was finished, we shifted to body awareness exercises using elements of the *Movement Ritual*[6] and focused on before-after and

left-right comparison. From this sensitization of the particular body part in focus, we then began movement improvisation with music—first in a more general way and second, a little later with the idea of "letting go of something." The participants explored the *Movement Metaphor* of letting go with arms and hands. While they moved the facilitator guided the attention to the *Three Levels of Awareness and Response* by saying: "On a *physical level*, are there movements or sensations that are present in the moment. Move from this physical level." After a few minutes of movement improvisation followed: "On an *emotional level,* are there any feelings or emotions coming up? Just recognize them and move with them." Again, after several more minutes: "On an *imaginative level,* are there images or memories rising up? Recognize them and move with them." The movement improvisation went on through all *Three Levels of Awareness and Response* (physical, emotional, imaginative level) and the *Movement Metaphor* of letting go. During the improvisation the facilitator posed the *Life Art Question*: "What do I want to let go of in my life?," and let them move with this question for a while.

Transitioning into the next phase of the session the facilitation might be: "In the next step give it an image, a drawing. What do you want to let go of, or what is present at the moment. Let the movement continue in color and form on paper. You don't have to know. Just draw." The participants of the workshop then shifted their action from moving to drawing while they sat on the floor, using oil pastels and paper.

After the drawing was finished, everyone stood up and held it in front of their chest and met each other with their drawings in a non-judgmental attitude. This display created a situation of simultaneous "see and being seen" without being exposed. This kind of encounter helped with forming pairs for the following partner exercise where the drawings of the partner were the inspiration for a movement exploration that provided *Aesthetic Feedback* to the drawer. Drawings contain certain elements that can be called "keys" to unlock the image in an active imagination process (Jung). The keys Tamalpa works with are color, form and symbol. After the explanation of the exercise and the keys, partner A stood holding up their drawing in front of their chest and observed partner B's movements inspired by the drawing of partner A. There were three one-minute rounds of moving either a color, a form or a symbol. That means projecting movement onto *e.g.* the color blue what might be a flowing light movement. In closing, partner A who observed the movement of partner B gave an *Aesthetic Feedback* in movement, a corporeal answer in this dialogue of movement. After alternating roles, the partners said goodbye and moved to their own drawing in the same way: three one-minute rounds where they moved to either a color, a form or a symbol. During the fourth round the whole drawing was moved. Subsequently the participants were invited to write a dialogue with their drawing or a specific element in the drawing. Facilitation might be: "If your image could speak what would it say?"

The following partner exchange gave the possibility to reflect on the process and share experiences. It is sensible to choose the same partner one had in the movement exercise. This exchange was facilitated within a time frame, communication guidelines, and a sequence of prescribed actions. Partner A began their sharing by showing the drawing and, if they wanted, reading parts of the dialogue. The report about the experiences during the session and the insights from the process should be done in the form of 'I' statements to make sure that no interpretation is transferred on the partner. "I see," "I feel," "I imagine" are proposed formulations that act as verbal crutches. Partner B should listen with an open, interested attitude without questions or comments. After partner A finished their report, partner B gave an *Aesthetic Feedback* in movement expressing what moved them, and the partners took turns.

In the sharing circle anyone who wanted to was encouraged to share a word and a gesture that expressed what they took away from the session, repeating it three times. The other participants answered at the same time with an individual gesture and/or sound. A joint movement sequence introduced by the facilitator closed the session.

Tamalpa Life/Art Process as a Movement-based Expressive Arts Therapy approach

The Tamalpa work is a versatile method whose models and instruments can be applied in diverse settings for many purposes. Usually, it is offered

in open or closed groups, workshops, and one on one sessions for therapy, self-development, consulting, or art creation.

The history of the Tamalpa Life/Art Process began in the 1950's when ANNA HALPRIN[7] turned towards an understanding and practice of dance as a healing art. Subsequently,

> "[i]n the early 1960's Anna began collaborating with other artists and leaders in a groundbreaking movement that aimed to bridge the fields of dance, movement, art, performance, somatics, psychology and education. These collaborations included exchanges between Anna's Dancers Workshop group and the Fluxus group of New York, FRITZ PERLS (founder of Gestalt therapy), MOSHE FELDENKRAIS (Awareness Through Movement), CARL ROGERS (Person-Centered Therapy), and THOMAS GORDON (confluent education)." (https://www.tamalpa.org/).

Out of this collaboration ANNA HALPRIN developed the Life/Art Process®. Another significant influential thinker was the environmental designer LAWRENCE HALPRIN, husband of ANNA HALPRIN, who worked on collective creativity and the creative process (cf. HALPRIN 1969).

DARIA HALPRIN danced in her mother's classes and ensembles since early childhood. As a trained Gestalt therapist, she co-founded the Tamalpa Institute in 1978 with her mother. From this time on the institute has been offering public workshops and professional movement-based expressive arts training in the Tamalpa Life/Art Process. Today Tamalpa Institute's programs are recognized by the International Somatic Movement Education and Therapy Association (ISMETA) and the International Expressive Arts Therapy Association (IEATA). This institutional embedding, too, reflects the main pillars of the Tamalpa Life/Art Process: Somatic Movement and Expressive Arts Therapy (https://www.tamalpa.org/).

While the Tamalpa Life/Art Process shares the basic principles of Body Psychotherapy and Dance Movement Psychotherapy (cf. PAYNE *et al.* 2016: 149–150, cf. HALPRIN 2003: 62–66), and works with similar tools and methods though it cannot be assigned to either of them. The Tamalpa Life/Art Process has no clinical focus, and does not work with diagnostics or (movement) analyses like national Dance Movement Psychotherapy institutions provide in order to, inter alia, establish these therapies in the public health sector. Accordingly, a growing corpus of evidence-based research on the efficacy of certain methods in certain groups and the development of theories foster the scientification of Dance Movement Psychotherapy (cf. PAYNE *et al.* 2019, 2016; PAYNE 2017; KOCH 2017a/b; EBERHARD-KAECHELE 2013; GOODILL *et al.* 2013). The focus of the Tamalpa work lies on "healing, education, and social transformation" (https://www.tamalpa.org/). It applies neither movement analyses nor correcting intervention. Also, verbalization of movement is not used. Tamalpa integrates movement, dance improvisation, drawing, creative writing, performance, and reflection as equal and intertwined exercises.

Another aspect in which Dance Movement Psychotherapy and the Tamalpa Life/Art Process differ are their theoretical and methodological roots. In addition to the above-mentioned, main influences for the models and methods of Tamalpa are Somatic Psychology (Wilhelm Reich), Expressive Arts Therapy (Paolo Knill), Psychosynthesis (Roberto Assagioli), Humanistic Psychology (Abraham Maslow, Carl Rogers, Fritz Perls, James Hillman), Existential and Phenomenological Psychology (William James, Edmund Husserl, Abraham Maslow, Fritz Perls), and Jungian Psychology (cf. HALPRIN 2003: 35–79).

In contrast, important influences on the varied fields of Dance Movement Psychotherapy were primarily dancers (cf. BENDER 2020).[8] Closest to the Tamalpa Life/Art Process is the work of ILENE SERLIN (kinesthetic imagining), who had also danced with ANNA HALPRIN in 1970 and worked with LAURA PERLS, co-founder of Gestalt therapy (SERLIN 1996, SERLIN & LEVENTHAL 2019: 39–48).

In conclusion, the Tamalpa Life/Art Process is a part of the Artistic Therapies, like Art Therapy, Music Therapy, Dance Therapy, or Drama Therapy. Specifically, it is an Expressive Arts Therapy integrating dance as a basic expressive modality, and facilitating somatic movement as bodymind awareness. With its focus on somatic movement education it can be called "somatic art" (cf. EDDY 2017). Its tools are: body, movement/dance, voice/sound, drawing, dialogue, improvisation, performance, and reflection. Methods and models used in the Tamalpa work described below are: *Movement Ritual, Psychokinetic Imagery Process/Cycle,*[9]

Movement Metaphors, *Body Part Metaphors*[10], the *Five Part Process*[11], *Scoring*[12], *Creative Writing, Witnessing/Active Listening*[13], *Aesthetic Feedback, and Life Art Questions*.

In the following subchapters, the five concepts of movement, metaphor, imagination, aesthetics, and healing help to structure the discussion and profile the methods and models of Tamalpa. *Movement* is addressed in terms of body memory and kinesthesia, the movement sense. Here, somatic movement awareness and the *Movement Ritual* are presented. *Metaphor* research in cognitive linguistics offers an explanatory model for *Movement Metaphors*. They can be used to enter an As-If reality (cf. Vaihinger 1911), a transitional, liminal sphere of imagination. *Imagination* is conceptualized in a working definition as an interface between body, mind, emotion, psyche, and the external world. Not only images, but all senses are engaged in the *Psychokinetic Imagery Cycle*, which explains the Tamalpa work as aesthetic embodied imagination. To connect the artful exploration experienced in the studio with daily life, *Life Art Questions* are employed. *Aesthetic* can be conceptualized as beauty or sensory perception depending on the philosophical or academic context. *Aesthetic response*[14] as a theoretical explanation and as a Tamalpa tool are presented in this section. *Healing* as a holistic concept is defined in terms of enlivenment, imaginary poetic interaction with unconscious content, and the ability to live life artfully. The importance of safe spaces, the role of the therapist, facilitator or teacher, and the sense of community will be addressed, and models to support and reflect transformation will be presented.

Movement

The Tamalpa Life/Art Process is a *movement based* Expressive Arts Therapy. Its key component and starting point is the moving body. By facilitating conscious movement and training the kinaesthetic sense it activates body memory and embodied imagination.

Embodiment has become a key concept to almost all fields of research concerned with human nature. Not only in neurophysiology and cognitive science, but also in the humanities it is applied to bridge the theoretical gap between body and cognition (cf. Gibbs 2010; Shapiro 2014). Anthropologist Thomas Csordas conceptualized the body as an existential ground of culture (cf. Csordas 1990, 1993). Application-oriented research fields (*e.g.* psychotherapy research and theory) also apply embodiment concepts like embodied communication or body memory (cf. Hauke & Kritikos 2018; Payne *et al.* 2019).

That the body is holding a certain kind of memory has long been discussed in body psychotherapies. Wilhelm Reich (2009) pointed out the connection between body and mind as well as the importance of the body in the psychoanalytic process. He proposed that muscular armour (tension) was a defense that contained the history of the patient's traumas. Accordingly, memory, emotional, and behavioral disorders have their origin in muscular tension or "armoring." Therapeutic methods working with the body, like Bioenergetics, Biosynthesis, or Biodynamics, refer to his research, as does the Tamalpa Life/Art Process. Developing Reich's ideas, Ken Dychtwald's (1981) work *Bodymind* has become influential in alternative therapeutic contexts. Trauma therapy also relies on the idea of body memory: Bessel van der Kolk (2015), Peter A. Levine (1998, 2015), Stephen W. Porges (2010), to name only a few, locate trauma and traumatizing memory in the body, for instance in the regulation of the autonomic nervous system.

Cognitive science and embodiment research also focus on the concept of body memory (cf. Koch *et al.* 2012). Concepts of (body) memory operate in dichotomies such as explicit/implicit, conscious/unconscious, procedural/declarative, episodic/semantic. The explicit/implicit is a basic concept in thinking about memory. Explicit memory is accessible through remembering and includes autobiographical and semantic contents. Implicit memory, on the contrary, is all the information the body holds (*e.g.* procedures, skills), and furthermore: "Body memory, thus, is a form of lived experience, which is constantly reactualized and implicitly lived through by a bodily subject." (Koch *et al.* 2012: 425).

Implicit memory is unconscious, yet still it influences all of our perception and action. Sometimes it restricts us: traumatic and pain memory, two of the six types of embodied memory (cf. Fuchs 2012), are examples of why it is salutary to have instruments that access body memory as key

aspects in trauma therapy. But beyond that, how can we access body memory? How can we transition from unconscious memory to conscious memory? Astrid Kotler *et al.* (2012) describe a "[…] procedural unfolding that does not necessarily proceed one way. Consciousness and the unconscious, explicitness and implicitness can certainly be analytically distinguished and described, yet they are always already intertwined and jointly inform the complex structure of lived experience." (*ibid*: 222)

As a bidirectional process, she describes the transition between implicit body and explicit "mind" memory that can be activated through movement, metaphoricity, and verbalization of movement. The boundaries blur between explicit and implicit as well as past memory and present experience. Maxine Sheets-Johnston (2012) conceptualizes memory as "[…] a matter of memory 'in and by and through the body,' not memory of an object-body" (*ibid.*: 68). She proposes to think of immanence rather than intersection between past and present – remembering as an active, intentional process in which memory is actualized in/by/through the moving body. As she proposes the category of *kinesthesia* "[…] at the core of our being, or in broader terms, that animation defines the nature of life." Sheets-Johnstone *(ibid.:* 69) introduces the movement aspect of body memory to the discussion and puts it at the center of human nature – and animate nature in general. In a way, she lets the scale turn towards the body. Whereas others "overestimate" the mind, she "overemphasizes" the body. Nonetheless, the fact that living bodies are moving bodies and that at least a part of body memory is kinaesthetic is a given.

Rudolf Laban (1920), dancer and choreographer, was one of the first who formulated the idea of a body sense (Körpersinn), the *body* or *kinaesthetic sense*: a capacity to perceive oneself as body in motion, that is closely connected to emotions, feelings, and sensations. Sabine C. Koch (2011: 30) poses the hypothesis that kinaesthesia is not only another sense, but the basis for all sensory perception. This way, kinaesthesia becomes the anchor of our self, that which keeps our subjective impression of holistic perception together. This applies not only to human individuals, but to all animate life. As Sheet-Johnstone (2012) puts it

> "[…] the fundamental fact that the faculties of kinesthesia and proprioception are its [animate life] inextinguishable phylogenetic and ontogenetic correlates" (*ibid.*: 47).

An important kinaesthetic technique is Mosche Feldenkrais' *Awareness Through Movement* (1978). Thomas Hanna (1988, 1994), trained in Feldenkrais technique, developed *Somatics* on one hand as a concept of seeing the body as an integrated entity that must be experienced in movement, and on the other hand as a method that trains this bodily sense and can be described as *somatic movement awareness*.

The work of Feldenkrais and Hanna as well as the movement studies of Anna Halprin as a dance artist and choreographer form the basis of *Movement Ritual*. This is a tool to cultivate the sensory awareness in movement in the Tamalpa Life/Art Process, to teach movement principles, and to train the kinaesthetic sense through performing this series of dynamic movements in different ways with different intentions. It can be used as a form of movement meditation, as a resource for movement education and improvisation, as performance material, etc. *Movement Ritual* is a series of movement explorations that integrate the basic principles of human body motion. It is not supposed to be a formula that can be repeated technically. Rather, it is a suggestion, a point to start from "[…] to experience the principles of human body motion at work" (Halprin 1979: 1). Performing *Movement Ritual* has an impact on emotions, feelings, and the inner state. It can be used as a check-in with the body sense, and regularly performed, tunes the kinaesthetic sense and the entire sensory apparatus. There are four parts of Movement Ritual: *Movement Ritual 1* is performed primarily lying down, using flexion, extension, rotation, etc. *Movement Ritual 2* is performed standing up, it applies falls, lifts, swings, and balance. *Movement Ritual 3* is focused on locomotor movements like walks, runs, crawls etc. The variation of 1, 2, and 3 is called *Movement Ritual 4* which can vary as people respond differently to motion.

Movement Ritual, movement improvisation, and metaphoric movement are applied to inspire metaphor and imagination and to deal with psychic content. Daria Halprin (2003) formulates

the core philosophy of the Tamalpa Life/Art Process:

> "The entire repertoire of our life experience can be accessed and activated through the body in movement. Since movement is the primary language of the body, moving brings us the deep feelings and memories. [...] When made conscious, and when entered into as mindful expression, movement becomes a vehicle for insight and change. [...] In this moving out of unconscious material, we bring all that we have not been aware of into clearer view." (*ibid.*: 17f).

The theoretical frame for this interrelation in the Tamalpa work is the *Psychokinetic Imagery Cycle* (Halprin 2003: 130–136). The term psychokinetic refers to the unity of psyche and body: "The anatomy of the body and the psyche reflect each other" (Halprin 2014: 93). Social Embodiment, for example, researches the bidirectionality of affect and motor behavior and says that not only affect expresses into behavior, but also behavior has influence on affect (cf. Koch 2011: 40, 2017b: 47). It is a dance of e-motion and activates metaphor and imagination.

Metaphor

A core concept of the Tamalpa Life/Art Process is metaphor used in *Movement Metaphor*s or metaphorization in the *Psychokinetic Imagery Process* (for a detailed discussion on metaphors cf. Goldmann 2019). There are not only verbal metaphors, but metaphors of different kinds: visual, audible, movement, or mixed metaphors (for mixed metaphors cf. Gibbs 2016). They all share a common structure: metaphors explain one thing in terms of another, and have a *source domain* and a *target domain* (Lakoff & Johnson 1980: 5). The source domain defines the area from which the metaphor is drawn, or in other words, it is the image that is used to describe something, *e.g.* an action. The target domain is this something, *e.g.* the action. The example George Lakoff and Mark Johnson give is "Argument is War." The action (argument = target) is described with a concept or image from a different source (= war). What is described? (target), How is it described? (source) (cf. Lakoff & Johnson 1980). Argument could also be described as a "dance" – "Argument is Dance." (argument = target, dance = source).

In the 1980s, a "cognitive turn" occured in the metaphor studies, when Lakoff and Johnson published *Metaphors We Live By* (1980). Formerly separate fields of research came together—neuroscience, philosophy, psychology, and linguistics – and formed new fields including cognitive linguistics, or psycholinguistics. The work of Lakoff and Johnson took metaphor to the core of cognition, and placed its origin in the body. They locate the source of metaphors in experience and postulate that human thinking processes are largely metaphoric. Metaphors are seen as the paradigms of our self-understanding (cf. Lakoff & Johnson 1980).

All senses can be metaphorical. Visual, movement, or acoustic metaphors differ from their verbal counterparts in their perceptual immediacy that is lacking in language (Forceville 2008: 463). Also, gestures have been studied as metaphors that are used—despite depicting concrete activities or objects—"[...] to represent abstract metaphoric concepts. This fact supports the hypothesis in cognitive linguistics that (many) metaphors are grounded in embodied action" (Cienki & Müller 2008: 495). It is of special interest here that Alan Cienki and Cornelia Müller refer to the dynamic aspect of metaphoricity and that "[...] gestures may trigger new verbal metaphoric expressions" (*ibid.*: 498).

Approaches to metaphor in cognitive linguistics refer to metaphors as spoken or visual images, and they mention the body merely as the origin of metaphorical cognition. Only a few authors conceptualize body and movement as the basic source domain (cf. Cuccio 2018).

Movement as Metaphor

Movement and metaphor are closely intertwined and methodically applied in Dance Movement Psychotherapy (cf. Kotler *et al.* 2012; Eberhard-Kaechele 2017). In the Tamalpa Life/Art Process the interplay of body (parts), movement, and metaphor has two dimensions. It is firstly intentionally used as an instrument to inspire improvisation, to introduce a theme (of a session), and to activate body memories. As *Movement Metaphor*s, they have a verbal expression that can be executed

in movement, for example "letting go," "walk my way of life," or "reach towards something." They function like an entrance door to the moving metaphorical body. It is important to state here "[...] that the field of play stays open within this grounding framework, allowing each body to reveal and tell its own unique story" (Halprin 2003: 170). As described in the introductory example, in a group setting one might start from one movement exploration (of arms and hands) and through metaphoric activation ("letting go") and/or *Life Art Questions* individual metaphors are developed and linked to personal memory and life themes (*e.g.* "letting go" of the anger towards somebody). Metaphors originate in body memory activated by paying attention to the movement and, therefore, activating mechanisms inside the body. Metaphorical movement accesses body knowledge/memory and develops new metaphors that can be linked to personal life stories:

> "This makes for a powerful metaphoric interplay between the actual and imaginal worlds. [...] the body parts play a similar function to the symbols or scenes in a dream." (Halprin 2003: 145).

Secondly, in a broader context, the Tamalpa Life/Art Process provides a "road map" to explore the landscape of the body and its memory: the *Body Part Metaphors* (Halprin 2003: 145–175). The division into body parts offers a guideline that helps to focus and provide depth. It also provides the opportunity to enter into movement and metaphor in an attainable way that can be adjusted to any clientele a practitioner is working with. *Body Part Metaphors* are made up of actual bodily *functions* (movements), (cultural and personal) *associations*, and *themes*. For example, functions of the body part "legs and feet" are "standing" and locomotor movements like stepping, running, moving toward and away from something or somebody. Associations are: finding your place or stance, to stop and start, moving toward a goal etc. From that point themes may be formulated to be explored in movement, drawing, and writing, for example regarding the *Movement Metaphor* "taking a stand." Bringing a theme into movement then again creates new *Movement Metaphors*.

By working with all body parts in depth—as it is facilitated during the first level of the training—exploring their metaphors, one accesses the personal mythology through the activation of the implicit body memory. In a second step all parts are integrated, bringing them into interaction. Through movement, dialogue, and drawing an individual *Body Part Mythology* is created, telling personal life stories grounded in body memory and individual life metaphor: "Movement then becomes the metaphor for our way of living our life stories" (Halprin 2003: 18).

With the ability to form metaphors, a mental space is created between logic and fantasy, where important therapeutic processes can take place (cf. Kirmayer 1993). Working with metaphors, one leaves the literal reality and enters into a fictional, psychic reality, that is highly subjective. Referring to Hans Vaihinger's *Philosophy of As-If* (1911) James Hillmann (2009) states:

> "The key is that *as though*, the metaphorical, as-if reality, neither literally real (hallucinations or people in the street) nor irreal/unreal ('mere' fictions, projections which 'I' make up as parts of 'me', auto-suggestive illusions)." (*ibid.*: 56).

Through moving or acting "as if," one enters an imaginative space and psychic reality. If, for example, the everyday movement of walking is performed metaphorically as if someone "walks her/his way of life," a whole new dimension of walking opens up, one that is full of memory, meaning, and imagination.

Imagination

Creative Imagination, using its "healing and reconstructive powers," is at the core of Expressive Arts Therapy (McNiff 2017: 30), it is central to understanding the Tamalpa Life/Art Process.

Imagination is a concept that regained importance in recent years – as a method for psychotherapy, in so called self-support-books, in neuroscience, literature studies, and cultural studies. In general, imagination explores the construction of the relation of "outer" and "inner" worlds (Traut & Wilke 2015). Historically, there are two main branches: First, the epistemological approach defines imagination in terms of the construction of reality. Currently, this perspective is prominent in philosophy and cognitive science. The second definition of imagination relates to arts theory and aesthetics. It focuses on imagination as cre-

ative invention. Lucia Traut and Annette Wilke (2015) thoroughly illustrate how the concept of imagination has been linked to the body throughout European intellectual history. Imagination has long been located in the body, for example, in the heart or the brain. Only since the 18th century, in the course of Cartesian division between subject and object, imagination has been understood as a cognitive operation of the subject in the mind, no longer materialized in the body (cf. Traut & Wilke 2015). The basic functions of imagination are: to represent and to link, to make present what is not present, to dive into other worlds, to provide things and humans with new meaning, to evoke affects, and finally every act of perception is imaginatively formed with meaning (cf. Wilke 2015: 505–506). In every imaginative act, similar to every sensual perception, several dynamics are at work: bio-neurological processes (brain functions), socio-cultural standards, religious prefigurations, interpersonal interaction, as well as individual forms of appropriation and creative performances. Traut and Wilke (2015: 62) assume an anthropologically founded, and therefore universal, homogeneous *competence of imagination* that is culturally shaped.

Following the epistemological definition, imagination serves as the missing link: there is no perception without imagination. This perspective connects sensory perception, emotion, and materiality with the conceptual, cognitive level. Accordingly, perception is already perception "as something"—the "pure" perception is, therefore, transcended and imaginatively superimposed with meaning (cf. Traut & Wilke 2015: 55–56). Lakoff and Johnson (1980), in this regard, refer to rationality as dependent on imagination, and emphasize the transformative power of metaphors as being able to construct "new realities" (*ibid.*: 235–236). An interpretation of imagination that combines on the one hand the aspect of reality constructions (epistemology, cf. Koch 2020), and on the other hand creative inventions (art theories, aesthetics), provides a rather flexible perspective on the interplay of perception, interpretation, sensemaking, and transformation.

Imagination, thus, is a *transitional sphere* (Traut & Wilke 2015: 34) that integrates body, mind, and emotion. Imagination is closely intertwined with aisthesis (sensual perception). Imagination and aisthesis influence each other bidirectionally. Culturally formed imaginative structures filter the individual sensory perception and allow a seeing "as something." In general, perception and imagination are ways of world-making.

Techniques of imagination—mediated through the body and the senses—must be seen as specific capabilities and competences (cf. Koch *et al.* 2015). They are somatic formations of possibilities, styles, and attractions of perception. As a result, they have power to form reality, in the way that they shape the relation of inner and outer worlds—sometimes in a new order. They relate worldviews and self-images often for the sake of happiness, healing, or (spiritual) perfection. Imagination techniques use the body as an experiential space as well as an object of imagination. In combination with aesthetic arrangements, they have a strong suggestive power and a power of factuality that is able to create new realities (Traut & Wilke 2015: 75–79). There is no transformation (neither individually nor collectively) without imagination (Wilke 2015: 507).

From this perspective, the Tamalpa Life/Art Process constitutes a technique of imagination that uses the interconnections of body, perception, imagination, emotion, and cognition to facilitate a holistic integration and communication of body, psyche, and mind in a creative process. As an *intermodal method* (Knill 1979), it brings different art modalities like movement, drawing, and poetic writing into play. The theoretical framework to describe and facilitate this process is the *Psychokinetic Imagery Cycle* (cf. Halprin 2003: 130–136). As the term psychokinetic and the role of movement have already been addressed, the focus now will be on the two other poles of the *Psychokinetic Imagery Cycle*: image and narration.

Making an inner image visible, perceptible—projecting it—opens up the chance to relate to it and communicate with and through this medium. In the Tamalpa work, drawing is usually done with oil pastels on paper that is readily available, because the drawing is not for the sake of high art or exhibition, but for the sake of communication. These images are free associations and follow a movement exploration, sensory awareness exercise, or are just made as a first step into the session often accompanied by a theme or *Life Art Question*. There is no (rational) interpretation of the image.

Rather, one stays in the imaginative realm and enters into creative ways of communication—in movement or narration. Narration (cf. PANHOFER *et al.* 2012; GALLAGHER & HUTTO 2019), the third pole in the *Psychokinetic Imagery Cycle*, can be a dialogue, a poem, a letter, a story, or any other kind of creative writing. One main instruction at this point is "If your body/the image could speak, what would it say?" The participants in Tamalpa remain in this As-If reality and vary movement, image, and narration through the differing interrelations of the art modalities.

Staying in this imaginative art space serves three purposes. First, it is *generative*, gathering additional information, understanding, and new resources. Second, it is *integrating*, art modalities and information come together in a new way. For example, at the end of a session the performance piece using all gathered resources (drawings, narratives, movement material) reveals a new meaning, thereby creating a new metaphor. Third, the *Psychokinetic Imagery Cycle* is *communicating*, intra-personal as well as inter-personal. One could talk with an image in a poetic narrative, one could move a drawing and so on. Interrelations of the art modalities can be facilitated with the material of one person (intra-personal) and between two or more (inter-personal).

The Tamalpa Process was created to navigate between life and art. Participants bring themselves and their daily lives into the studio and use life issues for artistic improvisation. To bridge the other direction, finding, or even better, creating the meaning of the artful expression, the *Life Art Questions* and Journal Writing methods are applied.

The imaginative art space stands on its own. And the changes made in art will unfold. The art has importance beyond rational interpretation or measurable outcome. Nonetheless, it is helpful to take the often critical minds by the hand and connect what happened in the art space to larger contexts. This way, realities are created and changed, or rather made visible for the thinking mind. And even thinking and verbalization are imaginative processes of meaning making and transformation (cf. TRAUT & WILKE 2015: 18). Furthermore, these reflections enable the participant to consciously implement transformation by planning actions of change in daily life.

By using *Life Art Questions* to inspire Journal Writing or spoken exchange, a relationship between metaphoric and literal reality can be established. It opens up a chance to reflect on the meaning of the art for the lives of the participants. For example, a *Life Art Question* working with the theme of personal boundaries could be: How can I create my space in everyday life? (cf. HALPRIN 2003: 133).

Aesthetics

Expressive Arts Therapy is an aesthetic practice. It is working with the body and the senses as well as a certain kind of beauty. *Aesthetic* is a term with different usages and meanings (cf. JOHNSTON 2020). In art philosophy, it traditionally regards beauty, grace, and often a kind of formalism. Alexander Gottlieb Baumgarten (1750–58) brought a new understanding which he called by the Greek term *aisthesis,* meaning sensation or sensory perception.

The Tamalpa Life/Art Process is an aesthetic, kinaesthetic or "somaesthetic" (SHUSTERMAN 2012, 2018) practice which has a certain understanding of aesthetics, specifically the aesthetic response. An *aesthetic response* is the act of being inwardly moved by a sensory perception that provides change within and finds expression through art. Aesthetic in this sense is not understood as a formal doctrine of beauty, but a form of communication through the senses. It rather derives from the concept of aisthesis and includes emotional as well as imaginal reactions inside the individual. As DARIA HALPRIN puts it "soul is touched" (2003: 93). This inner movement, the e-motion, changes the inner state of the perceiver who can express it through artful means like movement, drawing, and poetry. Even if they would not express it directly, they would express it through their face, posture, movement, or sound of voice. By making the inner movement visible, communication with the "inner world" becomes possible and offers ways of making sense and meaning, integrating it into thinking through reflection. Despite the inward moving, an *aesthetic response* is also the expression of the impression, which becomes a new impression to both the one who is expressing and the witnessing partner. It is a constant cycle that circles in both directions (cf. KOCH 2017a/b: em-

bodied aesthetics in psychotherapy). The inner life of a person is expressed and in a manner being shaped through the art medium. In this way, in moving a person inwardly, the artful expression becomes "beautiful." This offers only a broad working definition of the aesthetic practice of Expressive Arts Therapy (cf. Knill *et al.* 2005).

Different art mediums generate different responses depending on the materiality (oil pastels, clay, natural objects) or non-materiality (voice, sound, movement) of the medium. Bringing them together, like in the *Psychokinetic Imagery Cycle*, and facilitating communication among these modalities provide a wide range of combinations and interacting synergies within an aesthetic art space. As the basis of this practice is the moving body, the Tamalpa Life/Art Process is a method of *embodied aesthetics*. The theory of embodied aesthetics in psychotherapy of Sabine Koch (2017a/b) describes the aesthetic mechanisms of impression and expression similar to the *Psychokinetic Imagery*. In the Tamalpa Life/Art process *Aesthetic Feedback* is an intervention to facilitate interaction between partners. It originates in the sensory experience and imagination of the witness (aesthetic response). Exercises include, for example, partner A moving the drawing of partner B; or partner A talking about her experience during the session and partner B answering with a gesture or a drawing. It offers a possibility to respond to someone's expression while avoiding rational thinking which is often connected to judgement—positive or negative. A prerequisite for offering *Aesthetic Feedback* is witnessing. The dance (therapy) technique Authentic Movement facilitates witnessing as a relational approach (cf. Stromsted 2019) which influenced the practice of the Tamalpa Life/Art Process. Here, *Witnessing* and providing *(Aesthetic) Feedback* are learned and practiced like an art in itself. It offers possibilities of interaction that are based on respect and empathy, letting the partner be as they are, providing a safe space where the creative process can unfold. This instrument of *Aesthetic Feedback* based on empathetic witnessing often creates a feeling of being truly seen and accepted. (cf. Halprin 2003: 135, 2014: 102). That is healing in itself.

Healing

From an Expressive Arts perspective healing is a *process* of becoming whole, alive, imaginative, and connected. In this sense, it is not reduced to curing or physical health. Referring to the philosopher Andreas Weber, it is a process and ability to build creative connections – with myself, with the others, with all that is beyond, with life (cf. Weber 2016: 78). This process is non-linear and seemingly chaotic in its own self-organizing order. Healing refers to a human dimension beyond rational, materialist thought, which opens up new possibilities to live life fully. *Enlivenment*, being creatively connected, could be targeted as the aim of all healing:

> "One dimension of liveliness is artistic expression, artistic work, and research. Here too, one does not objectively represent, but experience through permeation. These creative processes do not display the world, but bring them to life in a symbolic way and pass this experience to the viewer. […] Artists work with imagination and know that this is a real power that can initiate productive change. Art and life are not separated. *Enhanced liveliness is always greater self-expression and intensified poetic experience*." (Weber 2016: 42–43, translation & emphasis AL)

Entering the imaginative (art) space is entering the "middle realm of psyche" (Hillman 2009: 73). Stephen K. Levine describes it as "transitional and liminal states" where new meanings can emerge or be changed through imagination (cf. 2005). Daria Halprin defines health as "the ability to live artfully with a changing reality." (2014: 98). Looking at life with the poetic or artistic eye using metaphor, image, song, movement, or gesture is a way to train the *fictional sense*, a concept that James Hillman (2009) introduced. He "[…] presents us with what might be called an *aesthetic or poetic psychology*, based on a phenomenology of the imagination." (Levine 2005: 54, emphasis AL). Engaging in artful expression makes active imagination perceptible and opens it up to conversation and change:

> "When art expression and felt experience truly meet, or when an individual's art fully reflects some important part of her psyche and story, she herself is moved and changed by it. […] this can be profoundly healing." (Halprin 2003: 94).

Stephen K. Levine, a founding father of Expressive Arts Therapy (Levine 2005; Levine & Levine 2017), formulates the concept of *poiesis* as the imaginative response to the world. He draws the word from Aristotle who "[…] distinguishes between three kinds of knowing: knowing by observing (*theoria*), knowing by doing or acting (*praxis*), and knowing by making (*poiesis*)." (Levine 2005: 32). Poiesis is not doing intentionally with a certain planned outcome. Rather, it is

> "[…] the capacity to let meaning emerge through a shaping of that which is given […] The poet is thus the mediator or facilitator who lends a hand to the process of formation, not the demiurge who creates *ex nihilo*." (Levine 2005: 32–40, emphasis i. orig.)

This way, the artist becomes an observer of the process, learning about themself through expressing what is emerging in the free play of creativity. "*Poiesis* is a performative art" (Levine 2005: 63–64, emphasis i. orig.). This aspect of Expressive Arts Therapy can transform trauma and suffering into tragedy. Levine describes the transformative power of performance as *catharsis* that

> "[…] allows us to bear the horror we witness and to experience compassion for those who suffer without giving way. The performance of tragedy marks the tragic as a mode of being human […]." (Levine 2005: 64)

To be able to work with intimate themes and memories participants need safety. This safety is neither objective nor propositional, but perceived on a subconscious level. Stephen W. Porges with the Polyvagal-Theory describes how this "neuroception" (neuro-per-ception) works and what clues the nervous system needs to feel safe: despite a safe environment (the studio, cf. Halprin 2014: 102) it needs safe relationships that engage in face-to-face interaction, facial expression, eye contact, and a friendly voice (Porges 2010). One could speak of *connectedness* which may provide the client with a feeling of being seen and accepted in the therapeutic dyad as well as in a group. An important dimension of creating a safe environment in a group is to facilitate safe encounter among participants through guiding, formulating rules of communication, and facilitating situations of witnessing and being seen with empathy.

D.W. Winnicott (1995) also saw creating a "holding environment" as essential for the development of the self (cf. Levine 2005: 49). One more aspect especially true for the practice of Expressive Arts Therapy with non-professional artists is the provision of a structure.

> "It is not enough to simply say to a person, or a group of people, 'Take this time to imagine and create.' Teachers and leaders are charged with establishing the overall context for creation and for inspiring actions according to a vision that is both tangible and open." (McNiff 2017: 27–28)

In the Tamalpa Life/Art Process the instrument of *scoring* is used to create this session structure or plan. In a score *theme, intentions, resources, activities, time, place, people* are defined. A score provides a frame in which the creative process can happen. This frame can be narrow for less experienced people and wider for people familiar to the practice of Expressive Arts Therapy. *Scoring* on one hand helps to structure a session, on the other hand it helps reflecting on what happened which is called "valuaction." This way *scoring* facilitates the creative process over time (cf. Halprin 1969).

Referring to Winnicott (1995) and his idea of free play, the aim is to provide a "[…] playground, where patient and analyst can play together without constraint." (Levine 2005: 50). The functions of the therapist, teacher or facilitator then are a) to provide a safe environment, b) to structure the session allowing creative expression, c) to hold the space, "[…] but only if holding is understood as a setting-free for the realization of one's possibilities" (Levine 2005: 72), and d) to provide "authentic care" that "[…] depends on the understanding that each existing individual is ultimately responsible for him or herself" (Levine 2005: 25).

Building a flexible, fluid relation between freedom and structure is a task the facilitator, therapist or teacher has to fulfill. Another one is to facilitate learning and self-reflection that may lead to changes in the lives of the participants. In the Tamalpa Life/Art Process the instrument that helps in structuring and tracking the transformation is the *Five Part Process*. It provides a background the experiences can be reflected onto, the learning can be integrated, and the development is made visible. The five phases are *identification, confrontation, release, change,* and *growth* (cf. Halprin

2003: 122–130). A second model was published in 2014 that is a refined development of the first. Here she describes *Six Phases of Transformation in Dance/Movement* (cf. Halprin 2014). These models help to describe and support the transformation as well as to implement the learnings and changes in daily life. They make the individual healing process tangible.

On a collective level healing is facilitated socially in communities and ecologically in local places. The Tamalpa Life/Art Process as well as the Tamalpa Institute are named after a myth. Mount Tamalpais close to the Mountain Home Studio in Kentfield, CA, is known to be a sleeping Native American princess. A modern play written for the outdoor *Mountain Play* (https://www.mountainplay.org) theater performed on Mount Tamalpais is the source of that myth. After a dramatic love story and struggles between good and bad, the princess died with the words: "I will not rise until there is peace between people and land." This can be seen as a motto or mission statement for the Tamalpa Institute that is engaged in promoting social justice by supporting underserved communities with the "healing power of creative expression" (https://www.tamalpa.org/tamalpa-artcorps).

An instrument in this field of social engagement are the *community dances* that serve to build a sense of community and raise awareness for social and ecological problems. Anna Halprin (2019) worked on these group dances almost all her life. Two of these dances are still performed: *Circle the Earth* and *Planetary Dance*. They promote not only a sense of community, but also a commitment to contribute in a meaningful way – serving life with art.

Conclusion

The Tamalpa Life/Art Process has been presented as an aesthetic embodied imagination practice. It is a movement-based Expressive Arts Therapy approach, that combines movement with artful expression to facilitate change, transformation, and healing. Expressive Arts Therapy favors experience instead of information and analysis. It uses sensory perception and the moving body to create new experiences that go beyond rational thinking and take the whole person into account. Movement and artistic expression become tools of action and self-efficacy that might be grasped as poiesis (Levine 2005, 2017)—making instead of enduring passively. Expressive Arts Therapy offers opportunities to confront and deal with challenging life themes, and in the end to rewrite life stories—changing the role of the actor, envisioning a happy end. Using imagination and metaphor transcend literal reality and offer an As-If reality (Vaihinger 1911) where change is possible, or at least imaginable. Through artistic expression the client or participant can distance themselves from a memory that might be too horrific to be said literally instead making it artistically perceptible and accessible to deal with. At the end of this process, at best, changes happen in perception, understanding, and meaning of an event or a life story, and the client finds ways to make peace with it, restoring their sense of safety.

Safety is the fundamental basis of all (psycho-) therapeutic work. Not only an objective security, but a subjective sense of safety that lies in the nervous system and depends on the environment as well as the relations with other people (cf. Porges 2010). The facilitator or therapist has to provide a safe studio space that is protected from the outside, they have to be a "safe" person with competence and the ability to be in reliable contact, and they have to offer a session structure with clear instructions. Working with a group over time can furthermore create a sense of belonging to the group, and beyond, to a larger community. Creating a safe space is fundamental to enable free play of expression and imagination, and also transformation and healing, because there is no transformation (neither individually nor collectively) without imagination (Wilke 2015: 507).

The aesthetic practice of movement-based Expressive Arts Therapy like the Tamalpa Life/Art Process is an approach that integrates sensory (aesthetic) perception, movement, metaphor, artistic expression, imagination, human encounter, and environmental as well as relational safety to offer opportunities for transformation, change, and healing.

Notes

1 The author's background in movement and dance facilitation is based on one hand on the three levels of the Tamalpa training which she accomplished in 2012, 2016/17, and 2019 (cf. https://www.tamalpa.org/professional-training/). Since 2016, she has been regularly leading open workshops in the Tamalpa Life/Art Process. On the other hand, she is a certified Biodanza instructor (System Rolando Toro, IBF) which is a group-oriented method that utilizes dance, music, and human encounter (cf. http://www.biodanza.org/en). She is also certified as a naturopath (Ger.: Allgemeine Heilerlaubnis) and holds a M.A. in the study of religion, philosophy, and psychology.
2 A *Movement Metaphor* is a metaphor brought into movement. Often verbal metaphors contain a body or movement component, like "standing on one's own feet," "walking my way," "poker face" etc. that can easily be used for movement improvisation. Also, visual or acoustic metaphors, symbols, or colors can become an inspiration for movement.
3 In the Tamalpa Life/Art process *Aesthetic Feedback* is an intervention tool to facilitate interaction between partners as a collaborative process. The *Aesthetic Feedback* originates in the sensory experience and imagination of the witness and may mirror, add to, intensify, or blend with what the enactor has already shared, or it could introduce completely new, contrasting, or missing elements that redirects the exploration. Exercises include, for example, partner A moving the drawing of partner B; or partner A talking about her experience during the session and partner B answering with a gesture or a drawing. It offers a possibility to respond to someone's expression while avoiding rational thinking which is often connected to judgement – positive or negative. A prerequisite for offering *Aesthetic Feedback* is empathic witnessing. (Halprin 2003: 116–118)
4 *Life Art Questions* are employed to connect the artful exploration experienced in the studio with daily life. Through reflecting on *Life Art Questions* a relationship between metaphoric and literal reality can be established. They can inspire journal writing or spoken exchange. As a bridge between life and studio they can also be used to bring themes and issues from daily life into the art studio, to deal with them creatively in the metaphoric art space.
5 The *Three Levels of Awareness and Response* is a map to facilitate awareness and response of "the body" not only on a physical level, but also on the emotional, mental, and spiritual level. Each is separate from the other, and they are all connected. Each of the levels open, reveal and reflect aspects of the self. The facilitation map separates and integrates the levels at the same time by using different ways of interaction and exploration. The three levels are: *physical*: sensory sensations, breath, body posture, body parts; *emotional*: feelings, such as anxiety, joy, calm, excitement, anger, sorrow; *mental*: thinking processes, such as planning, remembering, worrying, imagining, and fantasizing. The fourth spiritual level might open up when the first three levels integrate. It is not part of facilitation. (cf. Halprin 2003: 104-110)
6 *Movement Ritual* is a structured movement sequence to cultivate the sensory awareness in movement in the Tamalpa Life/Art Process, to teach movement principles, and to train the kinaesthetic sense. It can be used as a form of movement meditation, as a resource for movement education and improvisation, as performance material, etc. It integrates the basic principles of human body motion and has an impact on emotions, feelings, and the inner state. There are four parts of *Movement Ritual*. Part 1 is performed primarily lying down, using flexion, extension, rotation, etc. *Movement Ritual 2* is performed standing up, it applies falls, lifts, swings, and balance. *Movement Ritual 3* is focused on locomotor movements like walks, runs, crawls etc. The variation of 1, 2, and 3 is called *Movement Ritual 4* which can vary as people respond differently to motion (cf. Halprin 1979).
7 Anna Halprin, *July 13, 1920, is an American postmodern dancer, performer, and movement teacher. In the first part of her career she performed as a dancer, worked as choreograph, and founded the San Francisco Dancers` Workshop. After surviving cancer and a personal healing process facilitated through art, she became a pioneer in the field of dance as a healing art. In collaboration with body therapist, artists, psychotherapists, and her daughter, Daria Halprin, she has developed the movement-based expressive arts method Tamalpa Life/Art Process. In 1978 she co-founded the Tamalpa Institute with Daria Halprin. (cf. https://www.annahalprin.org/biography).
8 Rudolf Laban (Laban Movement Analyses), Irmgard Bartenieff (Bartenieff Fundamentals), Judith Kestenberg (Kestenberg Movement Profile), Marian Chace (Dance as Communication), Liljan Espenak (Psychomotoric Therapy), Mary Whitehouse (Movement in Depth, Authentic Movement), Trudi Schoop (Dance as investigation of reality and transcendence), and Mary Wigman (German Dance, Ausdruckstanz)
9 The *Psychokinetic Imagery Process/Cycle* is a theoretical frame to explain and facilitate the interrelations between different art modalities (movement, drawing, and poetic writing/dialogue) as well as the dynamics between the individual and the group. It is an intermodal arts model "[…] central to almost all of the expressive arts therapy approaches […]" (Halprin 2003: 130). The term psychokinetic refers to the unity of psyche and body/movement. Imagery refers not just to visualization processes, but rather to "[…] an active and expressive engagement with sensations, images, and narratives." (Halprin 2003: 130). It includes images as well as metaphors, symbols, stories etc. Different art mediums generate different responses depending on the materiality (oil pastels, clay, natural objects) or non-materiality (voice, sound, movement) of the medium. Bringing them together, like in the *Psychokinetic Imagery Cycle*, and facilitating communication among these modalities provide a wide range of combinations and interacting synergies within an aesthetic art space. (cf. Halprin 2003: 130–136).
10 *Body Part Metaphors* facilitate different approaches to the body as a "[…] powerful interplay between the actual and imaginal worlds." (Halprin 2003: 145). One is to explore the anatomy, functions and movements of each body part. Another is to identify collective associations, easily found *e.g.* in proverbs like "walk my way." A third

is to explore metaphoric themes, which Halprin also calls "archetypal themes" because they are "commonly held human responses" (2003: 147). These themes are then linked to individual life narratives and inform personal mythology. To facilitate the interplay between actual and imaginal body the teacher offers movement situations that invite the metaphoric theme of each body part to emerge. Another approach, especially suited for beginners, is to bring metaphors into movement (*Movement Metaphor*), *e.g.* walking as if "walking my way of life". The division of the body into body parts helps to focus and manage the exploration of each body part as well as the interrelation between the body parts and the body as whole. The body parts and areas are: head and face; neck, throat, and jaw; spine; ribcage; shoulder girdl; arms and hands; abdomen; pelvis; legs and feet. (cf. Halprin 2003: 145-175)

11 The *Five Part Process* is an instrument that helps structuring and tracking the individual and group transformation. It provides a background the experiences can be reflected onto, the learning can be integrated, and the development is made visible. The five parts or phases are *identification, confrontation, release, change,* and *growth* (cf. Halprin 2003: 122–130). Within one metaphoric life theme the process can go back and forth between the phases, it is not a linear development. The *Five Part Process* helps to describe and support the transformation and to implement the learnings and changes in daily life. They make the healing process tangible.

12 *Scoring* in the Tamalpa work is an instrument that facilitates the creative process over time. A score provides a frame in which the creative process can happen and it can be employed to create a session structure or plan. In a score *theme, intentions, resources, activities, time, place, people* e.g. of a session or performance are defined. An integral part of *Scoring* is "valuing the action" which is called "valuaction." Reflective questions help on one hand to refine the score before performing it by asking *e.g.,* "Are the activities likely to fulfill the intentions?". On the other hand, valuaction questions help to evaluate what had happened during the session/performance: "How are the intentions fulfilled? What are new resources? How could the score be recycled?". *Scoring* is a dynamic process, that helps to facilitate the creative process by making it visible (cf. Halprin 1969).

13 *Witnessing* and *Active Listening* as a means to cultivate an open, receptive, empathic, and present way of perceiving the expression of someone else. Feelings of being seen and heard might be responses of the person being witnessed. In the Tamalpa Life Art Process witnessing and providing feedback are learned and practiced like an art in itself. Teaching tools are specific communication skills for giving and receiving feedback, and approaches for giving non-critical and non-analytical Feedback by working with a communication model that honors individual experience: "I see, I hear, I feel, I imagine …" It offers possibilities of interaction that are based on respect and empathy, letting the partner be as they are, providing a safe space where the creative process can unfold collaboratively (cf. Halprin 2003: 135, 2014: 102).

14 An *Aesthetic Response* is the act of being inwardly moved by a sensory perception that provides change within and finds expression through art. Despite the inward moving, an aesthetic response is also the expression of the impression, which becomes a new impression to both the one who is expressing and the witnessing partner. It is closely related to the *Aesthetic Feedback* intervention.

References

Baumgarten, Alexander Gottlieb 1750–1758. *Aesthetica I & II*. Frankfurt/Oder: Kleyb.

Bender, Susanne 2020. *Grundlagen der Tanztherapie. Geschichte, Menschenbild, Methoden*. Gießen: Psychosozial.

Cienki, Alan & Cornelia Müller 2008. Metaphor, Gesture, and Thought. In Raymond W. Gibbs Jr. (ed). *The Cambridge Handbook of Metaphor and Thought*. Cambridge: University Press: 583–501.

Csordas, Thomas J. 1990. Embodiment as a Paradigm for Anthropology. *Ethos* 18, 1: 5–47.

––––– 1993. Somatic Modes of Attention. *Cultural Anthropology* 8, 2: 135–156.

Cuccio, Valentina 2018. *Attention to Metaphor: From Neurons to Representations*. Amsterdam: John Benjamins.

Dychtwald, Ken 1981. *Körperbewusstsein: Eine Synthese der östlichen & westlichen Wege zur Selbst-Wahrnehmung, Gesundheit & persönlichem Wachstum.* Essen: Synthesis. [orig. 1977. BODYMIND. New York, NY: Pantheon Books.]

Eberhard-Kaechele, Marianne 2017. Tanztherapie in der Psychosomatik: Implikationen der Embodiment-Forschung. *Zeitschrift für Sportpsychologie* 24, 2: 65–76.

––––– 2013. 30 Jahre Tanztherapie in Deutschland: Navigation auf den Wogen von Paradigmenwechseln. In Manfred Thielen (ed) *Körper – Gruppe – Gesellschaft: Neue Entwicklungen in der Körperpsychotherapie*. Gießen: Psychosozial: 203–216.

Eddy, Martha 2017. *Mindful Movement. The Evolution of the Somatic Arts and Conscious Action.* Bristol: intellect.

Feldenkrais, Moshé 1978. *Bewusstheit durch Bewegung: Der aufrechte Gang*. Frankfurt/Main: Suhrkamp. [orig. Hebrew 1967].

Forceville, Charles 2008. Metaphor in Pictures and Multimodal Representations. In Raymond W. Gibbs Jr. (ed) *The Cambridge Handbook of Metaphor and Thought*. Cambridge: University Press: 462–482.

Fuchs, Thomas 2012. The Phenomenology of Body Memory. In Sabine C. Koch *et al.* (eds) *Body Memory, Metaphor and Movement.* Amsterdam: Benjamins: 9–22.

Gallagher, Shaun & Daniel D. Hutto 2019. Narratives in Embodied Therapeutic Practice. Getting the Story Straight. In Helen Payne *et al.* (eds) *The Routledge International Handbook of Embodied Perspectives in Psychotherapy: Approaches from Dance Movement and Body Psychotherapies*. London: Routledge: 28–39.

Gibbs Jr., Raymond W. (ed) 2008. *The Cambridge Handbook of Metaphor and Thought*. Cambridge: University Press.

––––– 2010. *Embodiment and Cognitive Science.* New York: Cambridge University Press. [orig. 2005].

––––– (ed) 2016. *Mixing Metaphor*. Amsterdam: Benjamins.

Goodill, Sherry W., Judith Raeke & Sabine C. Koch 2013. Sich ausweiten, aufsteigen, voranschreiten: Entwicklungen in medizinischer Tanztherapie und Ausbildung. *Körper – Tanz – Bewegung* 1: 66–73.

Goldamann, Luiza 2019. *Phänomen und Begriff der Metapher: Vorschlag zur Systematisierung der Theoriegeschichte*. Berlin: De Gruyter.

Halprin, Anna1979. *Movement Ritual. An organization of structural movement to encourage creative exploration.* Kentfield, CA: Tamalpa Institute/Dancers' Workshop.

Halprin, Anna 2019. *Making Dances That Matter: Resources for Community Creativity.* Middletown: Wesleyan University Press.

Halprin, Daria 2003. *The Expressive Body in Life, Art and Therapy. Working with Movement, Metaphor and Meaning*. London: Kingsley.

––––– 2014. Body Ensouled, Enacted and Entranced: Movement/Dance as Transfomative Art. In Amanda Willamson *et al.* (eds) *Dance, Somatics and Spiritualities: Contemporary Sacred Narratives*. Bristol: Intellect: 87–113.

Halprin, Lawrence 1969. *The RSVP-Cycles: Creative Processes in the Human Environment.* New York: Braziller.

Hanna, Thomas 1994. *Das Geheimnis gesunder Bewegung: Wesen & Wirkung Funktionaler Integration. Die Feldenkrais-Methode verstehen lernen.* Paderborn: Junfermann. [orig. 1979. *The Body of Life*. New York, NY: Alfred A. Knopf].

Hanna, Thomas 1988. *Somatics: Reawakening the Mind's Control of Movement, Flexibility, and Health.* Reading: Addison-Wesley.

Hauke, Gernot & Ada Kritikos (eds) 2018. *Embodiment in Psychotherapy. A Practitioner's Guide*. Berlin: Springer.

Hillman, James 2009. *Healing Fiction*. Putnam: Spring Publications. [orig. 1983].

Johnston, Jay 2020. A Historiography of Aesthetics in a Western Context. In Anne Koch & Katharina Wilkens (eds) *The Bloomsbury Handbook of the Cultural and Cognitive Aesthetics of Religion*. London: Bloomsbury: 13–22.

Kirmayer, Laurence J. 1993. Healing and the Invention of Metaphor: The Effectiveness of Symbols Resisited. *Culture, Medicine and Psychiatry* 17: 161–195.

Knill, Paolo J. 1979. *Ausdruckstherpie: Künstlerischer Ausdruck in Therapie und Erziehung als intermediale Methode.* Halle: Ohlsen.

Knill, Paolo J., Ellen G. Levine & Stephen K. Levine 2005: *Principles and Practice of Expressive Arts Therapy: Toward a Therapeutic Aesthetics.* London: Kingsley.

Koch, Anne 2020. Epistemology. In Anne Koch & Katharina Wilkens (eds) *The Bloomsbury Handbook of the Cultural and Cognitive Aesthetics of Religion*. London: Bloomsbury: 23–32.

Koch, Anne *et al.* 2015. Imaginationstechniken. In Lucia Traut & Annette Wilke (eds) *Religion – Imagination – Ästhetik: Vorstellungs- und Sinneswelten in Religion und Kultur.* Göttingen: Vandenhoeck & Ruprecht: 75–79.

Koch, Sabine C. 2011. *Embodiment: Der Einfluss von Eigenbewegung auf Affekt, Einstellung und Kognition. Empirische Grundlagen und klinische Anwendungen.* Berlin: Logos.

Koch, Sabine C. 2017a. Arts and Health: Active Factors and a Theory Framework of Embodied Aesthetics. *The Arts in Psychotherapy* 54: 85–91.

Koch, Sabine C. 2017b. Was hilft, was wirkt? Wirksamkeit und Wirkfaktoren der Tanz- und Bewegungstherapie. *Zeitschrift für Sportpsychologie* 24, 2: 40–53.

Koch, Sabine C. *et al.* (eds) 2012. *Body Memory, Metaphor and Movement.* Amsterdam: Benjamins.

Kotler, Astrid *et al.* 2012. Body Memory and the Emergence of Metaphor in Movement and Speech. In Sabine C. Koch *et al.* (eds) *Body Memory, Metaphor and Movement.* Amsterdam: Benjamins: 201-226.

Laban, Rudolf von 1920. *Die Welt des Tänzers: Fünf Gedankenreigen.* Stuttgart: Seifert.

Lakoff, George & Mark Johnson 1980. *Metaphors We Live By*. Chicago: University of Chicago Press.

Levine, Ellen G. & Stephen K. Levine (eds) 2017. *New Developments in Expressive Arts Therapy: The Play of Poiesis*. London: Kingsley.

Levine, Stephen K. 2005. The Philosophy of Expressive Arts Therapy: Poiesis as a Response to the World. In Knill, Paolo J. *et al.* (eds) *Principles and Practice of Expressive Arts Therapy: Toward a Therapeutic Aesthetics.* London: Kingsley: 15–74.

Levine, Peter A. 2015. *Trauma and Memory. Brain and Body in a Search fort he Living Past. A Practical Guide for Understanding and Working with Traumatic Memory.* Berkeley, CA: North Atlantic Books.

––––– 1998. *Trauma Heilung. Das Erwachen des Tigers. Unsere Fähigkeit, traumatische Erfahrungen zu transformieren.* Essen: Synthesis Verlag. [orig. 1997 Waking the Tiger: Healing Trauma].

McNiff, Shaun 2017. Practicing Imagination. In Ellen G. Levine & Stephen K. Levine (eds) *New Developments in Expressive Arts Therapy: The Play of Poiesis*. London: Kingsley: 21–30.

Panhofer, Heidrun *et al.* 2012. The Embodied Word. In Sabine C. Koch *et al.* (eds) *Body Memory, Metaphor and Movement.* Amsterdam: Benjamins: 308–325.

Payne, Helen (ed) 2017. *Essentials of Dance Movement Psychotherapy. International Perspectives on Theory, Research and Practice*. London: Routledge.

Payne, Helen, Vicky K. Warnecke & Gill Westland 2016. A Comparative Analysis of Body Psychotherapy and Dance Movement Psychotherapy from a European Perspective. *Body, Movement & Dance in Psychotherapy* 11, 2: 144–166.

Payne, Helen *et al.* (eds) 2019. *The Routledge International Handbook of Embodied Perspectives in Psychotherapy: Approaches from Dance Movement and Body Psychotherapies*. London: Routledge.

Porges, Stephen W. 2010. *Die Polyvagal-Theorie: Neurophysiologische Grundlagen der Therapy. Emotionen, Bindung, Kommunikation und ihre Entstehung*. Paderborn: Junfermann.

Reich, Wilhem 2009. *Die Entdeckung des Orgon: Die Funktion des Orgasmus.* Köln: Kiepenheuer & Witsch. [orig. 1942 The Function of the Orgasm. The Discovery of the Orgone, Vol. I. New York, NY: Orgone Institute Press Inc.].

Serlin, Ilene 1996. Kinesthetic Imagining. *Journal of Humanistic Psychology* 32, 2, 25–33.
Serlin, Ilene & Marcia Leventhal 2019. History, Roots and Future Horizons. *American Journal of Dance Therapy* 41: 39–54.
Shapiro, Lawrence 2014 (ed). *The Routledge Handbook of Embodied Cognition.* London: Routledge.
Sheets-Johnstone, Maxine 2012. Kinesthetic Memory: Further Critical Reflections and Constructive Analysis. In Sabine C. Koch *et al.* (eds) *Body Memory, Metaphor and Movement.* Amsterdam: Benjamins: 43–72.
Shusterman, Richard 2018 (ed). *Aesthetic Experience and Somaesthetic*. Leiden: Brill.
Shusterman, Richard 2012. Introduction. In *ibid. Thinking through the Body: Essays in Somaesthetics.* Cambridge: University Press: 1–22.
Stromsted, Tina 2019. Witnessing Practice: In the Eyes of the Beholder. In Helen Payne *et al.* (eds) *The Routledge International Handbook of Embodied Perspectives in Psychotherapy: Approaches from Dance Movement and Body Psychotherapies*. London: Routledge: 95–103.
Traut, Lucia & Annette Wilke 2015. Einleitung. In Lucia Traut & Annette Wilke (eds) *Religion – Imagination – Ästhetik: Vorstellungs- und Sinneswelten in Religion und Kultur.* Göttingen: Vandenhoeck & Ruprecht: 17–73.
Vaihinger, Hans 1911. *Die Philosophie des Al Ob: System der theoretischen, praktischen und religiösen Fiktionen der Menschheit auf Grund eines idealistischen Positivismus*. Berlin: Reuther & Reichard.
van der Kolk, Bessel 2015 [2014]. *Verkörperter Schrecken. Traumaspuren in Gehirn, Geist und Körper und wie man sie heilen kann.* Lichtenau: G. P. Probst Verlag. [orig. 2014 The Body Keeps the Score. Brain, Mind, and Body in Healing Trauma. New York City, NY: Viking Penguin.]
Weber, Andreas 2016. *Enlivenment: Eine Kultur des Lebens. Versuch einer Poetik für das Anthropozän.* Berlin: Matthes & Seitz.
Wilke, Annette 2015. Schlussreflexionen: Ergebnisse des Bandes. In Lucia Traut & Annette Wilke (eds) *Religion – Imagination – Ästhetik: Vorstellungs- und Sinneswelten in Religion und Kultur.* Göttingen: Vandenhoeck & Ruprecht: 487–509.
Winnicott, Donald W. 1995. *Vom Spiel zur Kreativität*. Stuttgart: Klett-Cotta. [orig. 1971 Playing and Reality. London: Tavistock Publications Ltd.].

Online References

https://www.tamalpa.org/ (2020-07-24)
https://www.mountainplay.org (2020-07-24)
https://www.tamalpa.org/tamalpa-artcorps (2020-07-24)
https://www.annahalprin.org/biography (2020-10-22)
http://www.biodanza.org/en (2020-07-24)
https://www.tamalpa.org/professional-training/ (2020-07-24)

ANJA LÜPKEN is research assistant at the Institute for the Study of Religions, University of Muenster. After completing her studies in the study of religions, philosophy, and psychology with a master degree, she was trained in two different dance/movement techniques and became a Biodanza facilitator (System Rolando Toro, IBF) and Tamalpa Life Art Process practitioner. Her research interests are aesthetics of religion, museality, dance and religion, and embodiment. She is currently working on a PhD research project on religion and dance.

Institute for the Study of Religions, University of Muenster
Robert-Koch-Str. 40, 48149 Muenster
e-mail: anja.luepken@uni-muenster.de

Forschung mit den Sinnen

Phänomenologisches Vorgehen bei der Erkundung des *Vimbuza* Heiltanzes in Malawi

SVEA LINDNER

Einleitung

Der *Vimbuza* Heiltanz hat einen breiteren Bekanntheitsgrad erlangt, seitdem er 2008 zum immateriellen UNESCO Kulturerbe erklärt wurde. Ursprünglich war der Tanz nur eine lokale, medizinische Praktik, die vor allem von den *Tumbuka* im Norden Malawis praktiziert wurde. Meinem Empfinden nach konnte die Ernennung einer solchen Praktik zu einem international anerkannten Kulturerbe nur mit Spannungen einhergehen. Bereits aus der Literatur war mir bekannt, dass der Tanz von den Praktizierenden nicht als kulturelles Brauchtum, sondern als medizinische Notwendigkeit betrachtet wird. Für meine Masterarbeit forschte ich von Juli bis September 2018 im Norden Malawis zu den verschiedenen Haltungen zu dieser Heilpraktik und ob die Anerkennung als Kulturerbe eine Relevanz oder Veränderung für die Menschen vor Ort bedeutete. Dabei bildeten sich weitere Kontroversen um die Heilpraxis heraus, denen ich durch ein Erleben mit allen Sinnen begegnete. Das umfasste die Teilnahme an ganze Nächte andauernden Ritualen inklusive der Erfahrung, auch einmal im Zentrum des Geschehens zu stehen und selbst zu tanzen. Außerdem besuchte ich die von religiösen Vertreter*innen (v.a. presbyterianisch) auch als alternative, oder „richtige Heilung" bezeichneten Praktiken, wie christliche Exorzismen. Um eine dritte vorherrschende Perspektive einzubeziehen, betrachtete ich auch schulmedizinische Behandlungsansätze und führte Interviews mit einem in diesem Bereich forschenden Psychiater durch. Das Erleben meiner Informant*innen und auch mein eigenes, standen dabei im Zentrum der Erkenntnissammlung. Zusätzlich unterstützte mich mein filmendes Forschen im Bestreben, diese Erkenntnisse auch anderen Menschen durch eigenes visuelles und auditives Erleben wenigstens teilweise, erfahrbar zu machen. In meinen gefilmten Sequenzen wird Szenen der Praktiken ein Raum gegeben, selbst auf die Zuschauenden zu wirken, und Informant*innen kommen ebenso selbst zu Wort, um ihre Perspektiven darzustellen. Allgemein liegt der Erkrankung *Vimbuza* das Verständnis zu Grunde, Menschen würden von *Vimbuza Spirits* besessen. Betroffen sind vornehmlich weibliche Patient*innen, die sich mit diversen Beschwerden, von Lebensmittelunverträglichkeit bis völliger Wesensveränderung, mit der Erkrankung *Vimbuza* (gleichnamig wie der Heiltanz selbst) vorstellen. Durch das „Trancetanzen" erhofft man, mit Geistwesen[1] in Kontakt zu treten. Ein/e Heiler*in hilft dann bei der Deutung der Anliegen der Beschwerden verursachenden *Spirits* und wie diese zu besänftigen seien. Diese Praktik stößt bei religiösen Vertreter*innen, in Malawi größtenteils (75 %) christlich presbyterianisch, auf Ablehnung. In ihren Augen gilt die Kommunikation mit den Geistwesen als fehlgeleitet und im schlimmsten Fall sogar als dämonisch. Eine gültige Behandlung der Besessenheit sei in diesem Fall jedoch ein Exorzismus.

Vertreter*innen der Schulmedizin befassen sich ebenfalls mit den Phänomenen um die Erkrankung *Vimbuza*. Für sie stellt sich die Frage, ob es sich um ein kulturspezifisches Syndrom handeln könnte, oder ob es eine fehlinterpretierte Erkrankung wie Schizophrenie, oder gar eine lokale, sozial regulierende Praktik sein könnte. Für diejenigen, die die nächtlichen Heiltänze aufsuchen, steht jedoch fest, dass nur geschulte und ebenfalls besessene Heiler*innen durch die Kommunikation mit den *Spirits* herausfinden können, was erforderlich ist, damit eine Heilung eintreten kann (Soko 2014: 7). Von den Betroffenen werden die *Spirits* meist nicht als bösartig oder übelwollend

betrachtet. Die *Spirits* können sich beispielsweise bemerkbar machen, um auf eine Gefahr aufmerksam zu machen und werden somit sogar teils als Lebensretter wahrgenommen. Die kontroversen Haltungen sind bereits in der Kolonialzeit für die Heilpraktik beschrieben:

> "The analysis of the situation has shown that during the whole colonial era, Vimbuza was considered as a dance harmful to evangelization and modernization. The missionaries as well as the administrators shared this view, to the point where they found it necessary to ban it." (SOKO 2014: 22)

In meiner hier rezipierten Masterarbeit argumentiere ich, dass die Proklamation, dieser vor allem medizinisch assoziierten Praktik, zu einem international anerkannten Kulturgut durch UNESCO die Kontroversen weiter befeuert und verschärft hat. Die globalen Verflechtungen und Zertifizierungspraktiken habe ich in meiner Masterarbeit eingehend untersucht und dargestellt. Dies konnte ich im Feld vor allem durch die Intensität, der mir nahe gebrachten Haltungen zum *Vimbuza* Heiltanz und der Bestrebungen diesen zu erhalten, erleben.

Der südafrikanische Psychiater KARL PELTZER (1989) beschäftigt sich ausführlich mit den Symptomen des *Vimbuza* aus einer biomedizinischen, psychopathologischen Perspektive. Dazu untersuchte er 116 Proband*innen die an *Vimbuza* litten. Für ihn steht abschließend fest, dass die Erkrankungsbilder in psychiatrische Diagnosen wie dissoziative Störungen, depressive Neurosen; und insgesamt als Psychoneurosen übersetzt werden können (*ibid.* 148). Meiner Meinung nach stellt *Vimbuza* mit all seinen Besonderheiten eine eigene Kategorie dar. Die biomedizinische, psychopathologische Einschätzung übergeht das emische Erleben und die kulturelle Bedeutung vor Ort.

Dr. Chilale ist ein Psychiater mit eigener Klinik in der Nähe der zweitgrößten Stadt Malawis, Mzuzu. Er hatte sein Studium in Europa abgeschlossen, war aber nach Malawi zurückgekehrt und beschäftigt sich seit einigen Jahren mit dem Erkrankungsbild *Vimbuza.* Regelmäßig nimmt er an Ritualen teil, besucht Heiler*innen und untersucht deren heilsuchenden *Vimbuza*-Betroffenen. Er erklärte mir im Interview, dass er als Psychiater die Erkrankung als „kulturspezifisches Syndrom"[2] betrachtet und räumt der Heilpraktik eine Legitimität ein

> "[…] if you can't tease out: to make it an anxiety disorder it is this, and that, and that, and you find that it is not quite fitting. Then maybe, you are dealing with a cultural-specific syndrome. And especially if this person going there and found some relief: why not use it? Why do you want someone to keep on suffering when he can get relief?" (Dr. Chilale Interview 2018-09-04).

Abb. 1 *Vimbuza* Heiltanz

Dramaturgie der Heilpraktik

Die Therapie des *Vimbuza*-Betroffenen richtet sich ganz nach den Forderungen der *Spirits*. Menschen mit Verdacht auf *Vimbuza* suchen zunächst eine/n Heiler*in auf und bleiben meist für den gesamten Heilungsprozess, von teilweise mehreren Wochen, auf deren Land. In den nächtlichen *Vimbuza*-ritualen in speziellen Tempeln (*temphiri*) wird dann das „Tranceritual" praktiziert, um mit den *Spirits* zu kommunizieren. Je nach deren Forderungen ist dann im Sinne der Genesung eine der drei folgenden Vorgehensweisen indiziert und wird von der Heilerin / dem Heiler je nach Schweregrad einmal, oder wiederholt herbeigeführt (vgl. SOKO 2014: 31–74).

Doctor Tiyezghe[3] ist eine Heilerin in Hewe mit eigenem *temphiri* und bildet selbst viele Heiler*innen aus. Zudem ist sie als Vertreterin der Heiler*innen des Nordens Malawis in der *healers and dancers acossication*, deren Gründung von UNESCO unterstützt wurde. Ich konfrontierte sie mit der Haltung der Kirche, die eine Heilung nur durch Exorzismus für legitim propagie-

ren. Sie wies auf eine Frau, die rechts neben uns saß und sagte:

> "I already healed this one. I gave her medicine and she no longer needs to dance. It is possible, if you chose the right one [medicine], to heal it."

Sie fährt dann in ihrer Erklärung über das Heilungsprozedere weiter fort:

> "There are three different kinds when it comes to healing the Vimbuza. First the dancing, and one can get healed. Second is medicine, if it is additional required, and one become healed. And some need to be given *chilopa* [Tieropferung] to heal." (Doctor Tiyezghe: Interview 2018-08-17)

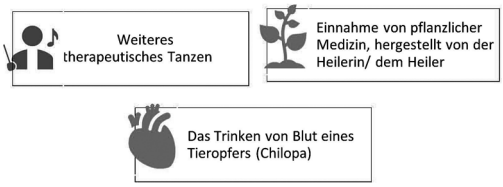


Abb. 2 Drei Behandlungsebenen im *Vimbuza*

Diese drei Behandlungsebenen werden von den Heiler*innen verschieden eingesetzt und verlaufen nicht zwingend nach einer einheitlichen Abfolge. So ist ein Tieropfer ihren Erklärungen zufolge meist nicht, wie in der Literatur beschrieben, bei besonders schweren Fällen notwendig, sondern erst bei der Initiierung einer neuen Heiler*in.

Um die Art der Besessenheit zu erfahren und mit den *Spirits* in Kontakt treten zu können, lassen die Heiler*innen ihre Patient*innen in den nächtlichen Ritualen tanzen. Dabei werden vielfältige Hilfsmittel eingesetzt, die unterstützend in diesem Prozess wirken sollen.[4] Die Schellen, die beim Tanzen laute Geräusche produzieren, zusammen mit dem Klatschen der Zuschauenden, den Trommeln und den Rasseln, stimulieren beispielsweise die *Spirits* in den Leidenden und der/dem Heiler*in gleichermaßen und fördern deren lebhaftere Präsenz. Dadurch wird ihnen in diesem erhöhten Bewusstseinszustand die Interaktion mit den *Spirits* möglich (Gilman 2018: 62). Die verschiedenen Gesänge und Texte richten sich jeweils an bereits bekannte *Spirits*. Je nachdem wie die besessene Person reagiert, kann abgeleitet werden, um welchen *Spirit* es sich handelt (Soko 2014: 43). Nicht zu unterschätzen ist in meinen Augen auch die soziale Komponente des Heilrituals, da zur Heilung Angehörige und viele weitere Menschen aus dem Umfeld der besessenen Person, an dem Ritual teilnehmen. Die Interaktion zwischen den Tanzenden (*Chimbuza*) und dem musizierenden Publikum gleicht einem Dialog, bei dem durch heuristisches Vorgehen wechselseitig musikalische oder tanzende Vorschläge angebracht werden, auf die die *Spirits* dann reagieren können (Soko 2014: 51). Ruth Finnigan (1977) spricht in diesem Zusammenhang von einer *participatory audience* (*ibid.* 231; cf. Soko 2014: 50). Weitere elementare Bestandteile der Heilzeremonie stellen Symbole wie Kreuze, Handlungsabläufe mit Maismehl, rituelle Gaben an die *Spirits*, spezielle Uniformen und Gegenstände wie beispielsweise ein Pferdeschweif, Tücher und Stöcke, dar. Die nächtliche Uhrzeit spielt ebenfalls eine relevante Rolle, denn die Nacht wird mit Erkrankung und Tod, und damit auch mit Diagnose und Therapie assoziiert. Notwendige Tieropferungen finden erst in den Morgenstunden statt, damit mit dem Tagesbeginn die Genesung beginnen kann:

> "[…] it would symbolize the final passage from the 'disease' to life; which corresponds to the passage from night to day." (Soko 2014: 64)

Meiner Auffassung nach kann man mit schriftlichen Beschreibungen der Komplexität *Vimbuza* nicht gerecht werden. Der Gesang, die Stimmung, die dunstige Raumluft, die tiefe Dunkelheit, die eigene Müdigkeit, der Lärm von Rasseln, aufeinander geschlagenen Stöcken und anderen Instrumenten, der Rhythmus der Trommeln, die Hitze, die Erschöpfung und Anstrengung beim Tanzen – all das sind Bestandteile des Rituals die einem bei der Teilnahme sehr körperlich widerfahren. Und obwohl diese Dinge entscheidend für den *Vimbuza* sind, erlebe ich eine Beschreibung durch Worte als unzulänglich. Bilder ermöglichen einer/m Betrachter*in noch Dinge zu bemerken, die man, durch die eigene Wahrnehmung gefiltert, für nicht erwähnenswert hielt. Klang und Töne erlauben eine weitere Wahrnehmungsebene durch die eigenen sinnlichen Eindrücke. Diese Überzeugung veranlasste mich zu einem phänomenologischen Vorgehen während meiner Forschung und auch bei der Präsentation meiner Ergebnisse.

Was bedeutet es in dem Zusammenhang phänomenologisch vorzugehen?

Tim Ingold (2000) argumentiert, dass die Unterschiede kulturellen Wissens nicht im diskursiven Wissen begründet sind. Er betrachtet die Verschiedenheit als Ausdruck der verkörperten Fähigkeiten eines Praktizierenden. Um diese Fähigkeiten zu erlangen ist der Austausch mit der gelebten Umwelt und sozialen Beziehungen notwendig. In meinen Augen ist dies ein sehr systemischer Ansatz, der verdeutlicht was zum Verständnis einer Praktik notwendig ist. Um „entdecken" zu können, was für die Praktizierenden selbstverständlich ist, muss die eigene Wahrnehmung geschult werden. Ingold spricht dabei von „fine-tune," wobei durch Beobachtung, aber vor allem auch durch Nachahmung, ein eigenes Erleben die Wahrnehmung verändert. Nicht nur die Sinne werden dadurch angepasst, sondern auch wie wir unsere Umwelt wahrnehmen. Die Beziehungen zwischen Subjekt und Objekt sind immer durch das Bewusstsein gelenkt, was in der Phänomenologie als Intentionalität bezeichnet wird. Da sich dies unbewusst und unreflektiert vollzieht, ist das eigene Erleben essenziell, um Vorgänge und Anschauungen zu begreifen. Dieser Auffassung zustimmend, halte ich ein phänomenologisches Vorgehen zur Erkundung im Feld für erforderlich. Erst das individuelle Erfahren und das Erleben durch die eigenen Sinne ließ mich grundsätzliche Erkenntnisse erschließen.

Das Vorhaben ein phänomenologisches Vorgehen im Feld anzustreben bedeutete bereits in der Vorbereitungsphase der Forschung, mich besonderen Erfahrungen auszusetzen, die im Feld für mich Herausforderungen darstellen könnten. So versuchte ich dem Verständnis von Tranceinduktion und Tranceerleben näher zu kommen, indem ich mich in einem interaktiven Workshop in Trancetechniken ausbilden ließ. Zudem bemühte ich mich, potenziellen Bias durch Primärerfahrung entgegen zu wirken. Aus der Literatur hatte ich die Auffassung gewonnen, dass ein Tieropfer im Zusammenhang mit dem Heilritual sehr üblich sei. Als langjährige Vegetarierin fürchtete ich, voreingenommen im Feld sein zu können und suchte daher Erfahrungen bei einem Landwirt meiner Region, dem ich übernächtigt nach einem Nachtdienst beim Schlachten von 15 Hühnern half. Diese Erfahrungen stellten sich in der späteren Forschung als gute Basis dar.

Nancy Scheper-Hughes (1995: 419) kritisierte an der Methode der „*Teilnehmenden Beobachtung*" eine oft eingeforderte neutrale Haltung der Beobachter*in. Sie beschrieb die Notwendigkeit einer *militanten Anthropologie* für ihre Bezeugungen von Selbstjustiz, bei der sie als Beobachterin gerade mit ihrer Neutralität Stellung bezogen hätte und daher aktives Bezeugen notwendig wurde. Diese rückkoppelnde Wirkung berücksichtigte ich auch bei meinen Untersuchungen. Mein Interesse an der lokal praktizierten Heilpraktik *Vimbuza*, für das ich so weit gereist war, veränderte bereits den Status des Heiltanzes selbst. Zwar war mir bewusst, dass er als umstritten galt, doch schien er für viele Menschen vor Ort nicht sonderlich relevant und konnte als „ländliche Tradition" abgetan oder ignoriert werden. Mein Interesse bewirkte jedoch, dass die Menschen gezwungen waren eine Position zu beziehen. Dabei sah ich mich mit einem Problem konfrontiert, welches Aunger 1992 als *Deference Effect* bezeichnete: „when people tell you what they think you want to know" (*ibid.* 274).

Scheper-Hughes' Erfahrungen waren sehr viel drastischer als meine eigenen und erforderten daher wohl auch dringlicher eine ethische Stellungnahme. Aber von den Vertreter*innen der verschiedenen Haltungen und Überzeugungen erfuhr auch ich Druck bzgl. der Einforderung einer eigenen Positionierung und Meinung. Dies veranlasste mich einmal mehr, mein eigenes Erleben der Rituale in die Ergebnisse einfließen zu lassen. Mir wurden derart widersprüchliche und stark wertende Meinungen zugetragen (einerseits über „satanische Tieropferungen", die ich durch mein Interesse noch bestärken würde und andererseits über gewaltverherrlichende Predigten und traumatisierende Exorzismen), dass ich zum Aushalten der Rollenambiguität eigene Erfahrungen sammeln musste. Mit meinen eigenen Erfahrungen bei den nächtlichen *Vimbuza*-Heilritualen und auch den Exorzismen nehme ich dementsprechend Abstand von der Position als Zuschauerin hin zu einer Rolle als Zeugin. Mit meinen eigenen Erfahrungen und meinem Erleben bezeuge ich die Wahrnehmungen während des Geschehens eines *Vimbuza*-Rituals, aber auch von Exorzismen. Wurden an mich als Christin, als Krankenpflegerin, oder als Forscherin bereits bestimmte Erwar-

tungen gerichtet wie ich mich zu positionieren habe, nahm ich mir heraus, meine eigenen moralischen Empfindungen zu berücksichtigen. Neben dieser Form der *Teilnehmenden Beobachtung* nutzte ich auch bei der Auswertung meiner Forschungsdaten vor allem Eindrücke aus meinem Feldtagebuch. Informelle Gespräche und Interviews dienten, neben den partizipativen Ansätzen wie *Free Listing, Pile Sorting* und *Gruppendiskussionen*, meinem Daten- und Erkenntnisgewinn. Für meine Feldforschung war es von entscheidendem Vorteil, dass ich bereits gute Kontakte geknüpft hatte, die mich vertrauensvoll an andere Informant*innen weiterempfahlen. Mein beruflicher Hintergrund als examinierte Gesundheits- und Kinderkrankenpflegerin und Mitarbeiterin eines deutschen Klinikums schienen mein Interesse an dieser Heilpraxis zusätzlich zu legitimieren. Ich bemühte mich um eine gewisse Reziprozität mit meinen Informant*innen, indem ich Waren mitbrachte, die in dörflichen Gebieten rar waren, aber besonders auch durch meine Mithilfe bei der Feldarbeit.[5] Dadurch konnte ich dementsprechend nicht nur etwas zurückgeben, sondern hielt sie auch weniger von ihren Pflichten ab. Es erlaubte mir sogar weitere Einsichten in das Alltagsleben der Menschen und einen einfacheren Zugang zur Erfahrung bis hin zur Filmerlaubnis nächtlicher Heilpraktiken. Zusätzlich wurde mir durch die Mithilfe beim „Pulen" der Maiskolben zugängig, wie es ist mit Schwielen und Blasen an den Händen in der Nacht beim Ritual noch stundenlang zu klatschen. Wir teilten somit nicht nur die Erfahrung des Rituals, sondern auch die ähnlichen körperlichen Schmerz- und Erschöpfungsempfindungen.

Erkenntnis durch Erleben

Katarina Greifeld (2003) bemühte beim Untersuchungsfeld der Medizinethnologie das Konzept von Gesundheitssystemen, die in einen sozialen und kulturellen Kontext eingebettet sind. Sie grenzt sich damit von rein biologischen Erklärungsmustern ab:

> „In jeden Körper ist Kultur miteingeschrieben, so daß Krankheit nicht nur ein biologisches Faktum basierend auf Dysfunktionen von Körperteilen ist, sondern vielmehr ein breites Geflecht auch philosophischer Vorstellungen über einen Bestzustand – was wir dann leichthin als Gesundheit bezeichnen" (*ibid.* 13).

Auch wenn in Malawi gleich mehrere Instanzen für sich allein beanspruchen, Symptome des *Vimbuza* heilen zu können, wäre hier das Konzept des „Gesundheitssystem" fehlgeleitet, da es exklusive Komplexe suggeriert (cf. Krause *et al.* 2012: 8). Betroffene von *Vimbuza* offenbarten mir jedoch teilweise, parallel gleich mehrere verschiedene therapeutische Ansätze in ihr Gesundheitsverhalten einzubeziehen. Die Überschneidungen und Verflechtungen der verschiedenen Heilungstraditionen wurden durch die Anerkennung zum UNESCO Kulturerbe offenbar noch weiter verstärkt, so dass sich erst dann klare Abgrenzungen oder aber Aufgeschlossenheit etablierten. Ich traf auf biomedizinische Erklärungen für Symptome des *Vimbuza*, bei denen vor allem psychiatrische Grunderkrankungen als Ursache betrachtet wurden. Ebenso stieß ich auch auf religiöse moralische Erklärungsmuster im Sinne einer Verfehlung und Bestrafung durch „evil spirits," was einen Exorzismus als Heilmittel nahelegte. Andere spirituelle Konzepte verstanden allerdings die Symptome als Hinweise wohlmeinender *Spirits*, die auf Unstimmigkeiten im Lebenswandel deuten und eine Veränderung anstoßen wollten. Heilung setze die Kommunikation mit diesen *Spirits* und entsprechende Verhaltensänderungen voraus. Forderungen der *Spirits* könnten beispielsweise auf Ehe-Probleme oder nachbarschaftliche Konflikte aufmerksam machen. In manchen Fällen wurden Symptome aber auch dahingehend interpretiert, dass Betroffene selbst zu Heiler*innen berufen waren; erst wenn sie dem Ruf folgten, würden die Symptome nachlassen bzw. verschwinden.

Die Kontroversen um den Heiltanz selbst zu erleben, bedeutete nicht nur die Teilnahme an der für mich eindrucksvollen Heilpraxis, sondern vor allem auch die Auseinandersetzung mit den verschiedenen Positionen und Meinungen durch Interviews und Gespräche. Aber gerade die Erfahrung machte mich schon in gewissem Maße zu einer „Wissenden." So richtete beispielsweise auch der Psychiater Dr. Chilale einen Appell an mich als „Eingeweihte," dass ich den Sog der Wirkung der Heilpraktik doch auch gespürt haben müsse:

> "But now: what really is it, that has healed within this person? That is the thing. Which I also don't know. But I have a feeling. That if you are in the *Vimbuza* dancing, the *Vimbuza* dancer, the music and everything [...] absorbs a person. And then absorbs the whole music. I'm sure, you were there, you had to see it so. What this music does. Than absorbs this person and occupies this space in his mind. And then when that is occupied, then he will have some relief eventually at the end of the dancing. And he wakes up with a free mind a little bit. And he will have to stay a few more minutes, or days to start having the *same feeling* he had at the beginning. So the real healing: is it the one—which I am not also very clear, very sure—I keep on speculating myself [...]. In Hewe I stayed in the healing session through the whole night. And when you are feeling, you are sitting and listening to this music, you get absorbed, too. The ordinary person. You get touched. You get a certain feeling, that you *move* them [...]. You start feeling like you are in a certain, special, a different person together. Because the rhythm of the music, the noise, occupies all the thoughts, that you wear in the conscious—in your consciousness. That has been occupying you most of your time. So big thoughts of trouble, thoughts of hate, thoughts of [...]. Those things move certainly to temporarily. And then you get occupied with this. Is that what they call healing? I don't know!" (Dr. Chilale: Interview 2018-09-04)

Um diese Fragen zu beantworten und die Effektivität dieser Heilpraxis zu verstehen, führte Dr. Chilale eine eigene Forschung durch, indem er Heiler*innen und Patient*innen über mehrere Monate begleitete. Aus medizinanthropologischer Perspektive schätze ich dabei seinen Versuch als akademisch ausgebildeter Psychiater, sich auf das Geschehen einzulassen, zu verstehen, was während des Rituals mit einer Person passiert, insbesondere aber eine potenzielle aber für ihn nicht nachvollziehbare Heilwirkung einzuräumen und damit die eigene Begrenztheit im therapeutischen Kontext anzumerken. Auch wenn er sich schlussendlich eher skeptisch bzgl. eines nachhaltigen Heilungserfolgs äußert, war ich persönlich beeindruckt, dass er an den Ritualen teilnahm und versuchte, evtl. Effekte an sich selbst wahrzunehmen und festzuhalten.

Dabei stellt er den „sportlichen Charakter" der Heilpraxis in den Vordergrund der Deutung von Linderungs- und Heilungserfahrungen, ähnlich wie auch Reverend Gondwe als Vertreter einer Kirche Presbyterianischer Christen (CCAP):

> "So, what those healers do, they go in a trance dance, and this is some kind of exercise [...] yeah, they are sweating. And this has some kind of soothing effect. Sometimes even the blood of a goat or a chicken is obliged. And with all this and completely fatigued, they will accept *whatever* the healer will tell them, and experience some kind of relief." (Makuni Gondwe: Interview 2018-08-30)

Während meines Forschungsaufenthaltes war Jacqueline Kouwenhoven Vertreterin für das nördliche Gebiet Malawis (*Rumphi West*) Mitglied im malawischen Parlament. Bei meinen Informant*innen war sie vor allem aber auch bekannt als „*Nzungu*, who also dances the *Vimbuza*" – also als „Weiße, die Vimbuza tanzt." Durch ihren europäischen Hintergrund als gebürtige Niederländerin aber langjähriger malawischer Nationalität sowie ihr Wissen als Krankenpflegerin und Heilpraktikerin, vermittelte sie mir mehrperspektivische Einsichten: sie selbst wurde mit *Vimbuza* diagnostiziert und in diesem Kontext therapiert, bis eine Heilerin feststellte, dass auch sie zur Heilerin berufen sei und dahingehend ausgebildet werden müsse. Schon in Ausbildung bei einer zweiten Heilerin, berichtete sie mir über Wissenssysteme und Erklärungsmodelle bzgl. der Symptomatik des *Vimbuza*. Im Gespräch appellierte auch sie an mein eigenes „Erleben" und nahm temporäre Erkältungssymptome meinerseits zum Anlass, auch über meine eigene Berufung nachzudenken. Unabhängig davon, ob ich nun „wirklich" an *Vimbuza* litt, ermöglichte sie mir so, Symptome und derer Interpretation innerhalb des *Vimbuza*-Kontexts anhand meiner eigenen Erfahrungen zu verstehen bzw. analysieren:

> "It can start as a cough [sie deutet auf mich, da ich immer wieder huste], a cold, sadness, mental problem. But *Vimbuza* can heal everything – every aspect of a problem. It's a very holistic approach, a holistic way of healing." (Jacqueline Kouwenhoven: Interview 2018-08-03)

Dementsprechend erläuterte sie mir auch weitere zentrale Aspekte des *Vimbuza* Heiltanzes, wie z. B. die Annahme eines Ungleichgewichts von „Körper und Geist." Ihrer Ansicht nach sind

die Symptome darauf zurückzuführen, dass Menschen zu „verkopft" seien und Energien nicht „durch den Körper hinausließen." Im „Westen" sei dies noch verbreiteter, da die cartesianische Annahme eines „Geists" der einen „schwachen Leib" kontrolliere, gesellschaftlich tief verankert und wirkmächtig sei. Im Gegensatz dazu rege *Vimbuza* zu einer physischen Auseinandersetzung an:

> "The main thing—if you want to make the *Vimbuza* therapeutic—it should be the body speaking. Indicating what you want, it's the body going wild. If your mind gets submitted, you surrender to your body, then this might be the beginning of the healing process. And this is the exact opposite of our daily life, where it is always the other way round. The mind is demanding and our body has to follow." (Jacqueline Kouwenhoven: Interview 2018-08-03)

Ihrer Auffassung nach muss dabei dem Körper Raum gegeben werden, um zu „weisen und erlösenden" Erkenntnissen zu gelangen, die mit dem Verstand nicht zu begreifen sind. Das intrinsische Erleben steht dabei vor dem logischen Begreifen und hilft, *Katharsis* in Form einer Linderung bzw. Auseinandersetzung mit dem Leiden herbeizuführen.

Filmendes Forschen als phänomenologischer Ansatz

Der phänomenologische Ansatz Tim Ingold's begleitete mich maßgeblich in meiner Forschung. Er differenziert „anthropologische" von „ethnographischen" Ansätzen, da letztere nur dokumentarische Absichten verfolgten, während „Anthropologie" das „Lernen" mit und von einer Fokusgruppe beinhalte:

> "My aim, to the contrary, is to replace *the anthropology of* with an *anthropology with*. It is to regard art […] as a discipline, which shares with anthropology a concern to reawaken our senses and to allow knowledge to grow from the inside of being in the unfolding of life." (Ingold 2013: 8)

Daran angelehnt bezeichne ich mein filmisches und forschendes Vorgehen nicht als ethnografisch, sondern anthropologisch. Ingold betrachtet „Ethnographie" als Untersuchungen *über* Menschen wohingegen in der „Anthropologie" das eigene innere Lernen gemeinsam *mit* Menschen im Vordergrund steht. Mein Ziel war es, mit „allen Sinnen" in mein Forschungsthema einzutauchen und damit auch eine Datenakquise auf Basis verschiedener medialer und partizipativer Methoden zu ermöglichen.

Bei gleichzeitiger Reflexion meiner „Rolle" als Forscherin und meiner eigenen „Glaubenssätze," standen für mich meine eigenen gelebten Erfahrungen im Vordergrund. Sarah Pink (2015) betont dementsprechend die Möglichkeiten, die sich daraus ergeben, wenn Anthropolog*innen und Ethnograph*innen sich auf ihre eigenen Sinneswahrnehmungen fokussieren, da sie zum Verständnis der Erfahrung und Wahrnehmung anderer beitragen können.

Diesen Ansatz verfolgte ich bei meiner Exploration von *Vimbuza* Heiltänzen, aber auch anderer, bspw. exorzistischer, Praktiken. Was man als narzisstische Neigung oder Überbewertung der eigenen Empfindungen missverstehen könnte, stellte für mich eine notwendige Auseinandersetzung mit meiner Positionalität im Kontext des Erkenntnisgewinns dar. Es ist meine persönliche Überzeugung, dass ich Praktiken und Dynamiken besser verstehe, wenn ich sie „am eigenen Leib" erfahren habe. Daher führte ich zusätzlich zu meinen film-basierten dokumentarischen Methoden auch ein Feldtagebuch innerhalb dessen ich eine achtsame und reflektierende Haltung gegenüber meinen eigenen Wahrnehmungen einnahm: Erst in den Momenten, in denen ich den Staub in meiner Nase wahrnahm, der mir das Atmen in den überfüllten Räumlichkeiten des *temphiri* noch zusätzlich erschwerte, mir die Gerüche des Feuers von draußen bewusst wurde, an dem sich die Trommler regelmäßig aufwärmten, sowie des Schweißes der Tanzenden, meiner klingelnden Ohren in den Musikpausen, meine eigene Müdigkeit und Erschöpfung, meiner Ergriffenheit durch die Rhythmen und Klänge, und sich mein Körper teilweise taub anfühlte, konnte ich die beschriebenen „extrakorporalen" Zustände nachvollziehen, von denen meine Informant*innen sprachen. Genauso erging es mir auch während stundenlanger christlicher Messen, wenn ein Chor lautstark sich ständig wiederholende Gesänge intonierte, während Exorzismen an „den Besessenen" durchgeführt wurden. Die eingängigen, an- und abschwellenden Gesänge erfüllten den Raum, während Ange-

hörige verschiedener Generationen und sozialer sowie ökonomischer Zugehörigkeiten sich einem Priester darboten, um als nächstes exorziert zu werden. Im einen Moment hatten sie mir noch als Expert*innen ihrer religiösen Praxis in Interviews Respekt abverlangt, und im nächsten Moment sanken sie durch eine bloße Berührung an der Stirn hingebungsvoll in sich zusammen. Eine Frau, die inbrünstig schrie und sich gegen die Austreibung wehrte und dabei von drei Personen festgehalten werden musste, hatte eben noch in aller Ruhe neben mir gebetet. Die tiefe Überzeugung, ihre Hingabe und die gesamte Szenerie lösten eine Ergriffenheit in mir aus, die ich aus einer reinen Beobachtungshaltung oder auf Basis geteilter Narrative nicht so erlebt hätte. Mit „allen Sinnen," wie Ingold (2013: 2) es ausdrückt, wollte ich mich auf die Geschehnisse einlassen und ließ die Kamera oft ohne aktive Bedienung stundenlang aufzeichnen, oder aber versuchte, sie ins Geschehen einzubinden. Im Sinne einer *education of attention*, also der Schulung meiner Aufmerksamkeit, war es mein Ziel, möglichst viele und divergierende Sinneseindrücke zu erfassen. Für Praktizierende selbstverständliche Aspekte, die für sie selbst nicht als erwähnenswert galten, aber auch den Kontext meiner eigenen Erfahrungen wollte ich damit einfangen. Aus diesem Grund ließ ich mich auch überreden, bei *Vimbuza*-Ritualen selbst im Zentrum des Geschehens zu stehen, Schellen umgelegt zu bekommen, und „in eine Trance zu tanzen." Die Sorgen und Ängste, unangemessen zu wirken bzw. den Eindruck erwecken zu können, die Erfahrung der „Besessenheit" für andere zu kompromittieren, ließ ich ebenfalls in mein Feldforschungstagebuch und somit in meine Datenerhebung einfließen. Entgegen meiner Erwartungen erlebte ich aber eher Anerkennung oder höchstens etwas Belustigung auf meine Kosten, was mir nur recht war, knüpfte ich doch gerade damit freundschaftliche Bande zu anderen Teilnehmer*innen.

Victor Turner (1985) plädierte für eine *Anthropology as Experience* und argumentierte, dass gemeinsame Erfahrungen Wissen zugängig machen. Die gemeinsame Erfahrung innerhalb eines geteilten Zeit-Raum-Kontinuums lasse eine gemeinsame Realität entstehen und stelle den Ausgangspunkt anthropologischen Verständnisses dar. Sich selbst Erfahrungen auszusetzen, anstatt sie nur zu beschreiben, half mir, Praktiken nachzuvollziehen und ein annähernd immersives Verständnis zu gewinnen, welches über „traditionelle" anthropologische Verfahren der Datenakquise hinausging (cf. Ingold 2013: 13). Es ließ eine Form von Insiderwissen zu, die für folgende Gespräche und Interviews förderlich war. Ich konnte gemeinsame Erlebnisse für Rückfragen, oder zum Gesprächseinstieg nutzen, indem ich mich auf Liedpassagen, Abläufe, oder verwendete Utensilien bezog. Darüber hinaus empfand ich es als höchst erkenntnisreich, als ich meinen Informant*innen eröffnete, wie ich während der Morgenstunden einer durchtanzten Nacht beim Filmen das Gefühl hatte, eine Person stünde neben mir in der Dunkelheit und behindere mich daran den Kamerawinkel zu verbessern. Obwohl ich nachsah und keine Person ausmachen konnte, wurde ich das Gefühl nicht los. Was ich für mich leichthin als Halluzination deutete, die der Erschöpfung und der Übermüdung geschuldet war, wurde von meinen Informant*innen völlig anders gewertet: Sie argumentierten, dass ich eine spirituelle Begegnung gehabt haben müsse und eröffneten mir eigene Erlebnisse, in die ich als „Außenseiterin" vermutlich sonst nicht eingeweiht worden wäre.

Turner betrachtete das eigene Erleben als essenziell für ein „wirkliches Verständnis." So ließ er seine Studierenden Ethnographien nicht nur lesen, sondern ermutigte sie, diese zum Leben zu erwecken und aufzuführen. Durch die Erfahrung dieser Performativität erhoffte er, ein „tieferes," inkorporiertes Verständnis zu generieren, welches verschiedene Ebenen der Wahrnehmung integriert. Das eigene Nervensystem und damit der eigene Körper und so auch das ganz persönliche Erleben werden dadurch stimuliert (cf. Cox *et al.* 2016: 6). Diese Komplexität sozialen Erlebens ist schwer in Worte zu fassen. Was ich zur Vorbereitung gelesen hatte, als auch was ich durch Worte zu beschreiben versuchte, erschien mir in Anbetracht der vielen Eindrücke als unzulänglich. Das Medium Film hat für mich dabei eine ganz besondere Rolle in der Forschung eingenommen, da es durch bewegtes Bild und Klang eine Art Begegnung ermöglicht:

> "They [the different media] are designed to open up a space of anthropological encounter [...] by the critical and phenomenological insights offered by thinking with and through images, ob-

> jects and sounds. The sensory faculties of looking, listening and feeling are activated by these media sometimes flow separately and at others mix and merge together in ways that transform our perception, experience and understanding of the world." (Cox *et al.* 2016: 16)

Die von Cox *et al.* beschriebenen Begegnungen durch Sinneseindrücke sind nicht über schriftliche Ethnographien transportierbar, wohl aber meiner Meinung nach, wenigstens ansatzweise, durch das Medium Film. Ich plädiere dafür, dass sich auch die Disziplin der Medizinanthropologie von Tim Ingold's Vorgehensweise anstecken lässt, bspw. studentische Abschlussarbeiten auch in nicht textlichen Varianten zuzulassen, was zumindest innerhalb meiner Affiliation bisher nicht möglich war. Ingold hatte mit seinen Studierenden unter dem Motto „Learning through Doing and Understanding in Practice" (*ibid.* 2004) angeregt, alternative Formen des Erkenntnisgewinns zu entwickeln. Gemeinsam erlebten er und seine Studierenden bspw. in Theaterworkshops, wie sich die Körperhaltung auf Stimmungen auswirkt, oder wie architektonische Skizzen je nach Tageszeit unterschiedlich ausfallen. Letzteren Sachverhalt deutete er als Erfahrung eines Kontexts unterschiedlicher Lichtverhältnisse im Laufe eines Tages, die nicht erlernbar, sondern nur erfahrbar seien. Wissensaneignung korreliert daher mit Erfahrung externer Sinneseindrücke und der internen Wahrnehmungsverarbeitung. Davon ausgehend, erscheint ein rein schriftlich vollzogener Wissenstransfer unzulänglich. Wenn Lernen mit dem eigenen Erleben und Begreifen einhergeht, muss Wissenstransfer mindestens ein *aktives Zusehen* ermöglichen.

Die Möglichkeit, Sequenzen nicht nur einmalig betrachten zu können und zuvor Übersehenes entdecken zu können, schienen mir speziell als „Alleinforschende" als sinnvolle Ergänzung. Dennoch war ich mir durch meine bisherige Auseinandersetzung mit ethnografischem Filmen der Tatsache bewusst, dass eine neutrale, objektive Abbildung einer Realität nicht existiert. Ich wechselte im Vorgehen zwischen Herangehensweisen und verwendete einerseits wie im *direct cinema* lange Einstellungen und bemühte den Versuch eines „Aufgehens im Geschehen." Andererseits setzte ich diesem Anspruch mit direkten Interviews einen Kontrast entgegen: Auf Sequenzen die Zuschauende auf sich wirken lassen können, folgen Sequenzen sogenannter „talking heads," bei denen ich Personen mit verschiedenen Positionen zu Wort kommen lasse.

Die ständige Präsenz der Kamera und die öffentliche Ankündigung meiner Filmtätigkeiten (nach vorheriger Erlaubnis zu Filmen) muss natürlich die Frage zulassen, inwiefern es hier überhaupt auch nur annähernd zu einer objektiven Betrachtung, selbst in Momentaufnahmen, kommen kann. Durch meine persönliche Kameraführung und die allgegenwärtige Präsenz der Kamera wurde natürlich keine Abbildung des Geschehens, sondern eine eigene filmische „Wahrheit" kreiert. So hatte auch schon Jean Rouch, der als Pionier des ethnografischen Films gilt, die Kamera als gezielten Kommunikationskatalysator bezeichnet. Rouch's Vorgehen mit der Kamera bezeichnete er selbst als *ciné-trance*:

> "a state of spirit possession (by the spirit of the camera) that allowed him to share in the trance and to participate in the ritual of spirit possession and thereby to dissolve the boundary between him as a film maker/ethnographer and the spirit mediums he filmed." (Behrend & Zillinger 2014: 22)

Diese Beschreibung des Filmens als „Verschmelzung" und „Trancegeschehen" ist für mich gut nachvollziehbar, wurde die Kamera im Laufe der Nacht doch meist Teil des Rituals, und ich als Filmende auf eine besondere Art in die Abläufe eingebunden. Dieser besondere Zugang wird damit aber auch späteren Zuschauenden eröffnet. Einen weiteren Vorteil ergaben die derart gewonnenen Einsichten, da ich die Sequenzen auch zu Queranalysen und Gesprächen mit meinen Informant*innen nutzen konnte. Dies erwies sich als überaus hilfreiches Instrument und führte zu Einsichten und tieferem Verständnis der Praktik, sodass ich den Vergleich mit einem Katalysator gut nachvollziehen kann. Durch die Partizipation der Informant*innen und den Einbezug in mein Forschungsmaterial veränderte sich meine Position. Von der Zuschauerin fand ich mich durch den Perspektivwechsel und die Rückfragen zum Filmmaterial in der Rolle der Schülerin wieder. Gleichzeitig machte mich dies aber auch zur Mitwisserin, da wir ein gemeinsames Erleben geteilt hatten, über das wir uns austauschen konnten.

Aus dem Feld kehrte ich mit einem umfangreichen Datenmaterial zurück, welches sich aus Feldnotizen, Interviews und informellen Gesprächen, über 74 Stunden Videomaterial, 4,5 Stunden Tonaufnahmen, und über 2200 Fotos zusammensetzt. Meine umfangreichen Forschungsdaten strukturierte ich unter Rückgriff auf die Methode der *Grounded Theory* (cf. Strauss & Corbin 1997) und versah Filmausschnitte, Audiosequenzen, Interviews und Notizen mit Paraphrasierungen, Kategorien und Unterkategorien. Obwohl ich dadurch schnell Erkenntnisse und Wissen zusammentragen konnte, machte ich mir die meisten Gedanken darüber, wie ich dieses Wissen vermittelbar machen könnte. Es war mir besonders wichtig, Raum für Erkenntnisse zu lassen, die sich auch unabhängig von meinen Interpretationen aus dem Material ergeben könnten. Das Medium Film schien mir auch hier angebracht zu sein, da es auditive und visuelle Sinneswahrnehmungen stimuliert und Eindrücke des Gesamtgeschehens, auch für spätere Betrachter*innen, vermittelt.

Fazit

Filmaufnahmen während anthropologischer Forschungen sind kein Neuland. Ganz im Gegenteil sind sie tief mit der Disziplin verwurzelt:

> "The Torres Strait expedition (by Alfred Cort Haddon) is considered the birth of modern anthropology, and that it coincides with the first film footage not only indicates that the two forms of data and knowledge acquisition are highly compatible but also shows that the pioneers of the discipline recognized the potential of the film and photo camera as a technical extension of the ethnographic eye very early on […]." (Schäuble 2018: 1)

Trotz dieser schon länger existierenden Verflechtung von Anthropologie und Film dominieren schriftliche Arbeiten die Wissenschaft.[6]

Erkenntniszuwachs und Präsentation von Forschungsergebnissen durch rein schriftliche Verfahren mangelt es an der Ebene des eigenen Erlebens. Gelesenes erschließt sich dem Lesenden zwar auch immer nur aus dem Horizont des eigenen Erfahrungsverständnisses. Ein Buch, durch das ich vor 20 Jahren zu erstaunlichen Erkenntnissen kam, eröffnet mir bei einem späteren erneuten Lesen vielleicht ganz andere Einsichten, weil ich um so viel Wissen und Erfahrungen reifer, viel mehr, oder einfach anderes aus den Zeilen lesen kann. Ein visuell- auditives Medium lässt als Momentaufnahme einer bestimmten Situation und Zeit noch viel mehr spätere Einsichten und Rückschlüsse zu. Zudem ist die Momentaufnahme nicht so stark durch eine Person und deren für erwähnenswert erachteten Beobachtungen gefiltert, sondern gibt auch den Blick frei für ganz andere Sichtweisen und Wahrnehmungen.

Das Konzept der „Ästhetik" beschreibt die Lehre von der Wahrnehmung und dem sinnlichen Anschauen. Ästhetisch ist, was unsere Sinne anspricht bei einer Betrachtung, egal ob es etwas schönes, hässliches, angenehmes, oder unangenehmes ist. Diese Übersetzung läuft „inkorporiert" im jeweiligen Individuum ab. Dadurch kann jedes betrachtende Individuum ganz eigene Einsichten aus visuell-auditivem Material gewinnen, die zum Gesamtverständnis eines Sachverhaltes beitragen.

Bei der Beschreibung einer so komplexen Heilpraktik wie dem *Vimbuza* Heiltanz, die sich kontinuierlich weiterentwickelt, empfinde ich eine schriftliche Momentaufnahme für unzulänglich. Die audiovisuelle Stimulation durch das Medium Film ermöglicht Zuschauer*innen eine Idee der kreierten Realität dieses Moments. Auch wenn das Betrachtete vielleicht sehr fern ist, kann die körperliche Erfahrung von Klang und Bild in meinen Augen mehr vermitteln, als es die beste Beschreibung und Verortung könnte. Auch wenn theoretisches Verstehen bedeutet, dass man Zusammenhänge und Kontexte kennt, sind diese leibhaften Erfahrungen essenziell für ein wirkliches Verständnis. Ich hoffe, dass meine Überlegungen beim Filmschnitt dem *aktiven Zusehen* und eigenen Erfahren zuträglich waren und wünsche mir, dass anthropologisches Filmen und Forschen mit allen Sinnen zukünftig noch etablierter Verwendung findet.

Anmerkungen

1 Ich verwende den Begriff *Trancetanzen*, da dies eine emische Beschreibung des Geschehens war. Im Folgenden benutze ich weiterhin den Begriff *Spirits*, da ich die deutsche Übersetzung „Geistwesen" für unzulänglich erachte. Mit Geistwesen wird durch unsere Sprachprägung eine Nähe zu Gespenstern und anderen unpassenden Assoziationsketten angeregt. Deswegen verwende ich die

Eigenbezeichnung als Fachbegriff, den es mit der *Vimbuza*-spezifischen Bedeutung zu betrachten gilt. Durch *Spirit* wird zudem die Nähe zum *Holy Spirit* verdeutlicht, der durch Christen als einzig zulässig in dieser Aushandlung betrachtet wird.

2 Vgl. Katarina Greifeld (2003): „Kulturspezifische Syndrome erlauben an einfachen Beispielen, die unterschiedlichen Wechselbeziehungen und Netzstrukturen, die sich um Kranksein und Wohlbefinden ranken, herauszuschälen. Kurz gefaßt lassen sich kulturspezifische Syndrome […] definieren als Erkrankungen, die nicht losgelöst von ihrem kulturellen oder subkulturellen Kontext verstanden werden können, wobei ihre Ätiologie zentrale Bedeutungsfelder und Verhaltensnormen dieser Gesellschaft zusammenfassen und symbolisieren." (*ibid.* 23)

3 Ich verwende hier die Schreibweise Doctor statt Dr. zur wertungsfreien Kenntlichmachung von Eigenbezeichnung und akademischen Grad. Heiler*innen benutzten oft für sich die Bezeichnung Doctor, die ich als emische Bezeichnung übernahm, aber im geschriebenen Text von den Ärzt*innen nachvollziehbar unterscheiden wollte.

4 Für einen Eindruck ist mein veröffentlichter Kurzfilm aus der UNESCO Welterbeklasse geeignet: http://welterbe.uni-koeln.de/vimbuza

5 Es ist gesellschaftliche Konvention, dass Personen, die aus urbanen Zentren in die Peripherie bzw. ländliche Gebiete reisen, Güter wie Tee, Zucker und Brot mitbringen. Für mich galt dies im Besonderen, da ich für meine Forschung die Zeit der Menschen in Anspruch nahm und für entsprechenden Ausgleich sorgen wollte.

6 Abseits der in diesem Artikel diskutierten Inhalte, ist es mir ein besonderes Anliegen darauf hinzuweisen, das in der Vergangenheit anthropologische Diskurse insbesondere auch unter Verwendung visueller Medien stereotypisierende Darstellungen rekurrierten, auf die sich Rassenideologien stützten und entsprechend weiter verbreitet wurden. Mit Hinblick auf aktuelle Entwicklungen bzgl. *Critical Whiteness Studies* unterstreiche ich die Herausforderung innerhalb der Kultur- und Sozialanthropologie, Lehr-, Forschungs- und Darstellungspraktiken, egal ob schriftlich oder visuell, rassismuskritisch zu überprüfen bzw. die Perspektive involvierter Personen kritisch zu hinterfragen. Eine Reflexion nicht nur ethnographischer Methoden sondern auch bzgl. der Entscheidung, welche Inhalte verbreitet bzw. unterschlagen werden, sollte daher transparent dargestellt werden, nicht ausschließlich, aber insbesondere beim ethnografischen Film.

Literatur

Aunger, Robert 1992. The nutritional consequences of rejecting food in the Ituri forest of Zaire. *Human Ecology* 20: 263–291.

Behrend, Heike & Martin Zillinger 2014. *Trance mediums and new media: spirit possession in the age of technical reproduction*. Fordham: University Press.

Cox, Rupert, Andrew Irving & Christopher Wright 2016. *Beyond text? Critical practices and sensory anthropology*. Manchester: University Press.

Gilman, Lisa 2015. Demonic or cultural treasure? Local perspectives on the Vimbuza, intangible cultural heritage, and UNESCO in Malawi. In Michael Foster & Lisa Gilman (eds) *UNESCO on the ground: local perspectives on intangible cultural heritage*. Indiana: University Press. 59–76.

Greifeld, Katarina (ed) 2003. *Ritual und Heilung: Eine Einführung in die Medizinethnologie*. Berlin: Reimer.

Ingold, Tim 2000. *The perception of the environment: essays on livelihood, dwelling and skill*. London: Routledge

––––– 2004. *Learning through doing and understanding in practice: sharing ideas and research in social sciences learning and teaching*. Birmingham: CSAP Project.

––––– 2013. Knowing from the inside. In *ibid.* (ed) *Making anthropology, archaeology, art and architecture*. New York: Routledge: 1–17.

Krause, Kristine, Gabriele Alex & David Parkin 2012. *Medical knowledge, therapeutic practice and processes of diversification*. Max-Planck-Institut zur Erforschung multireligiöser und multiethnischer Gesellschaften. Göttingen: MMG Working Papers.

Peltzer, Karl 1989. Nosology and etiology of a spirit disorder (Vimbuza) in Malawi. *Psychopathology* 22: 145–151.

Pink, Sarah 2015. *Doing sensory ethnography*. London: Sage.

Scheper-Hughes, Nancy 1995. The primacy of the ethical: propositions for a militant anthropology. *Current Anthropology* 36, 3: 409–440.

Schäuble, Michaela 2018. Visual Anthropology. In Hilary Callan (ed) *International Encyclopedia of Anthropology*. Hoboken: Wiley. 1–21.

Soko, Boston 2014. *Vimbuza: The Healing Dance.* Zomba: Imabili.

Strauss, Anselm & Juliet M. Corbin 1997. *Grounded theory in practice*. London: Sage.

Turner, Victor 1985. *On the edge of the bush: anthropology as experience*. Tucson: University of Arizona Press.

SVEA LINDNER M.A. (Ethnologie und Interkulturelle Kommunikation und Bildung) forschte für ihre Masterarbeit 2018 zum Vimbuza Heiltanz in Malawi. In ihrem Studium an der Universität zu Köln legte sie den Schwerpunkt stets auf medizinethnologische Themen. Sie ist seit 2010 examinierte Gesundheits- und Kinderkrankenpflegerin und arbeitet seither auf einer kinderneurologischen Station. Zudem absolvierte sie den Research Master an der Graduiertenschule a.r.t.e.s. der Philosophischen Fakultät. Ihr besonderes Interesse erstreckt sich über Ethnobotanik bis Medizinethnologie. Aktuell widmet sie sich der Nachfrage integrativer Ansätze und Reformen im therapeutischen Sektor, die auch so genanntes „traditionelles" Heilwissen berücksichtigen, wobei ihr Fokus auf dem Einsatz von Hypnose im medizinischen Kontext liegt.

Sana Kliniken Gerresheim, Gräulingerstr. 120, 40625 Düsseldorf
e-mail: svea.lindner@sana.de

FORUM
FORUM

Das Leben, die Toten, die Kunst

Zwei Biographien zwischen Begeisterung und Psychiatrie, Deutschland und Italien

Aufgezeichnet und montiert von EHLER VOSS

Einleitung

Ende 2015 kam ich nach einem Vortrag von Rainer Knepperges und mir über „Ghost Hunting" in den USA in der Kölner Temporary Gallery ins Gespräch mit Horst. Seine geschiedene Frau Donata sei wie die von mir beschriebenen Geisterjäger:innen ebenfalls in Kontakt mit Toten und male Bilder auf deren Geheiß. Das sei nicht immer einfach, aber die Bilder seien sehr beeindruckend und erinnerten ihn zum Teil an die Darstellung schamanischer Kosmologien aus Südamerika. Sie käme aus Italien und habe ein für hiesige Verhältnisse ungewöhnlich impulsives Temperament, auch das sei nicht immer einfach, weder für sie, noch für ihn, noch für alle anderen in ihrer Umgebung, deswegen sei sie auch immer wieder mal in der Psychiatrie, wenn es gar nicht mehr anders gehe. Da ich mich seit langem für die Unschärfe und die unterschiedlichen Auslegungen der Grenzen zwischen Kunst, Religion und Medizin interessiere und sowohl er als auch ich Interesse hatten, diese Geschichte zu vertiefen, verabredeten wir uns einige Zeit später und so lernte ich auch Donata kennen. Daraus ergaben sich mehrere Gespräche, die ich mit beiden zusammen oder zum Teil auch allein zwischen März und Mai 2016 in ihren jeweiligen Kölner Wohnungen geführt habe. Der erste Teil des folgenden Texts ist eine Montage aus Transkriptionen dieser Gespräche in der sich ihre beiden untrennbar miteinander verwobenen Biographien und zentrale Ereignisse aus unterschiedlichen Perspektiven nach und nach entfalten. Die Sätze aus den Gesprächen sind zum Teil stilistisch verändert, um sie lesbarer zu machen oder inhaltlich angepasst, um das Verständnis zu erleichtern. Dieser erste Teil erschien bereits 2017 in der Nummer 18 der Zeitschrift *Kultur & Gespenster* und wurde für den vorliegenden Nachdruck noch einmal Korrektur gelesen. Im Anschluss folgt ein zweiter, bisher unveröffentlichter Teil. Er beruht auf einem Gespräch mit Donata und Horst, das drei Jahre später, Anfang April 2019, in der Wohnung von Donata stattfand, nachdem ich Horst bei der Eröffnung der Ausstellung „Michael Oppitz. Bewegliche Mythen" im Kölner Kunstmuseum Kolumba wiedertraf und er mir kurz von der weiteren Entwicklung ihrer Geschichte erzählte. Die Sätze sind auch im zweiten Teil von mir zumeist leicht verändert, teilweise auch sinngemäß reformuliert und in eine neue Reihenfolge gebracht, um sie und die sich im Gespräch zunächst sehr unübersichtlich darstellenden Ereignisse verständlich zu machen. Donata und Horst haben beide Teile vor der Veröffentlichung autorisiert. Auch, wenn beide ihre echten Vornamen wählten, möchten sie auf die Nennung ihrer Nachnamen verzichten. Horst (67) studierte in den 1970er Jahren Ethnologie und Soziologie. Nach diversen Jobs lehrt er heute Wirtschaftsenglisch. Donata (69) studierte Philosophie und brach dies aufgrund der im Folgenden beschriebenen Ereignisse ab.

Der entstandene Text konzentriert sich auf die Binnenperspektiven der beiden und bietet damit einen Einblick in ihren alltäglichen Umgang mit dem Einbruch des Unverfügbaren und Unsichtbaren in den Bereich des Sichtbaren, in das daraus resultierende Ringen um Souveränität durch einen andauernden Prozess der individuellen und gesellschaftlichen Aushandlung von Normalität in unterschiedlichen Kulturen. Entstanden ist die Dokumentation einer Krise, in der die Selbstkategorisierung zwischen den Toten und dem häuslichen Malen einerseits und den Psychopharmaka und der Psychiatrie andererseits verläuft. Einen Zwischenbereich bilden „die anderen", „die Gesellschaft", das heißt die Nachbar:innen oder Bewohner:innen des jeweiligen Wohnorts, der

Vermieter, der Betreuer. Der Wohnraum hält verschiedene Ein- und Ausgänge bereit: als Brücke zur therapeutischen Institution und als Ort, an dem man die unsichtbaren Kräfte in Bildern kanalisieren und damit domestizieren kann. Auf der Ebene der partnerschaftlichen Beziehung sind in der Erzählung die Rollen klar verteilt: der Partner wirkt schützend und stabilisierend auf die Gefahren der Instabilität der Partnerin, und die Partnerschaft wird zum Ort der Antipsychiatrie, zum Schutz gegen die Grenzziehungen der anderen und zur einzigen Garantie der Mündigkeit gegen ihren Entzug durch die medizinischen und staatlichen Institutionen, und sie bleibt es auch über die nichtbestandene Zerreißprobe hinaus. Das Interview erweist sich selbst als eine Instanz auf Seiten der Stabilisierung, ist jedoch wie jeder Exorzismus und damit wie der Exorzismus der Psychiatrie gleichzeitig auch ein Beschwörung, die Ambivalenzen erzeugt. Das heißt das Interview als antipsychiatrisches ist gleichzeitig auch ein psychiatrisches Dokument (bezüglich des pathologischen Verlaufs, der sozialpsychologischen Kategorisierungen, der Interventionen usw.) Und zusammen mit den Bildern verspricht es die zumindest partielle Erfüllung der Hoffnung auf eine zweite institutionelle Probe: die öffentliche Ausstellung der Bilder. Das Interview mit seinen Bildern ist eine Gegen-Akte und ein Gegen-Bild zu den Akten, die die Probe der psychiatrischen Institution erzeugt: es ist ein Bild der Lebenden und der Toten und die Akte eines Plädoyers, das Leben, die Toten, die Kunst beim Wort zu nehmen. Dass die in unterschiedlichen Stadien entstandenen Bilder und der Text nun in einer medizinanthropologischen Zeitschrift veröffentlicht werden, kommentiert schon durch diese Verortung den prekären Status der Grenzen zwischen Krankheit und Mediumismus, Weltanschauung und Heilung. Das macht ihn keineswegs unheilsam, aber in gewissem Sinne unheilbar, denn auch die Medizinanthropologie behält etwas nicht zu Ende Kategorisierbares. Leser:innen mögen sich vorstellen, dies sei ein Text zu den Voraussetzungen von Donatas Bildern, und zwar ein kunsthistorischer Text – zumindest solange er von keiner kunsthistorischen Zeitschrift gedruckt wird.

Köln im Frühjahr 2016

Donata: Wir waren in Italien als das anfing mit dem Malen. Schon als kleines Mädchen hatte ich immer Phasen, in denen ich ein paar Bilder gemalt habe und das hatte mir immer gefallen. Dann, eines Morgens, das muss so 1997 gewesen sein, es war gegen vier Uhr, werde ich wach und ich fühlte mich von einer Kraft genommen, die sagte mir: „Jetzt stopp, du musst jetzt malen!“ Aber ich sag: „Wie?“ Ich hatte dort ein paar Stifte, aber ich hatte kein Papier, gar nichts. Und ich sagte: „Nee, das geht nicht!“ Das waren mehr Eingebungen und keine Telepathie, keine Stimmen. Und ich hab fast eine Stunde da gehadert, und gesagt: „Kannst mich am Arsch lecken, was soll ich? Ich hab anderes zu tun!“ Ich hab gearbeitet damals. Und dann hab ich irgendwann gesagt: „Na gut, in Gottes Namen!“ Und dann hab ich ein Stück DIN-A4-Papier genommen und die Stifte genommen und einfach gemalt. Das war dann sehr schön. Ich sagte aber: „Wow, das kann ich!“ Und da hat es angefangen. Und dann hab ich intensiv, Tag und Nacht fast, sehr intensiv, an die 280 Bilder gemalt. Wenn ich anfange zu malen, bin ich ganz normal, ich habe nur Lust, zu malen, manchmal habe ich bis zu 15 Stunden gemalt, von morgens früh um fünf Uhr bis abends spät. In voller Entspannung, locker. Ich bin dann ganz, ganz entspannt, das ist ein erhabenes Gefühl, als ob ich auf dem Mond wäre und überhaupt kein Gewicht hätte. So fühle ich mich, wenn ich male.

Horst: In manchen Bildern von Donata sehe ich verschiedene Ebenen, die sich gegenseitig durchdringen, zum Teil ist da ein ganzer Kosmos drin, das sieht fast so aus wie in einem Drogenrausch, wo sich ständig die Ebenen durchdringen. Das ist zum Teil schon fast wie eine Landkarte anderer Zustände, paralleler Welten. Ähnliches kenn ich eigentlich nur von Darstellungen aus dem peruanischen Amazonas, von einem ehemaligen Schamanen, der dann auch später eine Malschule gegründet hat. Also ein Mestize, der stand in dieser

Abb. 1 *Katastrophen auf der Erde;* entstanden vor 2005.

alten Tradition, basierend auf der Verwendung von Ayahuasca. Also irgendwie scheint Donata da auch aus uralten Quellen zu schöpfen, ohne dass sie selber damit in Berührung gekommen ist und ohne, dass sie Drogen genommen hat … Oft verwendet sie auch eine Art Weltenbaum-Motiv. Ihre Köpfe kennt man ja vielfach auch von Totempfählen, wo das Ganze ja auch eben da eine fiktive Linie der Verwandtschaft zeigen soll, nicht nur menschlicher Verwandtschaft, sondern eben auch der Verwandtschaft mit dem Tierreich, mit dem Pflanzenreich. Manches erinnert mich auch so ein bisschen an Aboriginezeichnungen, teilweise sieht das vegetabil aus, dann sind es aber nicht nur einfach irgendwelche pflanzlichen Skulpturen, sondern etwas, was dann auch wieder physische Formen annimmt, im Sinne von Wesenheiten. Wie zum Beispiel eine Pflanze, wie ein Korn, das aufgeht, aber es verwandelt sich in etwas, was tierische Elemente hat. Oft lauter schemenhafte, spukhafte Gestalten, schabernackartig … Also ich find das schon sehr, sehr spektakulär.

Donata: Ich bin 1949 in einer kleinen Region in Süditalien geboren, die heißt Basilicata und hat als zweiten Namen Lukanien, weil das eine Region voller Wälder war. Jetzt sind viele Bäume nicht mehr da, die sind dann gefällt worden. Ich hab meine Volksschule besucht, dann Ausbildung zur Kindergärtnerin gemacht, und dann bin ich in die Politik eingetreten, ich bin Kommunistin geworden, mit 17. Das war eine Zeit, wo der Kommunismus in Italien eine besondere, wie soll ich sagen, Anziehungskraft hatte. Und ich habe dann meinen ersten Mann kennengelernt, der war Chef der Gewerkschaft, ich arbeitete auch bei den Gewerkschaften, wir haben geheiratet, und dann hab ich aufgehört zu arbeiten. Später bin ich an die Uni und hab Philosophie und Pädagogik studiert. Mein Prof hatte mir empfohlen, die deut-

sche Sprache zu lernen, und dadurch bin ich nach Deutschland gekommen. Ich hatte dann schon fast alle Prüfungen und alle Referate gemacht, hätte nur meine Dissertation machen müssen, ich bin dann nach Deutschland, wollte das hier machen. Hier habe ich aber dann meinen zweiten Mann Horst kennengelernt, so hab ich dann mit dem ersten Mann Schluss gemacht und musste mir dann Brötchen verdienen, und ich hab dann nicht mehr geschafft, die Dissertation zu schreiben. So hab ich mein ganzes Studium fertig gemacht, fehlte nur die Dissertation. Ja, und dann hab ich beschlossen, in Deutschland zu bleiben.

Horst: Ich war 25 Jahre alt, als Donata in mein Leben trat, eher unerwartet. Ich war eigentlich auch gar nicht drauf eingestellt, dass es jetzt zu irgendeiner Partnerschaft so langen Datums kommen würde. Ich habe sie kennengelernt knapp zwei Monate nach meiner Rückkehr aus Amerika. Amerika will heißen, das waren mehrere Etappen. Das war USA, Ostküste, New York. Das war Mexico, Nordmexico. Das war aber hauptsächlich Ecuador und da wiederum hauptsächlich das Amazonasgebiet. Und auf der Rückreise habe ich mich sozusagen allmählich an Europa rangerobbt. Erstmal vom äquatorialen hin zum inzwischen kalt gewordenen Mexico, es war Winter, Dezember. Und dann quer durch die USA nach New York. Dort habe ich dann noch einen Schamanenspezialisten getroffen – interessant, wie sich die Ereignisse ankündigen, von denen man noch gar nicht weiß, dass sie auf einen zukommen werden. Ich treffe also auf einen in späteren Jahren berühmt gewordenen Schamanenspezialisten, Michael Harner, in dessen Fußstapfen ich in Ecuador gewandelt bin. Hatte mich aber dort vor Ort nicht mit schamanistischen und ähnlichen im spirituellen Bereich liegenden Dingen befasst. Hatte mich eher mit kruden materiellen Dingen beschäftigt, das heißt, wie organisieren sich die Shuar oder die Jivaro – Fragen, wie sie die Literatur eher kennt: wie organisieren die sich, unter welchen Bedingungen bricht das indigene System zusammen und so weiter. Und ich wollte Michael Harner explizit nochmal besuchen, er war damals an der New School for Social Research in New York, weil ich auf jüngere Familienangehörige genau der Leute getroffen war, die Harner als Informanten für seine Publikation *The Jivaro: People of the Sacred Waterfalls* gedient hatten. Sie nannten mir auch die Namen der im Buch auf den Fotos abgebildeten Personen, ebenso, ob sie noch lebten oder wann sie gestorben waren. Also schon ein ziemlicher Zufall. Und Harner ist eben später dann derjenige geworden, der nach Carlos Castañeda das Interesse am Schamanentum für den Massengeschmack erst so richtig losgetrommelt hat. War für ihn auch ein großer Businesserfolg. Und für mich war das das Vorspiel zu Donata, die mit ihrem ganz eigenen, in Anführungszeichen: Schamanismushintergrund in mein Leben getreten ist. Sie kam nämlich aus einer Kultur, wo Entfesseltsein, das In-Trance-Geraten, nicht unbedingt zum Alltag gehört, aber doch häufig genug auftritt. Die Literatur ist voll von diesen Dingen, spätestens seit den 30er, 40er Jahren durch Ernesto de Martino. Und ein solches Mädchen aus der ältesten Stadt Europas, Matera, die aussieht wie ein riesiges Pueblodorf, diese Frau tritt am 2. Februar 1978 in mein Leben. In Köln tobt zu dem Zeitpunkt der Karneval, es ist Weiberfastnacht. Wir haben uns dann während des Karnevals noch ein paarmal getroffen und waren dann auch recht schnell richtig zusammen. Was auffiel zu dem Zeitpunkt war, dass meine Erzählungen von ganz andersartigen Menschen bei ihr eher auf große Skepsis trafen, um nicht zu sagen, auf eine gewisse Ablehnung. Mein ganzes Indianertum, ich hatte zu der Zeit noch jede Menge Mitbringsel um mich herum, Federschmuck und all das, was später beim Rautenstrauch-Jost-Museum in Köln gelandet ist, und sie war da gleich sehr skeptisch. Was willst du mit den Indianern, warum schweifst du so in die Ferne? Du musst nur nach Süditalien kommen, wo ich herkomme, da triffst du auch Indianer. Fand ich damals ziemlich arrogant von dieser sehr schönen Frau, aber okay, ihre gewisse Arroganz und Frechheit mir gegenüber fand ich immer toll. Nicht, weil ich unterwürfig bin, sondern weil ich da irgendwie gut mit umgehen kann, weil Kontrastreiches mich eher angefeuert hat. Irgendwelche Ja-was-bist-du-toll-Sager brauchte ich irgendwie nicht. Dieser Kontrast, dieser Widerstand, der mir mit dieser Frau entgegentrat, der gefiel mir eher. So ist das also losgegangen. Und sie kam aus einer sehr linken, rationalistischen Kultur, war aus der Gewerkschaftsarbeit gekommen, und von daher war natürlich historischer Materialismus angesagt. Sich

Abb. 2 *Kosmische Wesenheiten*; entstanden irgendwann zwischen 2005 und 2010.

mit solchen exotischen, quasi esoterischen Phänomenen abzugeben, das stand einer Kommunistin nicht gut zu Gesicht. Ich kann mich noch erinnern, das muss so um 1979 gewesen sein, Michael Oppitz hatte in Nepal seinen Dokumentarfilm *Schamanen im Blinden Land* abgedreht und der wurde übertragen vom WDR 3, damals noch eine echte Augenweide das deutsche Fernsehen. Dass ich mir sowas anguckte, erzeugte bei Donata nur Kopfschütteln. Was gibst du dich damit ab? Das gibt's doch gar nicht! Das ist nichts, was man greifen und fassen kann. So Donata damals. Dass aber bei ihr auch das Nicht-Sichtbare lauert, das Nicht-Erklärliche, das kam dann recht rasch, ich glaube, es war schon 1982/83, wo sich das mit Sicherheit schon gezeigt hat, also nachdem wir vier bis fünf Jahre zusammen waren.

Donata: 1988 hatten wir einen Versuch gestartet, uns in Italien zu etablieren. Ich bin hier in Deutschland nicht zu Potte gekommen und hatte immer Sehnsucht nach Italien. Ich war aus Italien gewohnt, viele Bekannte um mich zu haben. Horst war dagegen ziemlich zurückhaltend, hatte keinen großen Bekanntenkreis, und so hab ich angefangen, zu weinen hier. Und dann sind wir durch seine Eltern auch noch nach Lüdenscheid umgezogen. Ich hab dort in einem Zentrum für jugendliche Diabetiker gearbeitet. Und das war wirklich das letzte Kaff. Das hat mich kaputt gemacht. Über einen Bekannten in Italien haben wir dann ein Appartement in der Nähe von Florenz gekauft, weil wir dann einen Anfang in Italien machen wollten. Und das Appartement, italienische Verhältnisse, wurde und wurde nicht fertig und es wurde immer teurer und teurer. Horst musste arbeiten, ich musste arbeiten, um diese Sache zu bezahlen. Wir sind dann in dieses Appartement, als es halb fertig war. Und dann war das so schnell und billig gebaut, da hörte man alles. Ich war aus Deutschland gewohnt, richtig ruhig zu leben, und dort hab ich dann nach einem Jahr durch diesen dauernden Lärm einen Nervenzusammenbruch gekriegt. Und dieser Nervenzusammenbruch hat dazu beigetragen, dass ich dann eines Morgens wachgeworden bin und angefangen hab, zu schreien. Ich wusste nicht, was los war und hatte den Eindruck, die Zeit sei gekommen, wo ich sterben musste. Ich hatte den Eindruck, dass meine Kundalini explodiert ist, diese Kraft, die es an der Wirbelsäule gibt. Und dann hatte ich den Eindruck, dass sich plötzlich auch Wesen im Wohnzimmer und im Schlafzimmer aufhielten, und ich hab dann Horst gesagt: „Gib mir Wasser und mach das Fenster auf!" Und ich hatte den Eindruck, ich komme aus dem Körper raus, also wirklich gewalttätig. Er hat mir eine Ohrfeige gegeben und dann bin ich wieder zurück. Und seitdem praktisch habe ich so eine Sensibilität bekommen für dieses andere …, für unsichtbare Dinge. Und ich hatte dann schon von Horst erfahren, dass es da so Leute gibt, Schamanen und so. Aber diese Sache hat sich dann allmählich entwickelt, es war nicht sofort da. Ich hatte an dem Morgen angefangen, auf dem Tisch zu tanzen: „Ich will kämpfen, ich will kämpfen!" Und ich war selbst total überrascht, warum ich mich so verhalten hatte. Als ob ich mit der anderen Realität und dem anderen Leben, womöglich, wenn es das gibt, verbunden wäre. Fast eine Art der Selbsthypnose.

Horst: Gezeigt hatte sich das schon damals dadurch, dass sie Phasen vor dem Einschlafen hatte, beziehungsweise unmittelbar nach dem Wachwerden, wo sie, nennen wir es mal so, wie es in der Bibel gesagt wird, mit fremder Zunge sprach. Es war unverständlich, aber es war nicht einfach nur ein babyhaftes Gebrabbel. Man hätte vielleicht irgendeine Form von Sprache daraus erkennen können, es klang artikuliert. Sie wirkte erstaunt, wenn sie mich anschaute und ich nicht antwortete, weil ich sie nicht verstand. Offenkundig sah sie in mir jemand anderen. Und es dauerte manchmal ne halbe Minute, wenn nicht eine Minute, bis sich dieser Zauber wieder brach, das heißt, wo sie dann merkte: „Hallo, das ist eine andere Realität, hier ist Deutschland, hier ist Horst … und jetzt spreche ich Deutsch." Das hat mich ziemlich fasziniert. Weil mich aber auch fremde Sprachen immer fasziniert haben, habe ich mir gedacht, es muss doch irgendeinen Ansatz geben, um zu erkennen, wo das eigentlich herkommt. Aber das würde wohl auch der beste Linguist nicht hinbekommen bei den tausenden von Sprachen. Es kann ja irgendwas Antikes sein, was aus ihr spricht, noch nicht mal eine heute gesprochene Sprache, wer weiß das schon? Aber für mich steht fest, es hatte was Artikuliertes. Es war kein Gebrabbel, wie bei jemandem, der seine Zunge nicht mehr kontrollieren kann wie im Alkohol-

Abb. 3 Ohne Titel; entstanden irgendwann zwischen 2005 und 2010.

rausch. Es war eindeutig artikuliert, aber eben nicht für mich verstehbar. Das waren so die ersten Symptome, dass an dieser sich so rational gebenden Frau doch andere Facetten vorhanden waren. Auffällig war ihre große Schwierigkeit, sich in Deutschland einzufügen. Sie hatte ständig das Gefühl, nicht akzeptiert und gemobbt zu sein, als dunkelhaarige Italienerin. Sie hatte manchmal recht damit, will ich gar nicht in Zweifel stellen, dass Leute ihr gegenüber diskriminierend aufgetreten sind. Des Öfteren waren es aus meiner Sicht aber einfach nur Signale, die sie falsch interpretierte. Wo dann aber auch auf meine Erklärung hin nicht mehr viel zu holen war. Dieses Unwohlsein, das Gefühl, nicht an dem Ort zu sein, wo man eigentlich hingehört, kam bei ihr immer wieder hoch. Das hat zu psychosomatischen Erkrankungen geführt. Das trat schon recht früh auf, an der Jahreswende 1978/79, wo sie ins Krankenhaus eingeliefert werden musste. Ihr ging es also offensichtlich so schlecht, dass sie die Augen verdrehte und eingeliefert werden musste. Dann wurde sie auf den Kopf gestellt, keiner fand was Richtiges. Dann immer wieder eben Symptome wie Herzrasen oder Probleme im Magen-Darm-Bereich, ständig irgendetwas, was nicht richtig funktionierte. Physis und Psyche waren bei ihr definitiv nicht im Lot. Und wie stark sich das dann noch äußern konnte, zeigte sich in einer weiteren Krise. Diesmal eine Rückkehrkrise. Weil sie neun Jahre lang an meiner Seite immer wieder gezeigt hatte, dass sie hier nicht klarkam, mich andererseits aber das Leben anderer Kulturen immer fasziniert hat und ich dank ihr Italien kennenlernen konnte, ich auch fasziniert war von den italienischen Städten, von der italienischen Kultur, war ich dann von der Idee, nach Italien zu gehen und dort zu leben, früh sehr angetan. Ich hatte inzwischen eine sehr gut dotierte Position, konnte also sehr viel Geld zurücklegen, und so sind wir dann in ein Hausprojekt eingestiegen, so eine Kooperative, wo also viele Leute ihre Gelder zusammentun und auf diese Art und Weise kostengünstiger zu Wohneigentum kommen können. Da haben wir uns dann eingeschrieben und 1987 war die Sache angeblich fertig. Es hat sehr viele Probleme bei dem Projekt gegeben, manchmal eben sah es so aus, als wenn die Gelder verloren wären. Man musste sich zusammentun mit den anderen Interessenten, um den Bau dieser Wohnanlage fortsetzen zu können. Das führte bei Donata zu weiterem Stress und als wir dann schließlich dort eintrafen, war das Ding entgegen der Aussagen nicht fertig. Dass wir mitten in einer Baustelle ankamen, mit Möbeln, das kann sich keiner vorstellen, was da abging, wie wir die Möbel hin und her schieben mussten in einer noch nicht mal 50 Prozent fertigen Wohnung. Kein Wasser, noch keine Elektrizität und nichts, also unglaubliche Zustände, aber wir konnten ja nicht zurück nach Deutschland. All das waren Dinge, die wie eine chinesische Wasserfolter waren, die wie Wassertropfen auf Wassertropfen auf ihr Gehirn, auf ihre Psyche niedergingen. Donata hatte, um beruflich Fuß fassen zu können, gleichzeitig noch an einem praktischen Studiengang an einem Institut für Tourismus teilgenommen und stand kurz vor einer Prüfung. Dann hatte sie einerseits den Stress dieser Situation in der Wohnung, dann aber auch den Vorbereitungsstress. Das führte dann dazu, dass sie immer erregter wurde. Und dann an einem Abend, sie hatte eine Freundin aus Brasilien mit dabei, war es irgendwie ganz eigenartig, ich weiß nicht genau, wie es ging, plötzlich war sie absolut in Panik, trat auf der Stelle und sprang wie so ein Rumpelstilzchen im Kreis herum und sagte: „Ich muss kämpfen, ich muss kämpfen, ich muss kämpfen!". Ich sag: „Wieso, was ist los?" Keine Antwort. Nur: „Ich muss kämpfen, ich muss kämpfen!" Sie war auch ziemlich laut dabei und auch nur halb angezogen. Ich weiß nicht mehr genau, was alles war, sie schlug glaub ich auch gegen die Wand und so. Die Brasilianerin stand so dabei, als wenn sie in Trance wäre. Ich versuch Donata wieder zu sich zu holen, hab ihr ein paar gescheuert. Das fühlte sich sehr eigenartig an, nicht so, als würde man auf echte, lebendige Haut treffen. Ich habe früher auch geboxt, ich weiß, wie es sich anfühlt, wenn man auf einen warmen, lebendigen Körper schlägt. Das hat also, das hat ein bestimmtes Gefühl. Wenn ich aber ihr ein paar klebe und schlage, damit sie wieder zu Bewusstsein kommt und das fühlt sich an, als wenn ich auf einen Sand, auf einen kalten Sandsack schlage, da ist es sozusagen, als wenn sie eine Mumie wäre. Da ist das schon ein eigenartiges Erlebnis. Da merkt man, das fühlt sich nicht menschlich an, die befindet sich in einem anderen Zustand, der ihrer Physis eine andere Stofflichkeit verleiht, die nicht der üblichen entspricht. So, als wenn sie ein toter Körper

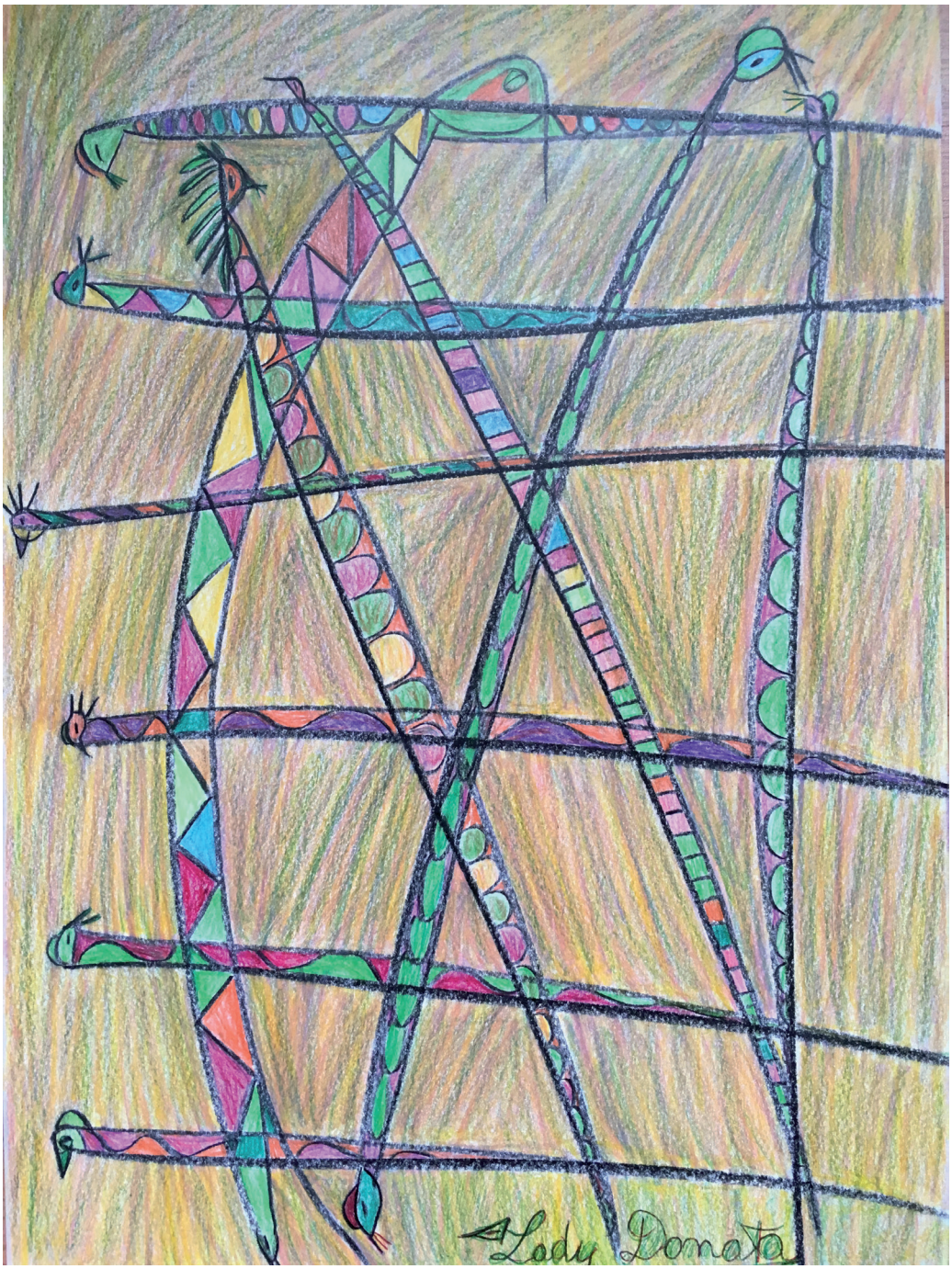


Abb. 4 *Schlangen*; entstanden irgendwann zwischen 2005 und 2010.

wäre, der vor einem steht, der sich bewegen kann. Sozusagen wie, was weiß ich, ein Monster wie aus einem Horrorfilm von Frankenstein geschaffen, so fühlt sich das dann an vermutlich. Also, das habe ich noch ganz plastisch, dieses eigenartige Gefühl und wie überrascht ich war. Ich dachte, ich hätte sie jetzt kaputt hauen können, aber es war klar, dass das gar nichts bringen würde, da kam nichts an. Genauso, als hätte ich eine Statue vermöbelt, wäre genauso effektvoll gewesen. Ich glaube, das ist ein guter Vergleich. Sie reagierte auch kaum drauf, außer dass sie plötzlich anfing, mich zu beißen, aber richtig, in den Arm, sodass es sofort blutete. Ich ließ dann los und dann ZACK, schoss sie davon. Das war in den frühen Morgenstunden, nachdem sie die ganze Nacht nicht hatte schlafen können, so gegen fünf Uhr morgens und sie raste so halb nackt aus der Bude raus. Ich konnte da nicht hinterher, weil mein Arm blutete. War auch zu überrascht, wie sie sich da entwunden hatte. Ich hab dann die Feuerwehr oder Polizei angerufen und gesagt, was da vorgefallen war. Sie sagten: „Ja, okay, wir halten Ausschau!" Dann habe ich aber nichts gehört, es war glaub ich dann acht oder neun Uhr morgens und dann rief mich eine befreundete Schneiderin an, die dann sagte: „Ja, Donata ist bei mir, spricht durcheinander, ist nicht ganz bei sich, kannst du kommen?"

Donata: Ich bin dann abgezischt von Zuhause, ich war nur mit einem kurzen Nachthemd bekleidet und barfuß, und dann draußen hab ich verschiedene Erlebnisse gehabt. Unter anderem war ich auf der Suche nach Zahlen. Und ich hatte den Eindruck, als ob Energien hinter mir liefen. Und dann kam mir ein Gedanke, Sappho, das ist eine Dichterin aus Griechenland. Da kam erst mal die Dichtung, dann kam die Philosophie, Sokrates, und dann kam Jesus Christus. Ich hab diese verschiedenen Epochen der Menschheit dann erlebt. Ich lief sehr schnell, ich lief von diesem Erlebnis weg irgendwie. Und ich wusste nicht, was ich machen sollte. Und dann bin ich in einer Art Krankenhaus gewesen, ich hatte den Eindruck, die wollten mich einsperren, bin ich halt weggelaufen. Dort hatte ich dann einen Kittel und ein paar Schuhe gekriegt. Unterwegs suchte ich weiter nach Zahlen, bei den Häusern. Dabei hatte ich eine Mutter und eine Tochter getroffen, und ich hatte gefragt: „Wohin geht ihr denn?" Sie hat gesagt: „Ich bringe meine Tochter nach Florenz, sie studiert Musik." Und dann kam mir alles hoch, dass ich auch Musik studiert hatte und dann hab ich gesagt: „Ja, guck dir das an: Synchronizität!" Hab ich mich dann eingehakt und gesagt, ich komme mit. In dem Moment war ich total frappiert, was alles mit mir geschah. Und dann bin ich in einem Hof gelandet und hatte den Eindruck, das wäre aber nicht hier in Italien, in der Nähe von Florenz, sondern das wäre in Palästina, und dort gebe es Leute mit verschiedenen Kopftüchern, das hatte ich gesehen, so als ob ich in eine andere Epoche katapultiert wäre. Naja. Dann hab ich mich hingesetzt, hab ich gesagt: „Okay, wenn jetzt der Tod kommt, kommt der Tod, ist mir scheißegal." Ich war total benommen von dieser ganzen Sache. Und dann hab ich mich erinnert, dass in der Nähe eine Schneiderin wohnte und bin dahin gegangen. Ich hatte Schuldgefühle. Dass meine Mutter krank war, irgendwie, weil ich keine gute Tochter gewesen bin, ich ihr nicht geholfen hatte und dass ich mein eigenes Leben gelebt hatte. Und dann hab ich zu der Schneiderin gesagt: „Ich will jetzt zu meinen Eltern gehen, die wohnten 200 Kilometer entfernt in der Nähe von Bologna." Und da sagt sie: „Nee, du bist doch mit Horst! Du musst da zurück!" Hab ich gesagt: „Nee, da geh ich nicht mehr zurück, ich geh zu meinen Eltern, ich muss meine Mutter pflegen!" Ich hatte so wahnsinnige Schuldgefühle, so eine Mischung von verschiedenen Erwartungen. Die Schneiderin sagte: „Weißt du was, nimmst mal diese Tablette, schluck diese Tablette und ich rufe Horst, und Horst holt dich ab." Und das hätte sie nicht machen dürfen, weil dann bin ich total fast kaputt gegangen von dieser Tablette, Tavor hat sie mir gegeben, ein Psychophar…, also Beruhigungsmittel, eine halbe Tablette. Und ich hab die genommen und das hat mich umgehauen. Und dann hat sie Horst angerufen. Horst ist gekommen, und eine Nachbarin, mit dem Auto und hat mich dann nach Hause gebracht. Na, okay. Dann hatte ich die Sache fast vergessen, ging ich nach Florenz und nach drei Tagen kriegte ich wieder Schuldgefühle und Stress und all diese ganzen Sachen wieder. Als ob jemand hinter mir her wäre, dass ich irgendwie eine Aufgabe lösen müsse und etwas auf mich nehmen müsste. Ich bin dann nach Hause gegangen, war total verängstigt, hab ich mich gebadet und gesagt, vielleicht, wenn ich jetzt in kaltes Wasser gehe, vielleicht geht es besser. Aber

am nächsten Tag bin ich dann in einen Mechanismus reingekommen von Angst, Stress, Erwartungen. Ich wollte mein eigenes Leben leben, wie es früher war, aber diese Zustände, die haben mich immer eingeholt irgendwie. Ich konnte das Ding nicht mehr loswerden.

Horst: Ich hab ihr auch Tabletten gegeben, ich glaube Tavor, viele Personen hatten was mit psychischen Problemen zu tun gehabt und anscheinend gehörte Tavor bei vielen zur Grundausrüstung. Sie war bei einer aufgetaucht, bei der Tavor schon im Hause war und die hat ihr das dann einverleibt, sodass sie so einigermaßen sediert war, als ich dann auftauchte. Und dann haben wir einen Arzt geholt und das angeschaut. Sie wurde dann ambulant behandelt, ist also zu dem Zeitpunkt nicht in die Psychiatrie gekommen. Es lagen ungefähr drei, vier Stunden zwischen dem Moment, wo sie aus dem Hause weggelaufen war und dem Moment, wo ich von dieser befreundeten Schneiderin informiert wurde. Sie hat in der Zeit wohl eine Art eigenartiger Wallfahrt hinter sich gebracht, hat bei einem Kloster angeklopft und wollte da rein und hat Personen angesprochen, mit denen sie dann seltsame Gespräche geführt hatte, sie hat die Personen dann für ganz andere Personen gehalten. Also eine Reihe an Episoden, die sie noch Wochen oder Monate danach zu verarbeiten hatte. Also jedenfalls, sie muss also mindestens auf ein Dutzend verschiedene Personen getroffen sein und diesen verschiedenste Bedeutungen gegeben haben. Interessant ist, dass es ja nicht normal ist, wenn eine halbnackte Frau durch einen 10.000-Einwohnerort läuft – und dass jemand das über Stunden veranstalten kann, ohne eingesammelt zu werden, wundert mich im Nachhinein. Zeigt aber vielleicht auch so eine gewisse italienische Nonchalance im Umgang mit solchen Phänomenen. Ich glaube nicht, dass man das hierzulande solange machen könnte, halb nackt in Köln oder sonst wo, geschweige in einer deutschen Kleinstadt. Ich denke mal, die Halbwertszeit wäre bei einer halben Stunde, keinesfalls länger. Ich denke, dass in Italien solchen Phänomenen gegenüber, dem Entrücktsein, den ekstatischen Zuständen, nicht total geschockt reagiert wird. Sondern man weiß halt, dass sowas auftreten kann. Exaltierte Personen bringt man halt zu irgendeinem Exorzisten oder sonstigen Personen. Sowas wurde in Italien, auch Norditalien, immer wieder durch Außenseiter in der Kirche aufgefangen. Wie ich später auch dann durch ähnliche Episoden mit Donata erfahren durfte, gehört das quasi zur einen Seite der italienischen Kultur, und das ist, denke ich mal, der Grund, warum sie so lange in dem Zustand durch einen Ort irren konnte und keiner sie einsammelte.

Donata: Ich bin dann beim Arzt gewesen und er hat mir Beruhigungsmittel verschrieben und ich hab das auch genommen, aber ich wollte eigentlich keine Medikamente. Und das war dann der Kampf mit den Beruhigungsmitteln, immer weniger, weniger, weniger. Dann hab ich verschiedene Psychokurse gemacht und habe viel gelesen, ich habe versucht, die Sache zu lösen, indem ich mich bilde. Aber die Sache wurde nicht besser. Ich fühlte mich vergiftet durch die ganzen Medikamente. In Florenz in einem Bioladen hab ich dann eine getroffen, der hab ich dann ein bisschen erzählt von der Sache, und sie sagte: „Mach dir keine Sorgen, da gibt's eine bestimmte Art von Ernährung, die kann Dir helfen." Ich war schon auf dem „Bio-Trip", sagen wir so, aber sie meinte, es ist eine orientalische Art von Ernährung und orientalische Philosophie, Zen-Küche. Hab ich erst gesagt: „Pff, ich weiß nicht, ob ich mir das antue." Weil ich hatte schon meine eigene Richtung ernährungsmäßig, ich hatte nicht mehr ganz italienisch gekocht, sondern auch verschiedene andere Küchen ausprobiert. Das hat mir immer Spaß gemacht, aus verschiedenen Ländern Rezepte zu kochen. Aber die Sache wurde nicht besser. Wir sind dann nach Deutschland erstmal. Dort hab ich dann auch noch einen Vortrag darüber gehört und ich war sehr angetan davon.

Ich war noch ganz jung, 1988 war ich 39, und ich hatte noch nichts zustande gebracht, ich war dann aus der Politik raus, ich hatte 1975 eine Krise, weil alles rauskam, wie es in Russland war, was Stalin gemacht hat. Hab ich gesagt, das kann doch nicht sein, dass, wenn man die Welt verbessern will, man immer blutige Revolution machen muss. Ich hatte also eine tierische politische Krise. Und ich war ausgetreten aus der Kommunistischen Partei, und dann hab ich gesagt, okay, vielleicht ist es eine Chance, jetzt etwas zustande zu bringen, indem ich Kochkurse oder sowas gebe. Bei dem Vortrag war so ein Berater und der hat

mir dann eine strenge Übergangsdiät gegeben und ich hab das dann so streng gemacht, dass ich in 14 Tagen fast 15 Kilo abgenommen hatte, und dann natürlich in meinem ganzen Körper ganz viel Schlacke sich gelöst hatte, dann ging es mir noch beschissener!

Dann wieder nach Italien, ich hab gebrannt am ganzen Körper, also diese Diät, ich hab das trotzdem durchgezogen. Psychisch hatte ich ja schon ein Theater, mich in das Leben einzureihen! Dann hatte ich auch noch physische Probleme. Ja, dann hatten wir verschiedene Bekannte, eine hatte mich eingeladen und als ich dann bei ihr war, ging es mir sehr schlecht, sie hatte dann einen anderen Berater angerufen und der hatte mir eine Adresse in die Hand gedrückt. Und das war eine Adresse in Bayern, die ich mir auch schon ausgesucht hatte in dem Heft *Das Große Leben*, das hatte ich gesehen in einem der ersten Bioläden. Hab ich gesagt, schon wieder Synchronizität, hab ich gesagt, okay, ich geh da hin, ein paar Monate, ich muss da hin, weil es mir so schlecht geht. Und ich hatte auch noch diese Tavor, dieses Beruhigungsmittel, ich hatte noch eineinhalb Tabletten, hab ich immer reduziert. Hab ich gesagt, ich muss das jetzt aufhören, weil die Medikamente wirken sehr stark und durch die Diät noch stärker. Ich muss jetzt etwas unternehmen, sonst krepiere ich. Dann hab ich mir von Bekannten Geld verschafft und wir haben das Appartement in Italien verkauft und hatten dadurch ein bisschen Geld. Ich bin dann zwei Monate dort in Bayern gewesen. Erstmal ging es mir sehr schlecht, weil die da ziemlich radikal mit dieser Zen-Küche waren. Und dann bin ich dort geblieben, fast ein Jahr, als Mitarbeiterin. Ja, und dort war ein Theater. Ich hab den Eindruck, da war schwarze Magie im Spiel, gerade bei dem Leiter, die haben mich total fix und fertig gemacht, kaputt gemacht. Und seitdem hab ich mich nicht mehr erholen können. Ich hab den Eindruck, als ob von dort immer noch negative Strahlungen auf mich kommen, seit 1988 bis jetzt, ich hab mich nicht mehr erholen können, ich werde systematisch angegriffen von unsichtbaren Wesen.

Horst: Sie hat dann angefangen, sich einen Reim auf ihre Erfahrungen zu machen, indem sie peu à peu dazu kam, sich Literatur anzulegen, um die Phänomene besser verstehen zu können. Sie hat also vorher gar keine Lektüren in dieser Art gehabt. Sie schaute also: Okay, wie sieht der Mensch aus, die Aura des Menschen, Chakren, all diese Themen, die zu einem Verständnis übersinnlicher Phänomene beitragen können. Und der erste Weg aus dieser, wie sie das sagt, „Tavorfalle" herauszukommen, war, dass sie im Laufe von 1988, also innerhalb weniger Monate nach dieser Art Nervenzusammenbruch im Mai, auf Makrobiotik gestoßen ist. Ich weiß nicht mehr, wie es kam. Das ist eine besondere Form der Lebensführung, die viele eigentlich nur mit einer bestimmten Form der Ernährung in Verbindung bringen. Gegründet durch zwei Exiljapaner, die eine Menge Anhänger in Florenz hatten, die Episoden spielten ja, wie ich eben geschildert hatte, vor den Toren von Florenz. Und es gab da wohl ein recht namhaftes Institut mit einem Leiter, der einen Namen hatte in der Makrobiotikszene Italiens. Und der hatte dann für solche Phänomene den Ratschlag, die Ernährung auf eine bestimmte Weise umzustellen. Und so hat sich allmählich ein Kreis aufgebaut von Personen, zu denen sie Zugang hatte. Es zeigte sich dann auch schnell, dass Makrobiotik nicht nur Essen in einer bestimmten Art und Weise war, sondern auch mit einem Glauben an solche Dinge wie Chakren und Geistwesen verbunden war. Das bedeutet, dass die dann eben auch andere Erklärungen für psychische Erkrankungen haben, das kann durchaus auch auf die Einwirkung von Geistwesen oder von Vorfahren oder sonst irgendetwas zurückgeführt werden. Es kommt ja nicht von ungefähr, dass die Makrobiotik aus einer Kultur kommt, in der der Umgang mit Geistwesen bis heute eine zentrale Bedeutung hat. Und Donata hat diese Sachen dann befolgt und hatte zwar auch immer mal wieder Probleme, aber nicht mehr in dieser gravierenden Form, aber ihr ging es trotzdem definitiv nicht gut. Sagen wir mal, sie war psychosomatisch einfach nicht im Gleichgewicht. Über diese makrobiotische Szene ist sie dann zu einem makrobiotischen Therapiehaus im Süden Deutschlands gekommen, das hatte einen italienischen Leiter. Sie ist dann dorthin gekommen und dort ging es erstmal primär um diese besonderen Ernährungsformen. Das kostete auch nicht wenig, sie hat aber dann, nachdem sie sich stark für die Sache interessiert hatte, dort auch in der Küche gearbeitet. Sie ist monatelang dort geblieben und das hat dazu geführt, dass sie das auch als beruflichen Weg für sich erkannt hat und in diese Rich-

Abb. 5 *Elemental*; entstanden irgendwann zwischen 2010 und 2013.

tung gehen wollte. Sie hat sich dann eingeschrieben bei einem Ausbildungsinstitut in der Schweiz, das damals den größten Namen genoss hier in Europa, das war im April 1990. Wir hatten übrigens in der Zwischenzeit, während dieses längeren Aufenthalts in Bayern, auch geheiratet.

Donata: Wir sind nach Mülheim an der Ruhr gezogen, periodisch sind immer diese Erlebnisse aufgetreten. Durch verschiedene Bekanntschaften, die ich machte, immer auf der Suche nach einer Erklärung für diese Erlebnisse, die ich hatte, auch bezüglich der Angriffe, die ich periodisch bekam, hab ich jemand kennengelernt, der aus Amerika Wasserfilter verkaufte und sagte, ich könne da mitmachen, nach diesem Schneeballsystem, Network-Marketing, das war 90er Jahre.

Und dann war ich noch in der Schweiz gewesen, da gab's ein Restaurant, dort hab ich gekocht für ein paar Monate, und dann bin ich weggegangen. In Mülheim an der Ruhr hatten wir eine Bekannte, sie hatte uns in dieses Geschäft eingeweiht, wir sind dann nach Köln, aber in Deutschland kamen wir nicht zu Potte, da haben wir gesagt, versuchen wir es wieder in Italien. Jedenfalls: hin und her. Sind in die Nähe von Mailand. Und in Mailand war's auch erstmal schwer, eine Wohnung zu finden, und dann gefiel mir das nicht, und in der Nähe von Mailand war Bergamo und so haben wir beschlossen, uns in Bergamo anzusiedeln. Und ich ging immer hin und her in die Psychiatrie, ich hatte immer dieses Theater, hab ich nichts machen können, auch mit diesem Kurs nicht. Ich bin dann nicht mehr in die Schweiz, hab die anderen beiden Staffeln nicht mehr gemacht, das war so lachhaft, was die angeboten haben. Und dann wurde ich systematisch auf Entfernung wie eine Marionette belästigt. Dass ich immer sprechen musste und ich immer verschiedene andere Realitäten und verschiedene andere Sachen wahrgenommen habe.

Eine Zeitlang habe ich gedacht, als die Sache noch nicht so negativ geprägt war, dass ich mich als Medium betätige, in Kontakt mit der geistigen Welt. Es gibt Geistwelt und geistige Welt. Also, die geistige Welt, sagen wir so, sind gute Wesen. Geistwelt ist das Reich der Toten. Und wenn diese Toten Zugang haben zu dir, dann gerätst du in einen Strudel, die sind zum Teil sehr negativ. Mein erster Mann, er ist schlecht gestorben, er hat erst einen Bypass gehabt und dann beim zweiten Bypass hat es das Herz nicht geschafft und er ist gestorben, relativ jung, mit 61. Der hatte Politik gemacht und hat überhaupt keinen Zugang zu dieser anderen Realität, aber als er gestorben ist, da war er hinter mir her. Ich habe ihn zum Teil sogar gesehen. Besonders in den 90er Jahren war es sehr schlimm. Diese Wesen, die haben eine hohe Energie und die pulsieren, ich spüre, wenn die mich anfassen, so eine Vibration. Horst hat das auch.

Horst: Man kann das tatsächlich spüren. Wenn ich normalerweise so die Hand bewege, dann spür ich keinen Widerstand. Manchmal ist es aber so, plötzlich ist da eine unsichtbare Art von Gegendruck. Dann ist das so, als wenn eine Matratze oder eine Decke aufgehängt ist, die ich nicht sehen kann, die aber noch Gegendruck erzeugt. Das ist schon ein sehr eigenartiges Gefühl.

Donata: Er hat mehr gesehen als ich. Als wir in Mülheim an der Ruhr waren, in diesem Haus ist wahrscheinlich was geschehen zur Nazi-Zeit. Weil ich war da auf dem Bett, ich war mich hinlegen, schlafen, plötzlich hörte ich: „Wenn wir an die Macht kommen, machen wir dich fertig!" Und dann hab ich wie einen Stock gespürt, der mich rammt. Und: „Diese Scheißausländer, wir werden die alle kaputtmachen!" Und so, das war die Hölle! Die Hölle da, in diesem Schlafzimmer. Und Horst hatte dann auch eine Vision gehabt, erzähl mal. Er hat so einen Indianer gesehen.

Horst: Ja, das war im Übergang, wenn man nicht in den Schlaf reinkommt, in dieser Zwischenphase.

Donata: Da sieht er noch mehr als ich.

Horst: Da fängt es dann an zu flirren, und irgendwann sah ich dann wie kleine Sterne, die plötzlich ins Zimmer eingetreten waren. Also wirklich so kleine funkelnde Sterne, so als wenn einer mit Wunderkerzen gespielt hätte.

Donata: Die hab ich auch gesehen.

Horst: Teilweise sind dann eben auch Umrisse von Körpern, Silhouetten, Körpersilhouetten da drin zu sehen gewesen und in einer, der größten Sil-

Abb. 6 *Göttin des Karma* (großes Gesicht Mitte rechts Selbstbildnis); entstanden irgendwann zwischen 2012 und 2015.

houette, erschien eine Person, die mich ganz stark an eine historische nordamerikanische Person erinnerte. Den meinte ich, erkannt zu haben. Hab dann auch am nächsten Tag ein Buch genommen, ich hab gesagt: „Das gibt's gar nicht, ich mein, ich hab den Typen gesehen!"

Donata: Ja, und dann ein anderes Mal, wir lagen im Bett und da spürte er plötzlich eine Wolke aus der Wand, die hat ihn angefasst, hat er richtig gespürt, und die wollten an mich und ich war auf der anderen Seite. Und da hat, und dann …

Horst: Ich find das irre, weil das nicht nur zu spüren, sondern auch zu sehen war.

Donata: Das war auch zu sehen, ja. Also, diese Wolken, die schmelzen zusammen und die haben mehr Kraft. Eine graue Wolke, es sind nicht Lichter, es sind unerlöste Wesen.

Horst: Also, ich hab das später mal gesehen, in Darstellungen, auch vor Kurzem in einer Ausstellung, wo versucht wird, solche Dinge zu fotografieren. Und da hat man gesehen, das war tatsächlich so ein Phänomen, wie auch immer man dazu stehen mag. Ich war ziemlich skeptisch in Bezug auf diese ganzen Dinge, aber das war schon sehr reell.

Auf jeden Fall hab ich die dann zurückgedrückt und dann verschwand es wieder in der Wand. Ich bin kein Typ, der vor irgendwas wegläuft. Und vielleicht hat es damit zu tun, dass ich durch Lektüren und so weiter wusste, dass solche Dinge auch passieren können, wenn ich Ayahuasca nehme zum Beispiel. Gerade dann werden Angriffe erfolgen und dem muss man sich stellen. Da muss man eben sozusagen zum Gegenangriff übergehen.

Donata: Ein anderes Mal, in Bergamo, da gibt's einen historischen Teil ganz oben. Und das war auch eine Messe, Buchmesse. Und hatte ich da ein Buch gekauft, über einen Meister und dann bin ich nach Hause gegangen, hab mich auf die Couch gesetzt und gelesen. Und dann hab ich angefangen zu spüren. „Wuuu", hab ich gesagt, „was ist das denn für n' Scheiß?" Und dann ist Horst gekommen und ich sag zu ihm: „Hör mal, ich hab schon wieder die Kacke am Dampfen." Und er sagt: „Ja, du wieder!" Aber dann hatte er sich dort hingesetzt, und dann ging das auch bei ihm: Wuuu…

Horst: Also, das war schon irgendwie irre, als wenn irgendwas Unsichtbares versucht, einen in die Ecke zu drücken, und ich sag: „Das gibt's ja nicht!"

Donata: Die haben Kräfte, und wenn sie verschmelzen, haben die noch mehr Kraft. Und ich habe den Eindruck, dass die mich dann an den Beinen fassen, und auch sexuelle Belästigung und alles. Also wirklich beschissen. Wir haben viele Sachen gemacht, damit das aufhört. Ich hab Reiki gemacht, dann Hypnose, Handauflegen und dann hab ich gesehen, dass ich eigentlich nur Geld ausgebe, ich hab sehr viel Geld ausgegeben. Unter anderem sind wir auch nach Rom gefahren zu einem berühmten Okkultisten, der angeblich auch von Wesen befreit und so, auch zu einem buddhistischen Mönch, der hat alles Mögliche gemacht, zu einem tibetanischen Priester und auch zur Moon-Sekte. Aber das hat alles nichts gebracht, wir haben nur viel Geld ausgegeben. Und dann hab ich gesagt: „Jetzt reicht's, weil so oder so werde ich angegriffen!" Ich hatte keinen Bock mehr. Aber bis vor ca. fünf, sechs Jahren, hab ich immer versucht, Hilfe zu holen. Aber es wurde nicht besser, eher schlechter.

Horst: Eher ließ sich beobachten, dass es zu einer Verstärkung führte. Als ob sozusagen in ein Wespennest gestochen worden wäre.

Donata: Diese Wesen lassen sich nicht vertreiben.

Horst: Das Malen der Bilder, das ist dann ab 2008, 2009 zentral geworden. Da hat sich das dann voll Bahn gebrochen. Ich hörte das dann wie sie sprach, wenn sie davor saß: „So soll's jetzt sein, ist das so richtig? Aha. Ja, ihr müsst mir auch ein bisschen helfen, ich weiß nicht, wie es hier weitergehen soll." So diese Art von Reden … Und dann irgendwann: „Ne, das ist doch Mist!" Und dann hat sie es zerknüllt. „Das war eure Schuld, dass ich das jetzt … Ihr habt mich gereizt und deswegen habe ich das jetzt zerknüllt, das war schön!" Solche Diskussionen spielten sich da ab. Gut und gerne mehr als die Hälfte der Bilder ist wieder vernichtet worden, aus Irritation heraus, oder weil sie sich zur

Wehr gesetzt hat. Sie sagte auch: „Jetzt Punkt: Ich kann hier nicht wochenlang Tag und Nacht arbeiten, ich muss auch mal raus, ich muss ein normales Leben führen!“ Und damit hatte sie ja recht, denn für mich, der ich ja diese Wohnung mit ihr teilte, war das logischerweise kein normales Leben mehr. Denn so abschotten kann man sich nicht, um davon nicht in einer negativen Form betroffen zu sein. Das heißt, ruhig schlafen zu können. Da gibt's keinen Quadratmeter, wo Ruhe herrscht. So was kann sich über Wochen und Monate hinziehen. Das sind Produktionsbedingungen von Bildern, die sehr bemerkenswert sind.

Wenn es einigermaßen aushaltbar war, habe ich mir auch die Zeit genommen, drauf zu schauen, hab ihr auch gesagt „Boah, das sieht gut aus!“ Wenn ich aber unter wochenlangem Bombardement stand und kaum Nachtruhe hatte, habe ich ihr gesagt: „Lass mich damit in Ruhe!“ … Dann wollte ich das gar nicht sehen. Jedenfalls: die Bereitschaft, mich wirklich mit den Bildern auseinanderzusetzen, eine echte Bereitschaft gibt es eigentlich erst seit verhältnismäßig kurzer Zeit. Ich habe natürlich des Öfteren schon erkennen können, dass da etwas Besonderes drin steckt, aber ich sah mich in einem Schlamassel. Es ging nicht nur um mich, es wurden ja auch andere Personen, die hier in diesem Haus lebten und leben, in Mitleidenschaft gezogen. Es ging manchmal sehr laut zu. Es sind Leute, die hier unter uns wohnten, sogar ausgezogen, weil sie es nicht mehr aushielten. Die Wohnung wurde gekündigt – okay, ich habe das dann wieder abwimmeln können. Also meine Anwältin, die hat sich über Jahre dauerhaft für mich einsetzen dürfen.

Donata: Ja, und Horst hat das nicht mehr geschafft und hat mich immer in die Psychiatrie eingewiesen. Ja, und dann gab es wieder eine Periode, wo alles in Ordnung war, und jedes Mal, wenn ich in der Psychiatrie war, wurde ich immer vollgepumpt mit Psychopharmaka, immer dieser Mechanismus. In Italien, Gott sei Dank, waren das nur 14 Tage, und dann wurde ohne Richter und ohne Zwang wieder entlassen. Und dann habe ich versucht, die Psychopharmaka zu reduzieren oder abzusetzen. Ja, und periodisch, manchmal jedes halbe Jahr, manchmal alle zwei Jahre oder ein Jahr wurde ich wieder angepeilt, ob das jetzt Wesenheiten, Tote, oder Leute sind, die durch verschiedene Techniken Leute unter Druck setzen, kann ich nicht feststellen. Und irgendwas, seit 1988, hat unser Verhältnis kaputt gemacht, Horst hat das nicht mehr schaffen können, es sind fast 26 Jahre vorbeigegangen, und ich hab immer noch diese Probleme, obwohl ich Medikamente nehme. Ich hab das nie ganz abstellen können, bin von einer Psychose in die nächste gekommen. Ja, und dann wurden natürlich die ganzen Pläne total durcheinandergebracht, statt nach Amerika sind wir nach Italien. 2003 sind Horst und ich wieder nach Deutschland umgezogen. Und ich war noch nicht hier angekommen, nach einem Monat merke ich, da sind Wesen drumherum, die mich wieder gefunden haben.

Horst: Ich habe unter den Umständen des Zusammenlebens mit einer psychisch erkrankten Person keine anderen Möglichkeiten gesehen. Solange, wie sich die Dinge einigermaßen so abspielten, dass ich noch weiter existieren konnte, solange, wie die Umstände so waren, dass Nachbarn nicht in ihrer Lebensführung beeinträchtigt wurden, solange, wie eine Vermieterin nicht auf mich zu kam und sagt: „Hallo, das geht so nicht weiter!“, solange war ich durchaus bereit, mich einzusetzen und die Dinge geschehen zu lassen. Teilweise auch zu hoffen, dass vielleicht diese Spitzen wieder nachlassen. Manchmal hat es Episoden draußen gegeben, wo sie mit Leuten aneinandergeriet, sich geschlagen hat, Polizei kam oder sie Hausverbote geradezu gesammelt hat, in verschiedensten Läden, dass also absehbar war: Okay, da kann schon auf der ganzen Straße niemand mehr einkaufen. Da kann ich ja nicht dabei zuschauen, bis schließlich ganz Köln zur unbetretbaren Zone für sie erklärt wird. Ich muss also gucken, dass es Möglichkeiten gibt, im Verbund mit Gesundheitsämtern. Ich brauchte nur meinen Namen zu sagen und es hieß: „Ach, ist es schon wieder soweit?“

Ich habe mich also immer in einer Verantwortung gesehen ihr gegenüber, auch wenn sie es natürlich erst einmal als Gegnerschaft empfunden hat, empfinden musste. Ich musste aber auch das größere Ganze sehen. Wir leben in einer Gemeinschaft und auch dafür muss man Sorge tragen, dass eben andere, die damit gar nichts zu tun haben, nicht in irgendeiner Form in Mitleidenschaft gezogen werden. Deswegen musste ich eingreifen.

Donata: Ja, wir haben schon viel erlebt, beide. Und leider hört das nicht auf bei mir. Ich hab die Schnauze total voll. Weil ich kann ja nicht ruhig bleiben und kann nicht machen, was ich will, weil diese Geistwesen verhindern, dass ich meine Ruhe habe. „Wir machen dich fertig!", „Du Nutte!", „Wir wollen mit dir ficken!", „Alle Frauen sind kacke!", „Du bist ein Schwein!", „Guck dir das an, ey, was für ein Badezimmer, guck mal, was für ein Appartement! Jetzt trinkt sie auch noch Kaffee, die frisst auch noch!" Solche Sachen. Ich kann so viele Tabletten nehmen, wie ich will, es ist kein Kraut dagegen gewachsen. Das ist genauso wie in der sichtbaren Welt. Du hast einen Feind, und dieser Feind findet andere Leute und plötzlich sind die alle gegen dich, also zusammen, das ist schlecht. In der unsichtbaren Welt ist es genauso. Einmal war ich am Zülpicher Platz, plötzlich, wenn ein Geist dich anfasst, da spürst du Elektrizität, da hat mir jemand eine geklatscht, eine andere unsichtbare Hand, sagt: „Seit langem hab ich dich nicht gesehen!" Klatsch. Wumm-Duwumm! Wie eine Schlag … das sind unsere Toten.

Horst: Ja, dann kamen innerhalb von einem halben Jahr oder einem Dreivierteljahr die nächsten stärkeren Episoden, die ich unaushaltbar fand, und da habe ich wieder Maßnahmen eingeleitet. Dann ging das halt seinen Weg. Das war ein sehr langer Weg. Fakt ist jedenfalls, dass ich mich nicht mehr davon habe abbringen lassen, weil ich nicht sah, wie das Zusammenleben mit ihr noch in irgendeiner Form ihr helfen konnte. Es konnte mir nicht helfen, verursachte Riesenstress – und ich muss mich wirklich sehr in meinem Beruf konzentrieren, es ist höllisch schwer gewesen oft, und ich konnte es nicht sehen, wie das Leben gemeinsam, wie ein gemeinsames Leben unter den Umständen noch möglich sein konnte. Ich konnte ihr nicht helfen, also war der einzige Weg die Scheidung.

Die örtliche Trennung, die hat dann wieder zu einem harmonischeren Umgang miteinander geführt. Auch mit den Bildern stellte sich bei mir dann wieder ein entspannter Umgang ein. Ich hatte auch schon mal gedacht, da müsste ich ihr irgendwann mal helfen, das einem größeren Publikum zu zeigen, da steckt einfach mehr drin, als dass es nur in irgendeiner Kammer eingeschlossen bleiben sollte. Durch all diese Umstände, durch diesen psychischen Kampf, den sie durchzustehen hatte, fast 20 Jahre lang, ist ihr eine normale berufliche Karriere verwehrt geblieben. Und auf dem Papier steht natürlich dann ein Leben, das man als voll gescheitert ansehen muss. Dass da auch etwas ist, was Anerkennung verdient, das habe ich durchaus jetzt auch gesehen und wahrgenommen. Und diese Bilder sind tatsächlich etwas, was auf der Habenseite steht.

Donata: Das Malen hat mir immer geholfen. Ich hab ja erzählt von diesem erhabenen Gefühl. Aber jetzt, mit den Medikamenten, wenn ich jeden Montag nachmittags zur Malstunde im sozialpsychiatrischen Zentrum gehe, dann male ich auch schöne Bilder, aber es ist irgendwie anders. Ich bin irgendwie nicht in dieser spirituellen Phase, in dieser Leichtigkeit des Seins.

Drei Jahre später – Köln im Frühjahr 2019

Donata: Es ist wirklich der Wahnsinn, was mir passiert. Hast du schon erzählt, Horst, von der Wohnung? Ich habe eine Kündigung bekommen. Wegen Brandstiftung und Belästigung. Das ist Wahnsinn! Das war Ende November letztes Jahr, da war ich wieder in der Psychiatrie, jetzt sind wir im April. Ich habe Briefe geschrieben und Stellung genommen. Seit viereinhalb Jahren wohne ich jetzt hier drin. Man kann in Köln keine Wohnung mehr finden, das hat sich total verschlechtert. Vor vier Jahren gab es immer noch Telefonnummern, da war nicht nur Besichtigung mit Email. Solange mir der Schlüssel nicht weggenommen wird, gehe ich nicht aus dieser Wohnung.

Für die Nachbarn bin ich die Verrückte aus der Klapsmühle, die sogenannte Stimmen hört, aber das sind nichts anderes als die Toten, die sich noch nicht verabschiedet haben von dem Planeten. Diese Stimmen, das machen die, also Verwandte, Bekannte, oder Verliebte oder Leute, mit denen du auch in der Vergangenheit zu tun hattest. Und die sprechen mit uns. Und bei mir ist das ein Wahn-

Abb. 6 Ohne Titel; entstanden 2017 beim Kreativen Gestalten im Sozialpsychiatrischen Zentrum.

sinn, was die damit anrichten. Und jetzt muss ich diese Scheiß-Medikamente nehmen. Ich werde überrumpelt, vom Diesseits und vom Jenseits. Das ist Wahnsinn! Aber jetzt ist alles okay. Ich habe auch hier die Leute aus dem Haus eingeladen, Kaffee zu trinken, aber es gibt ein paar Figuren, die wollen Drahtzieher spielen sozusagen. Die wollen mich aus dem Haus haben und machen den anderen Angst.

Horst: In den letzten drei Jahren war Donata etwa in einem halbjährigen Rhythmus immer wieder in der Psychiatrie für zwei, drei Monate, dann sechs Monate wieder raus und wieder zwei, drei rein, manchmal auch vier, das war also ein Kommen und Gehen. Im Haus haben Mietparteien den Eindruck gehabt, dass es zu außerordentlichem Lärm, zu Belästigungen gekommen ist. 2017 hatte ich ehrenamtlich für ein paar Monate die Betreuung übernommen, ich wurde dann angerufen, Leute aus dem Hause seien von Donata mit einem Messer bedroht worden. Ich wusste nicht, ob das stimmt. Ich kam gerade aus dem Krankenhaus und habe sie dann per Telefon und auch zu Hause nicht erreicht. Da ich selbst schon einmal eine Episode gehabt habe mit Donata, wo sie mich mit dem Messer bedroht hatte, wollte ich nicht dafür verantwortlich sein, dass irgendjemandem etwas passiert, da ich zu dem Zeitpunkt der Betreuer gewesen bin. Deswegen habe ich Bescheid gesagt, dass sie in die Psychiatrie soll. Danach habe ich dieses Amt sofort wieder abgegeben. Als Ex-Mann war ich einfach zu stark involviert. Das war too much. Das hat der Betreuer – bzw. genauer: das Betreuungsgericht – auch sofort eingesehen. Das war für mich ein echtes Dilemma. Und Donata war dann zwei Wochen extrem sauer. Aber dann hat sie eingesehen, dass ich in der Situation nicht anders hätte handeln können.

Donata: Die Nachbarn haben sich überhaupt nicht erkundigt, die haben nicht mal gewusst, dass ich Italienerin bin. Die haben gedacht, ich bin Flüchtling oder Türkin. Aber jetzt ist die Sache geklärt, von der Seite kommen jetzt keine Beschwerden mehr. Das war ein Missverständnis.

Horst: Missverständnis, ja, das kann man sagen. Es war einfach fremd, unbekannt, einerseits, dann abweichendes Verhalten andererseits. Das zusammen löst Ängste aus, dann bedarf es nur ein paar Momente, wie, dass du abends mal rumgelaufen bist über die Gänge.

Donata: Das habe ich nur einmal gemacht, Mann, das liegt vier Jahre zurück!

Horst: Ja, aus wenigen Momenten entsteht ein ganzes Gerüst aus Annahmen. Und am Ende stehst du dann da als jemand, der potentiell ein ganzes Gebäude gefährdet. Dann kommt es zu dem Brand und dann bist du jemand, der eine Brandstifterin ist, wie eine Hexe quasi, die alles mit sich in Brand steckt. Ich wurde von einer Mitbewohnerin, die sich als eine Art Concierge hier gebärdet, angerufen, weil Donatas Betreuer nicht zu erreichen war, und sie hat gesagt: „Kommen Sie, es brennt! Kommen Sie!" Und ich ras hier hin und dann war, also ich würde sagen, es war fast eine Lynchstimmung. Es haben sich andere vor mich gestellt, sonst wären mir die Leute an die Wäsche gegangen, so waren die außer sich. Mit Worten überhaupt nicht zu schildern. Wenn da nicht auch irgendwie Donatas Wohlergehen dran gehangen hätte, hätte ich einige Leute angezeigt wegen Beleidigung: Witzfigur, Arschloch, beschissener Typ, ich sei schuld daran, dass wir hier alle fast verbrannt sind usw. Das heißt, ich werde gerufen, komme hierher und bin plötzlich Schuld daran, dass es hier brennt. Da werden Sachen verknüpft, das ist unglaublich. Ich hatte wirklich das Gefühl: „Wenn du dich jetzt nicht hier vom Acker machst, hängen die dich hier noch auf!" Das waren Szenen wie im Film, was hier abging, Südstaaten in den USA.

Donata: Als ich hier eingezogen bin, gab es eine Kombispüle, einen Kühlschrank und zwei Platten zum Kochen. Das war aber eine alte Platte. Die Knöpfe waren so ausgeleiert, dass ich das nicht kontrollieren konnte, das heißt, es war nie klar, ist es wirklich ausgeschaltet oder nicht.

Horst: Du hattest, weil du wusstest, dass das schlecht kontrollierbar war, eigentlich immer drauf geachtet, den Stecker aus der Steckdose zu ziehen. Nur an dem Abend nicht, weil du stark übermüdest warst, sodass das, was da drauf war, ein paar Zeitschriften, in Brand geriet. Die Nachbarn haben das mitbekommen und jemand hat die Feuerwehr gerufen.

Donata: Ja, ich bin durch den Rauchmelder aufgewacht und hab dann den Stecker gezogen und dann war alles in Ordnung. Dann kam die Feuerwehr und hat die Tür eingeschlagen. Die haben nicht geklingelt, weil angeblich, wenn Brand ist, klingeln die nicht, sondern kommen sofort rein, weil sie Menschenleben retten müssen. Die Feuerwehr hat dann gesehen, dass alles in Ordnung war und ist wieder abgezischt.

Horst: Ich wurde angerufen: „Es schlagen Flammen aus dem Fenster!" Und dann komme ich hierher und es ist gar nichts. Drei, vier Magazine angekohlt, die ganze Küche ist noch weiß. Von Flammen überhaupt keine Spur. Als wenn die in einem anderen Film gelebt hätten. Unglaublich, wie sich so eine Masse aufputscht und Sachen behauptet, wovon dann vielleicht fünf Prozent stimmt.

Donata: Wahnsinn! Wahnsinn ist das! Und obwohl die Kripo eindeutig festgestellt hat, dass die Platten defekt waren, sagt der Typ aus dem Erdgeschoß neulich zu mir: „Ach, da kommt die Brandstifterin." Ich sag zu dem: „Wie bitte? Ich zeig Sie an wegen übler Nachrede!"

Horst: Es gab ja schon vorher so eine Stimmung. Donatas Schelle wurde regelmäßig beschmiert, unkenntlich gemacht, mit Nagellack und Spray oder was auch immer.

Donata: Ich traute mich schon gar nicht mehr nach Hause. Und jedes Mal guckte ich: Ist die Klingel beschmiert oder nicht?

Horst: Ich hatte Donatas Betreuer eine Woche vor dem Brand geschrieben, dass ich nicht glaube,

dass Donata jedes Mal daran denken kann, den Stecker rauszuziehen. Und dann meinte er hinterher: „Oh, ja, da hatten Sie ja recht." Ich sage ihm: „Ja, toll, das bringt jetzt auch nichts mehr!" Dieser Betreuer ist einfach ein lascher Typ, der den Weg des geringsten Widerstands geht. Der setzt sich nicht ein, springt nicht in die Bresche.

Donata: Der Typ ist steinreich, der hat ein ganzes großes Appartement und zwei Mitarbeiter. Der ist wirklich professionell. Das sind Leute, die haben Scheuklappen, gucken nicht links, nicht rechts, der hat vielleicht hundert Patienten oder so etwas, den interessiert das nicht. Das Gesetz sagt, wenn jemand die Gemeinschaft gefährdet oder sich selbst, dann muss er in die Psychiatrie. Und dann fragt der nie mich, sondern immer nur die anderen und glaubt denen.

Horst: Auf jeden Fall ist Donata nach dem Brand wieder in die Psychiatrie gekommen.

Donata: Die vom Roten Kreuz hatten mich mit ins Krankenhaus genommen. Zu Fuß. Die wollten mich die ganze Nacht dabehalten wegen CO2-Vergiftung. Aber nach einer halben Stunde habe ich gesagt: „Ich geh nach Hause!" Ich musste das dann unterschreiben. Klar, hab ich gemacht. Ich wollte dann in ein Hotel gehen. Am Ring wollte ich Zigaretten kaufen, ich habe mit einem 100 Euro-Schein bezahlt und gesagt: „Der Rest ist für Sie!" Ich wollte der Frau 100 Euro schenken, weil ich großzügig bin, wenn es mir gut geht. Dann hat die angefangen, zu schreien, dachte wohl, das ist falsches Geld und hat die Polizei gerufen. Und dann hat die Polizei mich gecatcht. Die haben mich an die Wand gedrückt und gefragt: „Woher haben Sie das Geld?" Ich meinte: „Ich hab das von meinem Konto. Sparkasse." Die Polizei ist so dämlich. Und dann sollte ich mitkommen. Ich hab gesagt: „Hör mal, ich geh jetzt nach Hause und zwar zu Fuß!" Und die meinten: „Nein, Sie gehen in die Psychiatrie!" Das ist alles. Dann haben die mich in die Psychiatrie gebracht, mich fixiert und mir zwei Spritzen gegeben.

Horst: Die Polizei hatte mich zwischenzeitlich angerufen und gefragt, wie deine Handynummer ist. Dann habe ich denen deine Handynummer gegeben.

Donata: Hast du mir gar nicht erzählt. Die haben mich auch nicht angerufen.

Horst: Doch, das hatte ich dir erzählt. Die haben die Handynummer genommen, um dich zu orten und dann haben die dich gefunden. Die können ja keine Nadel im Heuhaufen suchen. Es war ein Uhr in der Nacht. Das mit den 100 Euro war einfach nur ein äußeres Ereignis, das offenbar gar nicht damit zusammenhängt. Das heißt, die Polizei war aufgrund der Meldung, dass du potenziell gefährdet sein könntest, auf der Suche nach dir. Und dann haben die mich kontaktiert als Ex-Ehemann: „Wie ist die Nummer? Wir möchten sie orten." Dann habe ich auch erstmal kapiert, dass man dazu nur die Handynummer braucht. Und dann haben die dich über dein Handy geortet und waren zufällig in der Nähe als du diesen Streit hattest an diesem Kiosk. Mehr kann man dazu nicht sagen.

Donata: Das ist das erste Mal, dass nicht mein Betreuer mich in die Psychiatrie gebracht hat, sondern die Polizei.

Horst: Das sind die Ereignisse selbst, die dich darein gebracht haben.

Donata: Das ist Wahnsinn. Ich bin dann viereinhalb Monate in die Psychiatrie. Die haben mich gespritzt und drei Tage und drei Nächte fixiert. Ich wollte keine Medikamente und dann haben die gesagt: „Wenn du die Medikamente nicht nimmst, dann fixieren wir dich und tröpfeln dir das in den Mund." Ich wollte das nicht. Und dann haben die mich gezwungen, die Kacke zu schlucken. Drei Tage und drei Nächte. Haben mir Neuroleptika gegeben. Ich wollte das nicht. Warum sollte ich das nehmen? Dann krieg ich bestimmt Parkinson. Ich wusste Bescheid über die Nebenwirkungen. Und jetzt nehme ich diese Neuroleptika und nehme auch noch Medikamente, die die Nebenwirkungen von den Neuroleptika abschwächen. Und ich merke auch, seit ich meine Übungen wieder machen kann nach der Entlassung und mein Körper elastischer wird, dass ich die Nebenwirkungen im Griff habe. Aber das hat Monate gedauert. In dem psychiatrischen Zentrum, in das ich immer gehe, sind fast alle krank. Manche Leute haben Krebs, eine hat Parkinson, diese Medikamente

machen krank, und die sind alle tablettensüchtig. Ich nicht. Das ist mir gelungen durch meine Übungen und Bewegungen und kaltes und warmes Duschen nach Kneipp, was ich immer mache, wenn ich nicht in der Psychiatrie bin. Aber sobald ich in die Psychiatrie komme, ist das wieder vorbei. In der Psychiatrie wird man zermürbt. Wenn ich nochmal in die Psychiatrie gehe, schaffe ich das nicht wieder. Auch jetzt: Die Disziplin, die ich vorher hatte, hab ich nicht ganz wieder hingekriegt. Ich gehe nicht mehr in die Psychiatrie. Horst, du hast mir versprochen, mich da wieder rauszuholen.

Horst: Ich habe versprochen, dass ich Dir helfe, klar.

Donata: Ich weiß nicht, was ich machen soll, ich kenn das in- und auswendig. Und dann bin ich gezwungen diese Medikamente zu nehmen, die überhaupt nicht mit meinem Weltbild übereinstimmen. Das ist schlimm. Für mich ist Freiheit das Wichtigste. Und Demokratie auszuüben. Und gesund zu essen und Bewegung. Spazierengehen, Yoga, Dehnübungen. Aber mein Leben ist in den Händen von anderen, ob es mir gut geht oder schlecht geht. Wenn jemand in so eine Mühle kommt, da kommst du nicht mehr raus. Meine Diagnose lautet schizoaffektiv, das bedeutet, dass meine emotionale Psyche nicht funktioniert. Das ist keine Schizophrenie, das ist schizoaffektiv. Affekte bedeuten auch Liebe, Vertrauen und Zuverlässigkeit, das ist meine Diagnose. Wenn ich jetzt zu begeistert bin für manche Leute, die Typen die mich nie kennengelernt haben, die nehmen an, dass ich in einer manischen Phase bin und dass danach die Depression kommt. Ich bin jetzt bipolar, das ist die Diagnose. Aber das ist normal, dass eine Begeisterte auch Traurigkeit empfindet. Unzurechnungsfähigkeit ist eine veraltete Scheiße. Und ich komme aus dieser Scheiß-Diagnose nicht mehr raus. Wenn der Scheiß wiederkommt, dann muss ich mehr Medikamente nehmen und die glauben dann, dass das abgeschwächt wird. Ich bin dann in den Händen von diesen psychischen Mördern. Die Menschen werden so schlecht behandelt in der Psychiatrie. Und dann dieser Fraß! Meine Ernährung wird unterbrochen, meine Übungen werden unterbrochen, ich bin nur ein Wrack. Und du hast überhaupt keinen Freiraum für dich, bist immer mit anderen Leuten in einem Raum, es ist immer jemand bei dir. Da kannst du nicht schlafen, das ist Wahnsinn, was da passiert. Obwohl es eigentlich gute Gesetze gibt, die uns schützen. Aber die Ärzte haben immer das letzte Wort, wie üblich. Und auch die Richter sind total bekloppt. Die müssen in die Psychiatrie, nicht ich. In Italien zum Beispiel gibt es nur 14 Tage Psychiatrie. Nach 14 Tagen schicken sie dich wieder nach Hause. Und in Süditalien gibts überhaupt keine Psychiatrie, nur in Norditalien. Und die, die sich etwa übersteigert verhalten, ja, wir haben zusammen gelacht, auch als Kind haben wir gelacht, aber die müssen nicht in die Psychiatrie. Und wenn man traurig ist, dann ist das die Melancholie, weil wir auch griechisch geprägt sind, von wo ich stamme. Und die Griechen waren immer ziemlich melancholisch, die haben Gemütskrankheit, das ist aber kein Fall für die Psychiatrie. Ich mein, ich bin nicht anders als ich gewesen bin, oder Horst?

Horst: Wie meinst du?

Donata: Als du mich kennengelernt hast: bin ich nicht die Gleiche wie damals?

Horst: Also, im Sinne vom Temperament oder so: selbstverständlich. Da hat sich keine Änderung ergeben.

Donata: Siehste, aber die denken, sie ist manisch. Also, wenn ich jetzt Begeisterung zeige, machen die sich Sorgen, dass ich wieder in einer manischen Phase bin. Ich weiß nicht, wie diese Scheiße entstanden ist. Das ist Wahnsinn. Mir sind die Hände gebunden. Alle sechs Monate bringt mein Betreuer mich in die Psychiatrie. Der macht alles, was er will. Auch mit meinem Konto: statt mich mal vorher anzurufen, überweist der einfach alles. Ich sollte jetzt Nebenkosten zahlen, 2000 Euro. Das ist Wahnsinn, sowas hatte ich noch nie. Ich bin total sparsam die ganze Zeit und jetzt habe ich kein Geld mehr. Der hat das einfach alles bezahlt, statt dem mal auf den Grund zu gehen und wirklich zu gucken, wieviel ich verbraucht habe. Er bezahlt einfach, statt das anzufechten. Niemand ist auf meiner Seite.

Horst: Das ist wirklich nicht nachvollziehbar, warum das nicht angefochten wird. Es ist auf Anhieb zu erkennen, dass das ein unmöglicher Verbrauch ist bei den wenigen Gegenständen in der Wohnung, die Strom verbrauchen können. Da bräuchte man einen ganzen Fuhrpark, um das zu erreichen.

Donata: Dieses Jahr habe ich den Betreuer seit fünf Jahren. Nach fünf Jahren fragt der Richter, ob man den behalten will. Ich werde sagen, dass ich einen anderen will. Also, wenn einer abgestempelt wird als psychisch krank, da kommst du nicht mehr raus aus diesem Scheißdreck. Ich bin empört, wie ich behandelt werde, ich habe ein gewisses Temperament, aber ich bin ein friedlicher Mensch. Und jetzt kündigt mir die Verwaltung auch noch die Wohnung, weil ich angeblich Leute belästige und die Nachbarn sich beschwert haben.

Horst: Es war wohl vor allem das Ereignis mit dem Feuer, was wahnsinnig aufgebauscht wird, wo im Prinzip gar kein Feuer war. Aber durch so ein bisschen Papier ist Rauch entstanden und das war dann der ausschlaggebende Moment: Okay, das Maß in Anführungszeichen ist voll, jetzt wird gekündigt. Das war genau vor einem Jahr.

Donata: Das sogenannte Brandereignis war am 23. März. Die Kündigung kam in der Woche, als ich in der Psychiatrie war. Ich habe das erst drei Monate später erfahren. Ich war total geschockt.

Horst: Jetzt erinnere ich mich wieder. Dein Betreuer hatte mich angerufen: „Ich habe da jetzt die Kündigung von dem Vermieter, ich glaube aber, jetzt ist sie nicht in der Lage, das auszuhalten, zu erfahren. Ich werde erstmal gucken, wie die Entwicklung so läuft, bevor ich es ihr sage."

Donata: Ja, toll, ey. Und ich erfahre das dann später und frage: „Was sind denn die Gründe für die Kündigung?" Sagt er: „Belästigung und Brand." Ich: „Wie bitte?" Jemand hat sich bedroht gefühlt mit einem Messer. Ich kannte den überhaupt nicht.

Horst: Auf jeden Fall gab es diese Kündigung und Donata hat dann zusammen mit einer Rechtsanwältin Einspruch erhoben und seitdem ist nichts mehr passiert. Die Frist für die Räumungsklage ist seit fünf Monaten verstrichen. Die Anwältin hat das wohl so formuliert, dass eine Reihe von den Dingen, die ihr vorgeworfen wurden, nicht haltbar sind und dass die Schellen beschmiert waren und du dadurch in Angstzustände versetzt warst. Das war ein Beleg dafür, dass diese Parteien, die hier Protest eingelegt haben gegen dein angebliches asoziales Verhalten im Vorfeld selbst viel asozialer agiert haben. Und das war eine Tatsache, die dein Betreuer nie ins Feld geführt hatte, um dich zu verteidigen, obwohl ich ihm das mehrfach gesagt hatte. Das ist dann zum ersten Mal von deiner Anwältin aufgerufen worden. Ich denke mal, das hat dann die andere Seite, die dir das vorgehalten hat, ihrerseits überprüft und gesehen, das ist ja gar nicht eindeutig und von daher denke ich mal, dass die Aussichten auf Erfolg einer Räumungsklage nach den neuen Tatsachen, die dann bekannt wurden, als zu gering eingeschätzt wurden. Aber es ist ein Schwebezustand momentan. Auch deine Position.

Donata: Schlimm, schlimm, die Menschheit. Aber trotzdem, man muss immer weitergehen und versuchen, den schönen Planeten zu retten, vielleicht werden unsere Kinder das machen, aber auch wir haben Verantwortung. Wir müssen den Planeten sauber übergeben. Hoffentlich ist die Kacke-Scheiße mit dem Atom und der Kohle bald mal vorbei. Und dann die Massentierhaltung. Ich habe Berichte gesehen im Fernsehen, wie die Tiere gehalten werden. Das ist schlimm. Wir fressen auch die Angst. Und dann die Vergiftung der Böden. Holland und Spanien, da muss man schon aufpassen, die haben keine Bewusstsein, die schmeißen so viel auf die Äcker. Und in Deutschland leider auch, das tut mir so leid.

Horst: Jetzt ist es zum ersten Mal so, dass Donata ohne Unterbrechung seit einem Jahr keine Psychiatrie gesehen hat. Sie hält die Medikation ein und es kommt auch jemand morgens vorbei, mit dem sie auch noch zusätzlich spricht. Es gibt praktisch drei betreuende Instanzen: Zum einen der gesetzliche Betreuer, dann diese Gruppierung, die morgens die Einnahme der Tabletten kontrolliert und drittens die Einrichtung, die sich Betreutes Wohnen nennt, wo Teile der Personen auch im Sozi-

alpsychiatrischen Zentrum tätig sind. Einmal die Woche kommen die auch zu ihr nach Hause.

Donata: So kontrollieren die mich.

Horst: Ja, quasi Kontrolle.

Donata: Ist schon fast wie im Polizeistaat.

Horst: Auf jeden Fall denke ich mal, dass die Chancen gut stehen, dass es ohne Psychiatrie weitergehen kann. Malen tust du allerdings kaum noch.

Donata: Im Psychosozialen Zentrum sowieso nicht mehr, weil da werden wir belehrt. Das mach ich lieber zuhause. Aber nur ein paarmal in den letzten Jahren, da ist nicht mehr viel gekommen. Meine Malerei ist da im Schrank säuberlich aufgehoben. Die Sache mit der Malerei ist eine Tragödie, weil ständig, jeden Tag etwas malen können, wäre gut, aber die unterbrechen mir alles, mein ganzes Leben. Und das hat mich so geschmerzt, dass ich gesagt habe: „Ihr könnt mich alle am Arsch lecken, ich muss nur überleben." Ich habe weniger Einfluss auf mein Leben, weil die Scheißdiagnose an mir klebt. Angeblich ist meine emotionale Sphäre immer noch schlimm, ist nicht ganz in Ordnung, aber inzwischen habe ich das selbst überwunden. Dabei hat mir niemand geholfen. Auch Psychotherapie: das bringt überhaupt nichts. Ich habe eine bestimmte Stimme, wenn ich die erhebe: Oh Mann, sind die Deutschen so empfindlich, oder was? So mimosenhaft? Was soll ich machen, soll ich mir die Stimme rausreißen? Ich habe immer Schwierigkeiten gehabt mit meiner Stimme.

Horst: Ja, das ist die Sache mit der Fremdheit, damit können viele nicht umgehen.

Donata: Was ich am Ende nochmal klarstellen wollte: Ich höre die Toten, aber weiß immer, was ich tue. Ich bin nicht besessen. Das ist telepathisch. Ich habe Leute gesehen, die besessen sind, das ist was ganz anderes. Am Anfang habe ich viel Angst gehabt. Ich habe Wörter gesagt, die ich nie benutzt habe, wo ich dachte, jetzt bin ich wirklich verrückt. Aber das kam von denen. Und das ist das. Die Toten, gut oder schlecht, ist ja scheißegal, manche haben auch Angst, die wissen nicht einmal, dass sie tot sind und denken: „Irgendwann wach ich wieder auf." Aber ich bin nicht besessen. Aber auch der Kontakt zu den Toten ist weniger geworden. Ab und zu höre ich noch etwas in der Luft. Ich war gestern zwischen schlafen und wachen und dann hatte ich den Eindruck, jemand kommt durch die Tür. Ich mache die Tür zu, wenn ich schlafe. Und dann habe ich das Licht angemacht, aber es war niemand da. War vielleicht etwas übersteigert. Ich bin ein Medium, aber ich will das nicht, weil die Toten müssen auch selbständig zurechtkommen. Und die Medien werden nur verarscht und das ist eine Sauarbeit. Und in der Psychiatrie versteht das natürlich auch keiner. Das ist immer noch so. Ich habe auch einen schüchternen Versuch gemacht, die Situation zu klären. Und die haben gesagt: „Nee, Sie sind in einer Wahnvorstellung." Für die ist das Bipolarität, das ist nicht real. Die glauben nichts, denn tot ist tot und nicht mehr. Ich kann erzählen, was ich will: dass wir einen feinstofflichen Körper haben und so weiter, damit komme ich nicht durch. Ich glaube sehr fest daran, dass man die Leute wieder trifft, mit denen man in vergangenen Leben zu tun hatte. Ich muss jetzt leben, ich muss mich daran gewöhnen, von Tag zu Tag zu leben. Bald werde ich 70 und da kann es auch jeden Tag passieren, dass ich mich verabschiede. Wenn der Tod näher kommt, dann gibt es mehr Angst davor, aber ich habe überhaupt keine Angst. Ich will nur niemanden treffen, der mich erst belästigt hat. Aber normalerweise, wenn einer dich liebt, dann trifft man sich wieder. Und ich glaube, dass es Seelenverwandtschaft gibt. Mit Horst beispielsweise habe ich Seelenverwandtschaft. Mit meinem Betreuer nicht, aber mit dem vom Betreuten Wohnen schon, mit dem verstehe ich mich sehr gut. Ich glaube schon, dass wir uns wiedersehen. Und wenn mir jemand sagt: „Die können mich in eine Orangenkiste reintun, wenn ich gestorben bin, dann bin ich in Frieden", dann kann ich nur sagen: „Okay, der wird sich noch umgucken!" Wir sind nach dem Tod genauso, wie wir jetzt sind. Der Geist zählt mehr als der Körper, ist fast ewig. Aber wenn der Planet im Arsch ist, wo sollst du dann einen neuen Körper finden? Das ist auch eine Frage. Irgendwann geht das auch auf die Nerven mit dem feinstofflichen Körper.

ZUSAMMENFASSUNGEN
ABSTRACTS
RÉSUMÉS

Zusammenfassungen der Beiträge der *Curare* 42 (2019) 3+4

Ästhetiken des Heilens. Sinnesarbeit im Thearpeutischen Kontext

HERAUSGEGEBEN VON HELMAR KURZ

Editorial von Die Redaktion S. 3, verfasst auf Englisch

Inga Scharf Da Silva: Eigen-Sinnig: Prolog, S. 7–10, verfasst auf Deutsch und Englisch

Helmar Kurz: Sinnlichkeit in Gesundheit, Fürsorge & Medizinanthroplogie. Einleitung in den Themenschwerpunkt Ästhetiken des Heilens: Arbeit mit den Sinnen im therapeutischen Kontext, S. 13–26, verfasst auf Englisch

Graham Harvey: Animistische Perspektiven auf Gesundheit und Heilung. Keynote, S. 27–34, verfasst auf Englisch

Cathy Fournier & Robin Oakley: Raum für das „Heilige" in der Krebstherapie. Integration Indigener Medizin ins Gesundheitswesen, S. 35–48, verfasst auf Englisch

Das Konzept einer *Indigenous First Voice* wird zum Zwecke eines *Two-Eyed Seeing* („Etuaptmumk") herangezogen, um sich einer Integration Indigener Therapieformen in die Gesundheitsversorgung Kanadas anzunähern. Ähnlich einer Autoethnographie stellt dieser Ansatz individuelle Erfahrung und Wissen in den Fokus der Analyse, wobei ursprünglich vergessenes, verzerrtes oder diskriminiertes Wissen an die Oberfläche geholt wird. Insbesondere beziehen wir uns auf Fournier's Beschreibung einer kürzlichen Krebserkrankung und ihrer Erfahrungen als *Métis*-Frau. Es werden Spannungen aufgezeigt, die einer Aushandlung bedürfen, um nicht von einem dominanten biomedizinischen Verständnis von Gesundheit und Wohlbefinden absorbiert zu werden. Wir stellen ihre sinnlichen Erfahrungen beim Gebrauch Indigener Heilpraktiken und der Biomedizin in der Krebstherapie gegenüber und argumentieren für die Rahmung einens dynamischen, multiperspektivischen Prinzips des *Two-Eyed Seeing/Etuaptmumk*.

Schlagwörter – Krebs – Indigene – Etuaptmumk – Two-Eyed Seeing – Ureinwohner – biomedizinischer Dualismus – Kritische Medizinanthropologie – Ästhetiken des Heilens

Andrew R. Hatala & James B. Waldram: Maya Cosmovision. Formative Prozesse therapeutischer Ästhetik, Moral und Praxis bei den *Q'eqchi',* S. 49–63, verfasst auf Englisch

Im Laufe der Geschichte haben Individuen und Gemeinschaften komplexe Weltsichten entwickelt, auf deren Basis lokale Ökologien, Geschichtsschreibung, Sprache und Interaktionen mit benachbarten Kulturen entstanden. Um sich zeitgenössischen Praktiken der *Q'eqchi'* Maya-Heiler anzunähern, beschreibt dieser Artikel zwei „formative Prozesse" bzw. „Interpretationszugänge" innerhalb der *Q'eqchi'* cosmovision: die Beziehung zu den Bergen und Tälern und eine moralische Ökonomie der „Erlaubnis." Diese Aspekte beeinflussen die medizinische Realität der *Q'eqchi'* Maya und ihrer Interpretation, genauer Konzeptionen von Krankheit, Gesundheit und medizinischer „Objekte" der Maya-Heiler. Auf Basis einer detaillierten Fallstudie im Rahmen einer zehnjährigen ethnographischen Feldforschung in Süd-Belize beschreibt dieser Artikel zeitgenössische Weltsicht und Ethos als Aspekte einer medizinischen Realität über die Beziehungen von Patienten und Heilern hinaus, nämlich auch zu Geistern und lokalen Ökologien, und einer moralischen Ästhetik von sozialer und spiritueller Relevanz.

In diesem Kosmos-zentrierten therapeutischen Rahmen können wir das *Q'eqchi'* Maya Wissen besser begreifen, sowie inwiefern ästhetische Ansätze therapeutischer Begegnungen Ursachen von Leiden externalisieren und personifizieren.

Schlagwörter – Indigenes Wissen – Q'eqchi' Maya – Moral – Heilung – Ethnographie

Johanna Kühn: *Licht-Sehen*. Heilung in einem Meditationskurs in Beirut, S. 65–78, verfasst auf Englisch

Der Artikel verbindet die „sensorially engaged anthropology" (Nichter 2008) mit der Analyse von zeitgenössischen spirituellen Praktiken im Nahen Osten. Auf der Basis von zehn Monaten ethnografischer Forschung in Beirut werden die körperlich-sinnlichen Empfindungen von Teilnehmer*innen eines Meditationskurses sowie das damit verbundene Verständnis von Heilung analysiert. Die Autorin zeigt, dass der zentrale Aspekt der Meditationspraxis, die Empfindung von *seeing lights*, dazu dient auf körperlich vermittelte Art und Weise Selbstliebe zu erleben und zu erlernen. Die Fähigkeit zur Selbstliebe ist demnach zentral für den Heilungsprozess. Aus der Sicht der Meditationsteilnehmer*innen besitzt nur eine sich selbst liebende Person die Fähigkeit, das Leben gemäß individuellen Vorstellungen zu gestalten und somit schwierige Lebenssituationen zu überwinden. Die Auffassung von Heilung als Erlangung individueller Handlungsmacht („agency") spiegelt hierbei Bestrebungen der vorwiegend weiblichen Mittelklasse-Libanes*innen wider. Besonders vor dem Hintergrund der ökonomischen Krise im Libanon ist das Ansinnen ein selbstbestimmtes Leben zu führen von zentraler Bedeutung für die Teilnehmer*innen. Der Wunsch nach Selbstbestimmung umfasst hierbei eine Balance zwischen Autonomie und Individualität und sozialer Eingebundenheit zu finden. Darüber hinaus verdeutlicht der Beitrag nicht nur, dass der analytische Fokus auf körperlich-sinnliche Empfindungen ein tiefergehendes Verständnis unterschiedlicher Heilungspraktiken und -vorstellungen ermöglicht. Die Analyse des Meditationskurses zeigt auch, dass in der repetitiven Körperpraxis jene Werte reproduziert und bekräftigt werden, die die Vorstellungen der Teilnehmer*innen von einem erstrebenswerten Leben speisen.

Schlagwörter – Sensory Anthropology – Meditation – Heilung – Libanon – Handlungsmacht – Mittelklasse – Individualität – Autonomie

Tessa Bodynek: Verhandlung des Selbst. Ästhetiken und Verkörperung spiritueller Medialität und Heilung in der brasilianischen Umbanda, S. 79–91, verfasst auf Englisch

Die Inkorporation und somit die Einverleibung spiritueller Geistwesen ist ein integraler Bestandteil der Rituale sowie der Kosmologie der *Umbanda*. In diesem Zustand nähern sich die sogenannten *guias* (spirituelle „guides") oder *orixás* (afro-brasilianische Gottheiten) den Medien der jeweiligen *Umbanda* Gruppe bis diese sie einverleiben und in ihr Bewusstsein aufnehmen. Sinneseindrücke vor, während und nach dieser Erfahrung geben Aufschluss über Hintergründe und persönliche Verbindungen zu den spirituellen Entitäten. Darüber hinaus ist die Wahrnehmung von emotionalen Reizen, die im Körper des Mediums entstehen, im Zusammenhang mit der Inkorporation relevant. Zusammen mit der inkorporierten Entität geben die Medien Rat, helfen, segnen oder heilen Hilfesuchende, die häufig selbst keine Mitglieder der Umbanda sind. Dieser Artikel untersucht die Rolle eines verkörperten Heilens (*embodied healing*) und die Ästhetik des Medium-Seins (*aesthetics of mediumship*) vor dem Hintergrund der Anthropologie der Sinne. Neben der Untersuchung gelebter Sinneserfahrungen lässt dieser Artikel die Mitglieder der spezifischen *Umbanda* Gruppe in der brasilianischen Metropole São Paulo zu Wort kommen, in der ich meine ethnographische Feldforschung durchführte. Meine Forschungstätigkeit fand in der spirituellen Gemeinschaft *Tenda de Umbanda Caboclo de Oriente* (TUCO) statt. Hierbei konzentrierte ich mich auf die Anwendung ethnographischer Methoden, wie teilnehmende Beobachtung und formelle als auch informelle Interviews sowie persönliche Gespräche mit verschiedenen Mitgliedern der Gruppe. Das Beispiel, auf welches ich mich mit meiner Forschung beziehe, stellt lediglich eine Form vieler unterschiedlicher Formen zeitgenössischer urbaner *Umbanda* Praktiken dar. Dennoch ist es besonders relevant im Kontext des akademischen

Diskurses und fügt der bestehenden Forschung über die Vielfalt spiritueller Gemeinschaften in Brasiliens Metropolen eine weitere Ebene hinzu. Dieser Artikel erstellt damit eine Verbindung zwischen der Kosmologie und Heilung in der *Umbanda* und der brasilianischen Gesellschaft, in der die Religion entstanden ist und sich ständig reproduziert. Dafür verbindet er zeitgenössische Theorien und Debatten über die *Anthropologie der Sinne* und die *Ästhetik des Heilens* mit dem Wissen und der Praxis der *Umbanda* und den persönlichen Erfahrungen meiner Gesprächspartner*innen.

Schlagwörter – Spirituelle Heilung – Gesundheitswesen – Sinne – Selbst – Emotion – Verkörperung – Religion – Medizin

Sabrina Del Sarto & Esther Jean Langdon: Subjektive Heileffizienz bei Langzeitbewohnern eines spiritistischen Asyls, S. 93–106, verfasst auf Englisch

Dieser Artikel basiert auf einer ethnographischen Untersuchung der sozialen Einbindung von Langzeitpatienten in einer spiritistischen Psychiatrie im Inneren des brasilianischen Bundesstaats São Paulo. Er konzentriert sich auf deren Teilnahme/-habe innerhalb eines *passe* genannten spirituellen Heilrituals. Wir beschreiben erzwungene alltägliche Routinen und damit einhergehende teils unfreiwillige soziale Beziehungen, um aber auch individuelle Handlungsmacht bzgl. des Ausdrucks eigener Wünsche und Überzeugungen zu eruieren. Obwohl die Patienten in einem eher offenen Bereich mit eigenen Wohneinheiten untergebracht sind, ist ihr Leben von Erfahrungen und Praktiken der Institutionalisierung durchzogen, beispielsweise in Form obligatorischer religiöser und therapeutischer Routinen inklusive moralischer Bewertungen ihres Handelns.
Auf Basis unseres ethnographischen Materials untersuchen wir soziale Praktiken im Kontext einer innerhalb der Krankenhausroutine aufgezwungenen normativen Ordnung bzgl. Medikation und spiritistischer Praxis. Anstatt sich in die rituelle Performanz der *passe* aktiv einzubringen, widersetzen sich viele Patienten durch Manifestationen eigener Ziele und Wünsche, welche durch Langzeit-Internierung, Medikalisierung und obligatorische Teilnahme an Ritualen oftmals unterdrückt werden.

Schlagwörter – Geisteskrankheit – Institution – therapeutische Praktiken – Subjektivität – Spiritismus

Shirley Chubb, Ann Moore, Neil Bryant, Kambiz Saber-Sheikh: Das „Significant Walks" Projekt. Ästhetische Verknüpfung von Gang, Technologie und Ort, S. 107–120, verfasst auf Englisch

Dieser Artikel beschreibt das Forschungsprojekt *Significant Walks* (2014), welches sich dem Zusammenhang von Gang und chronischen lumbalen Rückenschmerzen (CLBP) widmet. Ein interdisziplinäres Forschungsteam fokussiert die Zusammenarbeit mit Patienten, um zu dokumentieren, wie die Praxis individueller Spaziergänge und Wanderungen als Maßstab bzw. Marker physischer und psychischer Erfahrung Erfahrung gelesen werden können. Methodologisch kombiniert das Projekt Videodokumentationen dieser Gangerfahrungen bei simultaner Erhebung biomechanischer Daten und individueller Narrative. Verschiedene Visualisierungsformen werden herangezogen, um auch herauszufinden wie ästhetische Interpretation und Erfahrung korrelieren. Die zusätzliche Erhebung biomechanischer Daten bringt interozeptive, visuelle und narrative Erfahrung im Kontext von Ort, Bewegung und Sinneswahrnehmung zusammen.
Mit Fokus auf die Bedeutung einer Erfahrung der Wirklichkeit, geht das Projekt heraus aus den Laboren und Kliniken um der veränderten Wahrnehmung von CLBP-Patienten innerhalb ihrer Umwelt und alltäglichen Praxis Rechnung zu tragen. Der methodologische Ansatz rückt die ästhetische Interpretation der Teilnehmer ins Zentrum der Agenda eines Zusammenspiels von Kunst, Gesundheit, Phänomenologie und Neuem Materialismus. Diese Überschneidung wird kommuniziert durch individuelle Filme als Zeugnis der Konnektivität von Erfahrung, Ort, Materilaität, Technologie und Umwelt.

Schlagwörter – Kunst & Gesundheit – Visuelle Kunst – Physiotherapie – Phänomenologie – Neuer Materialismus

Hannah Drayson: Bis zum Bitteren Ende. Affekt, Erfahrung und chemische Ökologie, S. 121–130, verfasst auf Englisch

Dieser Artikel widmet sich dem Geschmackssinn in seiner Gesamtheit chemischer, gustemologischer und affektiver Qualitäten und der Frage, wie wir mit „bitterer Erfahrung" umgehen. Er schlägt einen Ansatz einer Perspektive auf das Zusammenspiel menschlicher Affekte und chemischer Ökologie vor, und damit der Kohärenz von sinnlicher und emotionaler Wahrnehmung von Bitterheit/-keit.
Zwei Beobachtungen stützen diese Herangehensweise. Erstens entspricht eine ambivalente Reaktion bitteren Geschmacks einem kulturellen Idiom, dass Medizin bitter zu sein habe, aber auch die Schwester eines tödlichen Gifts sei; zweitens, dass Pflanzen durch Geschmack mit anderen Lebensformen interagieren, und dass es gerade die bitter-schmeckenden sind, die hier von besonderer Bedeutung sind. Diese Metabolismen sind tief verankert in menschlicher Physiologie und Kultur. Der Gebrauch bitter schmeckender Pflanzen in Nahrung und Medizin bedarf eines spezialisierten und technischen Wissens bzgl. Identifizierung, Verarbeitung und Dosierung – eine Anforderung die in vergleichbarer Weise weltweit und in verschiedensten Epochen artikuliert wird. Viele kulturelle Traditionen kennen die Assoziation von Bitterheit/-keit, Erinnerung, Wissen und Heilung. Ähnliche Herangehensweisen suggerieren einen Zusammenhang ökologischer und affektiver Qualitäten innerhalb des Phänomens der Bitterheit/-keit.

Schlüsselwörter – Bitterheit – Bitterkeit – Medizin – Geschmack – Affekt – Erfahrung

Dirck Van Bekkum: Zusammen Übergangsräume schaffen und bewegt sein. Eine Exploration der Grenzgebiete Pluralistischen Heilens und Therapeutischer Kontexte, S. 131–144, verfasst auf Englisch

Natalie Harriman: Homöopathische Ansätze als Annäherung an das Ganze. Wie beeinflussen sie unser Konzept von Heilung? S. 145–155, verfasst auf Englisch

Paul Dieppe: Die Bedeutung des Pluralismus im modernen Gesundheitswesen. Placebo-Effekt, Milieu und Kunst in der Heilung, S. 157–165, verfasst auf Englisch

Anja Lüpken: Ästhetisch-Verkörperte Imagination im Tamalpa Life/Art Process®, S. 167–182, verfasst auf Englisch

Svea Lindner: Forschung mit den Sinnen. Phänomenologisches Vorgehen bei der Erkundung des *Vimbuza* Heiltanzes in Malawi, S. 183–193, verfasst auf Deutsch

Article Abstracts of Curare 42 (2019) 3+4

Aesthetics of Healing. Working with the Senses in Therapeutic Contexts

EDITED BY HELMAR KURZ

Editorial by The Editorial Team p. 3, written in English

Inga Scharf da Silva: With my own Senses: Prologue, p. 7–10, written in German & English

Helmar Kurz: Sensory Approaches in Health, Care and Medical Anthropology. Introduction to the thematic focus on the Aesthetics of Healing: Working with the Senses in Therapeutic Contexts, p. 13–26, written in English

Graham Harvey: Animist Contributions to Rethinking Wellbeing and Healing: Keynote, p. 27–34, written in English

Cathy Fournier & Robin Oakley: Creating Space for the "Sacred" in Cancer Care. Integrating Indigenous Medicines into Health Care, p. 35–48, written in English

Indigenous First Voice is utilized to explore the *Two-Eyed Seeing* ("Etuaptmumk") principle to theorize the integration of Indigenous medicines into health care in Canada. Similar to autoethnography, Indigenous First Voice positions the experiences and knowledge of the researcher at the heart of the analysis, while bringing formerly erased, contorted and stigmatized knowledges to the fore. In particular we draw on Fournier's account of a recent cancer experience and exploration of her experiences as a *Métis* woman to illustrate tensions that require negotiation in order to avoid being absorbed into a dominant biomedical way of understanding health and wellness. We juxtapose her sensory experiences of using Indigenous healing alongside biomedicine for cancer care and call for a dynamic, multi-eyed seeing framework which more accurately captures the nature of the *Two-Eyed Seeing/Etuaptmumk* principle.

Keywords – cancer – Indigenous – Etuaptmumk – Two-Eyed Seeing – aboriginal peoples – biomedical dualism – critical medical anthropology – aesthetics of healing

Andrew R. Hatala & James B. Waldram: Maya Cosmovision. Exploring Formative Processes of *Q'eqchi'* Medical Aesthetics, Morality, and Healing Practice, p. 49–63, written in English

Throughout history, individuals and communities have developed complex cultural visions of the world around them shaped by local ecology, history, language, and interactions with neighboring peoples and their ways of life. To better understand, interpret, and appreciate the contemporary healing practices of Q'eqchi' Maya healers, this article describes two "formative processes" or "interpretive activities" of Q'eqchi' cosmovision: a relationship to the Mountains and Valleys; and a moral economy of permission. Each of these aspects influence the interpretive structures of Q'eqchi' Maya medical reality and thereby shapes Q'eqchi' conceptions of illness and health and the medical "objects" to which traditional Maya healers attend. Through a detailed case study drawn from over ten years of ethnographic fieldwork with Q'eqchi' Maya communities in Southern Belize, this paper outlines a contemporary worldview and ethos where aspects of medical reality are spread out beyond interactions between patients and healers to include vital relationships with the spirits and local ecologies, aesthetic moralities of social and spiritual significance. In this "cosmic-centered" therapeutic framework, we can appreciate more fully how Q'eqchi' Maya knowledge and aesthetic ways of being shape contemporary therapeutic encounters in ways that externalize and personify the source of affliction and suffering.

Keywords – Indigenous knowledge – Q'eqchi' Maya – morality – healing – ethnography

Johanna Kühn: Seeing Lights. Healing in a Meditation Class in Beirut, p. 65–78, written in English

This article links "sensorially engaged anthropology" (Nichter 2008) to the research of contemporary spiritual practices in the Middle East by exploring the notion of healing among practitioners of a meditation class in Beirut. Based on ten months of ethnographic research, participants' sensory processes during the meditation class are analysed. The author shows how the central aspect of the practice, the sensation of *seeing lights*, can be understood as a bodily mediated attempt to learn and experience love for oneself. This attitude was the basis for healing, as from the practitioners' perspective only a self-loving individual could possess the ability to build

a life according to one's wishes and thus heal from difficult life situations. In this way, the practice proposed a notion of healing as the acquisition of individual agency that reflected the aspirations of the primarily female and middle-class practitioners. Particularly against the backdrop of the recent economic crisis in Lebanon, efforts to build a self-determined life—one that balanced the drive for autonomy and individuality with the need for embeddedness in the social environment—played a central role in the practitioners' lives. More broadly, the article demonstrates that focusing on the sensory experiences of those involved in healing practices not only enables a better understanding of how people manage to "become better," but also draws attention to the fact that repetitive learning and experience of sensations are the means by which contemporary spiritual practices (re)produce and reaffirm distinctive values centred around the question of how to live one's life.

Keywords –sensory anthropology – meditation – healing – Lebanon – agency – middle class – individuality – autonomy

Tessa Bodynek: Negotiating Self. Aesthetics of Mediumship and Embodied Healing in Brazilian Umbanda, p. 79–91, written in English

The incorporation of spiritual entities is an integral element of *Umbanda* rituals and cosmology. In this state, mediums are approached by spiritual entities, such as the so called *guias* ("spiritual guides") or *orixás* (Afro-Brazilian deities). Subsequently, the mediums are incorporated by them. Sensory impressions before, during and after this period cast light on underlying circumstances and personal connections to these spiritual entities. Moreover, the perception of emotional stimuli developing in the medium's body is relevant in the context of incorporation. Together with the incorporated entity, mediums give advice, help, bless or heal their consultants; many of whom are not themselves *Umbandists*. This article examines the role of embodied healing and the aesthetics of mediumship from the perspective of an *anthropology of the senses*. In addition to the examination of lived sensory experiences, this article gives a voice to the members of the specific *Umbanda* group in the Brazilian metropolis of São Paulo, where I conducted ethnographic fieldwork. I carried out my research activities in the spiritual community *Tenda de Umbanda Caboclo de Oriente* (TUCO), focusing on ethnographic methods such as participant observation and formal as well as informal interviews, plus personal conversations with various members of the group. The example I refer to of the many different forms of contemporary urban *Umbanda* practices is particularly relevant within the context of academic discourse, adding another layer to the existing research on the wide variety of spiritual communities in Brazil's metropolises. As an implicit add-on, this article draws a line between the *Umbandist* cosmology and healing practices and the society in which the religion emerged and constantly is reproduced. It connects contemporary theories and debates concerning the *anthropology of the senses* and *aesthetics of healing* with *Umbanda* knowledge and practice, and the personal experiences of my interlocutors.

Keywords – spiritual healing – health care – senses – self – emotion – embodiment – religion – medicine

Sabrina Melo Del Sarto & Esther Jean Langdon: Healing Efficacy and Subjectivity among Long-Term Residents in a Spiritist Asylum, p. 93–106, written in English

The article presents an ethnography of the social life of permanent residents interned in a Spiritist psychiatric hospital in the interior of the State of São Paulo (Brazil), focussing their participation in a "healing ritual" known as *passe*. It describes the ways of living and sociabilities that emerge in a compulsory daily routine, in order to identify agency and expressions of subjectivities and desires. Although they are in a hospital wing composed of individual residences, institutionalisation is a major characteristic of their lives, such that their histories often intertwine with a life in institutions. Their residential life is marked by a compulsory religious and medical routine that imposes a moral order on their actions. Through ethnographic research, we seek to understand their social practices that diverge from the normative order imposed by the hospital routine of enforced medications and participation in the Spiritist healing ritual of the *passe*. Rather than engaging in the ritual performance, these long-term residents resist through the enactment of alternative goals and desires. Long-term

institutional experience and excessive medication contribute to other subjectivities and goals within the walls of the institution and its mandatory rituals.

Keywords – mental affliction – institutional order – therapeutic practices – subjectivity – Spiritism

Shirley Chubb, Ann Moore, Neil Bryant, Kambiz Saber-Sheikh: The Significant Walks Project. Aesthetic Articulations of Walking, Data, and Place, p. 107–120, written in English

This paper discusses how the *Significant Walks* (2014) research project explored the impact of walking with chronic low back pain (CLBP). The project involved an interdisciplinary research team working with participants to document how the familiarity of personal walks might be understood as a measure of physical and mental experience. The research methodology combined point of view video documentation of each walk, with simultaneously gathered biomechanical data recording the movement of the spine. Verbal data on pain levels experienced whilst walking was also collected. Additional layers of visualisation were added to the synthesized footage as the team worked with participants to explore how the interpretive aesthetics of visual effects applied to each walker's documentary film of their walk could further express their experience of walking with CLBP. Driven by the biomechanical data, the intensity of these effects captured interoceptive visual narratives that explored place, movement and sensory perception. Focussing on the importance of real-world experience, the project took research out of the laboratory and clinic to investigate how personal walks might act as a measure of the changing physical experiences associated with chronic low back pain. By engaging directly with each participant's environment, these encounters revealed how individualised documentation can simultaneously express quantitative and qualitative responses to physical experiences. The research methodology reinstated each participant's aesthetic interpretation at the core of understanding and engaged with the arts and health agenda, phenomenology and aspects of new materialism. The resulting films act as a communicative interface, conveying the impact and lived experience of the prevalent, but often overlooked, condition of CLBP and exploring the connectivity of human, site, materials, technology and environment.

Keywords – arts & health – visual art – physiotherapy – phenomenology – new materialism

Hannah Drayson: To the Bitter End. Affect, Experience, and Chemical Ecology, p. 121–130, written in English

This article explores taste in its chemical, gustemological and affective senses, asking what we speak of when we talk about "bitter experience." Drawing lines of connection between human affect and chemical ecology, it suggests a way of thinking about taste as a chemical entanglement of affective qualities and ecological relations. Two observations underpin the argument. First, the ambiguous resonance of bitter-tasting compounds in human culture is grounded in their ambiguous medical meaning, the same drug may serve as poison or cure. Second, plants interact with many other life-forms by producing chemical compounds, many of which are bitter tasting, that have effects on the metabolisms of the organisms around them. These *secondary metabolites* have become entangled in human physiology and culture. The use of bitter-tasting plants in food and medicine requires specialised technical knowledge for identification, processing and dosing, a necessity that expresses itself in various yet comparable cultural responses to bitterness. A number of cultural traditions hold strong associations between embitterment, wisdom, healing, and remembrance. In these similar responses to bitterness, the article suggests that there is an ecological and affective resonance that might be located in the idea of bitter experience.

Keywords – bitterness – medicine – taste – affect – experience

Résumés des articles de Curare 42 (2019) 3+4

L'Esthétique de la Guérison. Travailler avec les Sens dans les Contextes Thérapeutiques

SOUS LA DIRECTION DE HELMAR KURZ

«Indigenous First Voice» est utilisé pour explorer le principe de «Two-Eyed Seeing/Etuaptmumk» afin de théoriser l'intégration de la médecine autochtone dans le milieu des soins de la santé au Canada. S'apparentant à l'auto-ethnographie, «Indigenous First Voice» situe l'expérience et les connaissances du chercheur au cœur de l'analyse, tout en soulignant certaines connaissances auparavant effacées, déformées et stigmatisées. Nous nous appuyons plus précisément sur le témoignage personnel de Mme Fournier à la suite d'un cancer récent et sur l'exploration de ses expériences en tant que femme métisse afin d'illustrer les tensions qui doivent être négociées de manière à éviter d'être absorbées dans une compréhension biomédicale dominante de la santé et du bien-être. Nous juxtaposons ses expériences sensorielles de l'utilisation de soins autochtones aux côtés de la biomédecine pour le traitement du cancer et faisons appel à un nouveau cadre de recherche dynamique à multiples perspectives qui représente mieux la nature du principe de «Two-Eyed Seeing/Etuaptmumk».

Mots-clés – cancer – Indigène – Etuaptmumk – two-eyed-seeing – peuples aborigènes – dualisme biomédical – anthropologie médicale critique – esthétique de la guérison

Andrew R. Hatala & James B. Waldram: Maya Cosmovision. Une Exploration des Processus de Formation dans les Esthétiques Médicales, la Moralité et la Pratique de Guérison *Q'eqchi',* p. 49–63, rédigé en anglais

Tout au long de l'histoire, les individus et les communautés ont développé des conceptions culturelles complexes du monde qui les entoure, façonnées par l'écologie locale, l'histoire, la langue et les relations aux peuples voisins et à leurs modes de vie. Afin de mieux comprendre, interpréter et apprécier les pratiques curatives des guérisseurs Maya-*Q'eqchi'*, cet article étudie deux « processus de formation » ou « activités d'interprétation » de la vision du monde *Q'eqchi'*: une relation aux montagnes et vallées; et une économie morale de la permission. Chacun de ces aspects influence les structures d'interprétation de la réalité médicale Maya-*Q'eqchi'*, façonnant ainsi les conceptions de la maladie et de la santé et les « objets » médicaux dont s'occupent les guérisseurs mayas. À travers une étude de cas détaillée, tirée de plus de dix ans de travail ethnographique de terrain auprès des communautés *Q'eqchi'* vivant dans le sud du Bélize, cet article expose une vision du monde et une philosophie contemporaines, au sein desquelles les aspects de la réalité médicale s'étendent au-delà des interactions entre soignant et soigné, pour inclure des relations vitales aux esprits, aux économies locales, et aux moralités esthétiques ayant une signification sociale et spirituelle. En étudiant ce système thérapeutique centré sur le cosmos, nous pouvons mieux apprécier comment le savoir autochtone et les façons d'être Maya-*Q'eqchi'* influencent les rencontres thérapeutiques contemporaines de manière à externaliser et personnifier la source de la souffrance et du malheur.

Mots-clés – savoir autochtone – Maya *Q'eqchi'* – moralité – morale – guérison – ethnographie

Johanna Kühn: Voir de Lumières. Guérison dans un cours de méditation à Beyrouth, p. 65–78, rédigé en anglais

Cet article fait le lien entre « l' anthropologie sensoriellement engagée » (Nichter 2008) et la recherche sur les pratiques spirituelles contemporaines au Moyen-Orient. Pour cela, il explore la notion de guérison en s'appuyant sur dix mois de recherches ethnographiques effectuées à Beyrouth auprès des participant-e-s d'un cours de méditation et de leurs sensations corporelles.
L'auteur démontre que l'aspect central de ces pratiques de méditation, la sensation de «seeing lights», sert à apprendre et éprouver, de manière corporelle, l'amour de soi. Cette attitude est considérée comme la base de la guérison car, selon les participantes, seule une personne qui s'aime soi-même serait capable de mener une vie suivant ses propres idées et souhaits et de surmonter des situations existentielles difficiles. La notion de guérison, comme proposée dans les cours, reflète les aspirations des pratiquantes en majorité féminines et appartenant à la classe moyenne car elle vise l'acquisition du pouvoir d'agir. Dans le contexte de la crise économique actuelle au Liban, les efforts entrepris en vue de mener une vie autonome jouent un rôle central pour les pratiquantes. Ces efforts englobent le désir de trouver un équilibre entre autonomie et individualité d'un côté, et l'encastrement social nécessaire de l'autre. Plus largement, l'article met en évidence deux effets de l'étude des expériences sensorielles des personnes engagées dans les pratiques de guérison: il permet, d'une part, de mieux comprendre comment les pratiquant-e-s parviennent à se sentir mieux, et il attire l'attention sur le fait qu'apprendre de façon répétitive et ressentir des émotions sont les moyens entrepris par les pratiques spirituelles contemporaines pour réaffirmer les valeurs abordées par la question: comment bien vivre sa vie?

Mots-clés – anthropologie sensorielle – méditation – guérison – Liban – pouvoir d'agir – classe moyenne – individualité – autonomie

Tessa Bodynek: Négociation de Soi. Esthétiques de la Médiumnité et Guérison Incorporée dans l'Umbanda Brésilien, p. 79–91, rédigé en anglais

L'incorporation d'entités spirituelles est un élément important des rituels et de la cosmologie d'*Umbanda*. Dans cet état, les médiums sont approchés par des entités spirituelles, telles que les *guias* (guides spirituels) ou les *orixás* (divinités afro-brésiliennes). Par la suite, les médiums sont incorporés par eux. Les impressions sensorielles avant, pendant et après cette expérience mettent en lumière les circonstances sous-jacentes et les liens personnels avec ces entités spirituelles. En outre, la perception des stimuli émotionnels qui se développent dans le corps du médium est pertinente dans le contexte de l'incorporation. À l'aide de l'entité incorporée, les médiums donnent des conseils, aident, bénissent ou guérissent leurs consultants, dont beaucoup ne sont pas eux-mêmes des *Umbandistas*. Cet article analyse le rôle de la guérison incorporée et l'esthétique de la médiumnité du point de vue d'une *anthropologie des sens*. Outre l'examen des expériences sensorielles vécues, cet article donne la parole aux membres du groupe spécifique des *Umbanda* dans la métropole brésilienne de São Paulo, où j'ai effectué un travail ethnographique de terrain. J'ai mené mes activités de recherche au sein de la communauté spirituelle *Tenda de Umbanda Caboclo de Oriente* (TUCO), en me concentrant sur des méthodes ethnographiques telles que l'observation des participants et des entretiens formels et informels, ainsi que sur des conversations personnelles avec différents membres du groupe. À travers mon enquête, je souhaite donner un exemple des nombreuses formes différentes de pratiques urbaines *Umbanda* contemporaines. Cet exemple est particulièrement pertinent dans le contexte du discours universitaire, car il vient ajouter une strate supplémentaire à la recherche existante sur la grande variété des communautés spirituelles dans les métropoles brésiliennes. En tant que complément implicite, cet article établit une relation entre la cosmologie et les pratiques de guérison *Umbandistas* et la société dans laquelle la religion a émergé et est constamment reproduite. Il relie les théories et les débats contemporains concernant l'*anthropologie des sens* et l'*esthétique de la guérison* aux connaissances et aux pratiques umbandistes, ainsi qu'aux expériences personnelles de mes interlocuteurs.

Mots-clés – guérison spirituelle – soins de santé – sens – soi – émotion – incorporation – religion – médecine

Sabrina Del Sarto & Esther Jean Langdon: Efficacité Thérapeutique et Subjectivité chez les Résidents de Longue Durée d'un Asile Spiritiste, p. 93–106, rédigé en anglais

L'article présente une ethnographie de la vie sociale de résidents permanents internés dans un hôpital psychiatrique spiritiste de l'État de Sao Paulo (Brésil), en mettant l'accent sur leur participation à un « rituel thérapeutique », connu sous le nom de passe.
Il décrit les modes de vie et de sociabilisation qui émergent d'une routine quotidienne obligatoire, afin d'identifier l'agencement et les expressions des subjectivités et des désirs. Malgré le fait qu'ils vivent dans une aile de l'hôpital composée de résidences individuelles, l'institutionnalisation est une caractéristique majeure de leur vie, si bien que leurs histoires personnelles se confondent souvent avec une vie en institution. Leur vie résidentielle est marquée par une routine religieuse et médicale imposée, les obligeant à se comporter selon un ordre moral. À travers les recherches ethnographiques, nous cherchons à comprendre de quelle manière leurs pratiques sociales divergent de l'ordre normatif institué par une routine hospitalière faite de médication forcée et de participation au rituel spiritiste *passe*. Plutôt que de participer à la performance ritualistique, ces résidents de longue durée résistent grâce à la réalisation d'objectifs et de désirs alternatifs. L'expérience institutionnelle à long terme et la médication à outrance contribuent au développement de subjectivités et de volontés nouvelles, entre les murs d'une institution et de ses rituels forcés.

Mots-clés – souffrance psychologique – ordre institutionnel – pratiques thérapeutiques – subjectivité –spiritisme

Shirley Chubb, Ann Moore, Neil Bryant, Kambiz Saber-Sheikh: Le projet « Significant Walks ». Articulations Esthétiques de la Marche, des Données et du Lieu, p. 107–120, rédigé en anglais

Cet article étudie la façon dont le projet de recherche «Significant Walks» (2014) explore les effets de la marche en cas de lombalgie chronique. Une équipe de recherche interdisciplinaire a été impliquée dans le projet et a travaillé avec des participants afin de savoir si la connaissance de la marche peut servir de mesure de l'expérience physique et mentale. La recherche s'est basée sur une méthodologie composée d'une documentation vidéo adoptant le point de vue de chaque marcheur, et de la collecte simultanée de données biomécaniques enregistrant le mouvement de la colonne vertébrale. Des données verbales sur le niveau de la douleur éprouvée lors de la marche ont également été réunies. Des niveaux supplémentaires de visualisation ont été ajoutés aux images de synthèse alors que l'équipe de recherche a exploré avec les participants la manière dont l'esthétique interprétative des effets visuels s'est appliquée aux films documentaires de chaque marcheur. Déterminée par les données biomécaniques, l'intensité de ces effets a permis de saisir des récits visuels interceptifs, explorant le lieu, le mouvement et la perception sensorielle. Afin de mettre l'accent sur l'importance des expérience concrètes, le projet a étendu ses recherches au-delà du laboratoire et de la clinique, et a étudié comment la marche peut servir à mesurer l'évolution des expériences physiques associées à la lombalgie chronique. En rentrant directement en contact avec l'environnement de chaque participant, ces rencontres ont révélé que la documentation personnalisée peut servir de réponse, à la fois quantitative et qualitative, aux expériences physiques. La méthode de recherche remet l'interprétation esthétique de chaque participant au cœur du processus de compréhension et attire l'attention sur les objectifs artistiques et thérapeutiques, la phénoménologie et les aspects du néo-matérialisme. Les films qui résultent de cette étude agissent comme une interface communicative, tout en faisant part du vécu et des impacts de la lombalgie, une condition souvent ignorée et pourtant si répandue, et explorent la connectivité entre être humain, lieu, matériel, technologie et environnement.

Mots-clés – art et santé – arts visuels – kinésithérapie – phénoménologie – néo-matérialisme

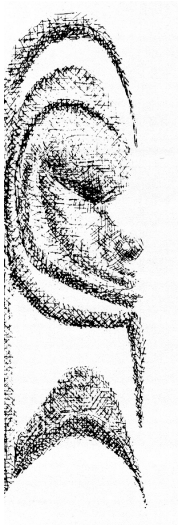
Hannah Drayson: Un Goût Amer – Jusqu'au Bout. Affect, Expérience et Écologie Chimique, p. 121–130, rédigé en anglais

Cet article étudie le goût dans ses dimensions chimique, gustémologique et affective, s'interrogeant sur la signification de l'expression «expérience amère». En rapprochant l'affect humain de l'écologie chimique, il invite à envisager le goût comme un entremêlement chimique de qualités affectives et de relations écologiques. Cet argument est étayé par deux observations. Tout d'abord, la résonance ambiguë des composés chimiques au goût amer dans la culture humaine est fondée sur leur signification médicale ambivalente, le même médicament pouvant servir de poison ou de remède. Ensuite, les plantes interagissent avec de nombreuses autres formes de vie en produisant des composés chimiques, dont bon nombre ont un goût amer et ont des effets sur les métabolismes des organismes environnants. Ces métabolites secondaires ont été impliqués au fil du temps dans la physiologie et la culture humaines. L'usage de plantes au goût amer en médecine ou dans l'alimentation requiert une connaissance technique spécifique de l'identification, de la transformation et du dosage; une nécessité que l'on retrouve dans des réponses culturelles à l'amertume diverses mais comparables. Un certain nombre de traditions culturelles établissent des liens étroits entre l'amertume, la sagesse, la guérison et la mémoire. À travers ses réactions similaires à l'amertume, l'article suggère qu'il existe une résonnance écologique et affective qui pourrait se situer dans l'idée d'expérience amère.

Mots clés – amertume – médecine – goût – affect – expérience

ANTHROPOS 114.2019

Articles



Book reviews by:

M. Ayabe, D.D. Barata, H. Behrend, S. Binder, S. Cachel, C. Cassarini, M.S. Cipolletti, R. Corr, H. Floss, A. Ford, O. Gächter, K. Gauderman, H. Grauer, S. Grodź, V.A. Gunawan, A. Gunsenheimer, E. Hernández, R. Jadinon, P. Jäggi, A. Jones, E. Kasten, M. Knüppel, A.M. Law, M. Flitsch, J.R. López Morín, R. Madden, R. Marjavaara, H. Mossbrucker, H. Mückler, J. Nielsen, D.J. Piwowarczyk, N. Porath, A. Rödlach, S. Romero, R. Seib, L. Trein, P. Valsecchi, X. Wang

---

ANTHROPOS is published twice a year totalling more than 700 pages.

Individual subscription 2 issues per annum, incl. Online € 98.00 (single-site access); Students € 39.00 (singel-site access); Firms/Institutions € 158.00, multiple use, unrestricted number of online users (either access data or IP address)

Subscription orders should be sent to: Nomos Verlagsgesellschaft mbH, D-76530 Baden-Baden, Germany, E-Mail: orders@nomos.de

Manuscripts and books to be reviewed be addressed to: Anthropos Redaktion, Arnold-Janssen-Str. 20, D-53757 Sankt Augustin, Germany; Fax: 02241-237491; E-Mail: editorial@anthropos.eu

ACADEMIA ISSN 0257-9774

Aims & Scope

Since 1978, *Curare. Journal of Medical Anthropology*, has provided an international and interdisciplinary forum for the scientific discussion of topics in medical anthropology, understood as encompassing all aspects of health, disease, medicine and healing, past and present, in different parts of the world.

After a first internal review by the editorial team, all research articles are subject to a rigorous, double-blind external review procedure. All other submitted manuscripts are internally reviewed by the editorial team. In addition to research articles, the journal publishes conference reports and book reviews. Furthermore, the journal's forum section offers space for essayistic contributions, interviews and ethnographic vignettes.

Curare is unique among medical anthropology journals in that it publishes articles in English and German. Curare also supports the publication of guest-edited special issues.

If you are interested in submitting an article or a special issue proposal, please send an email to curare@agem.de.

For further information on manuscript submission and guest editorships, please see agem.de/curare.

Die Zeitschrift *Curare* bietet seit 1978 ein internationales und interdisziplinäres Forum für die wissenschaftliche Auseinandersetzung mit medizinanthropologischen Themen, die sämtliche Aspekte von Gesundheit, Krankheit, Medizin und Heilung in Vergangenheit und Gegenwart in allen Teilen der Welt umschließt.

Alle wissenschaftlichen Forschungsartikel werden nach einer ersten Durchsicht durch das Redaktionsteam einer externen Begutachtung im Doppelblindverfahren unterzogen. Alle anderen Beiträge werden von der Redaktion intern begutachtet. Neben Forschungsartikeln werden auch Tagungsberichte und Buchbesprechungen veröffentlicht. Die Rubrik Forum bietet darüber hinaus Raum für essayistische Beiträge, Interviews und ethnographische Vignetten.

Curare publiziert Beiträge auf Englisch und als einzige Zeitschrift für Medizinanthropologie auch auf Deutsch. Sie unterstützt die Publikation von Schwerpunktheften durch Gastherausgeberschaften.

Bei Interesse an der Veröffentlichung eines Beitrages oder der Übernahme einer Gastherausgeberschaft freuen wir uns über eine Email an: curare@agem.de.

Nähere Informationen zu den Bedingungen von Artikeleinreichungen und Gastherausgeberschaften finden Sie unter agem.de/curare.

Formatvorlage | Stylesheet

Manuskripte

Bitte nur Originalbeiträge auf Deutsch oder Englisch als Word-Dokument mit einer Zusammenfassung aus 250 Wörtern plus fünf Schlagworten einreichen. Im Falle einer Annahme benötigen wir das Abstract auf Deutsch, Englisch und Französisch. Bitte auf Fußnoten möglichst verzichten, sie erscheinen als Endnoten. Quellenangaben im Text als (Autor Jahr [ggf. Jahr der Ersterscheinung]: Seite–Seite). Autorennamen werden in Kapitälchen gesetzt. Alternativ können sie auch unterstrichen werden. Namen von Zeitschriften und Institutionen sowie fremdsprachige Begriffe werden kursiv geschrieben.

Alle englischsprachigen Beiträge sollten vor der Einreichung ein muttersprachliches Korrektorat durchlaufen.

Manuscripts

Please submit only original contributions in German or English in the form of a Word document with a summary of 250 words plus five keywords. In case of acceptance, we would need the abstract in German, English, and French. Please avoid footnotes as far as possible, they appear as final notes. Please indicate references in the text as (Author Year [if different, year of first publication]: Page–Page). Author names should be placed in small caps. Alternatively, they can also be underlined. Names of journals and institutions as well as foreign language terms should be written in italics. All English-language contributions should be proofread by a native speaker before submission

.

Monographien | Monographs

Favret-Saada, Jeanne 1977. *Les mots, la mort, les sorts. La sorcellerie dans le Bocage.* Paris: Gallimard.

——— 2009. *Désorceler*. Paris: L'Olivier.

Favret-Saada, Jeanne & Contreras, Josée 1981. *Corps pour corps. Enquête sur la sorcellerie dans le Bocage.* Paris: Gallimard.

Hauschild, Thomas; Staschen, Heidi & Troschke, Regina 1979. *Hexen – Katalog zur Sonderausstellung im Hamburgischen Museum für Völkerkunde.* Hamburg: „materialien" der Kunsthochschule Hamburg 51.

Beiträge in Sammelbänden | Articles in Edited Volumes

Csordas, Thomas J. 1994. Introduction: the body as representation and being-in-the-world. In Csordas, Thomas J. (ed) *Embodiment and Experience. The Existential Ground of Culture and Self.* Cambridge: Cambridge University Press: 1–26.

Hannah, Seth D. 2011. Clinical care in environments of hyperdiversity. In Del Vecchio Good, Mary-Jo; Hannah, Seth D.; Willen, Sarah S.; Vickery, Ken & Park, Lawrence Taeseng (eds) *Shattering Culture. American Medicine Responds to Cultural Diversity.* New York: Russell Sage Foundation: 35–69.

Beiträge in Zeitschriften | Journal Articles

Lindquist, Galina 2005. Healers, leaders, and entrepreneurs. Shamanic revival in southern Siberia. *Culture and Religion. An Interdisciplinary Journal* 6, 2: 263–85.

Internetquellen | Online Resources

Kehr, Janina 2015. Alltägliche Krisen. Flucht, Medizin und Migration. Ein Denkeinstieg. https://www.medizinethnologie.net/alltaegliche-krisen/ [10.05.2018].

Bei Übersetzungen und Neuauflagen bitte zusätzlich die Erstausgabe angeben:
With translations and new editions, please also indicate the first edition:

Favret-Saada, Jeanne 1979. Entschuldigung, ich wollte doch nur … Wie man Mitglied einer „Schule" wird – oder nicht. *Kursbuch* 55: 163-175. [orig. 1977. Excusez-moi, je ne faisais que passer. *Les Temps modernes* 371: 2089–2103].

Fleck, Ludwig 1980. *Entstehung und Entwicklung einer wissenschaftlichen Tatsache. Einführung in die Lehre vom Denkstil und Denkkollektiv.* Frankfurt am Main: Suhrkamp [orig. 1935. Basel: Benno Schwabe].

Freud, Sigmund 2000. Psychoanalytische Bemerkungen über einen autobiographisch beschriebenen Fall von Paranoia (Dementia paranoides). In Freud, Sigmund *Zwang, Paranoia und Perversion. Studienausgabe. Band VII.* Frankfurt am Main: Fischer Taschenbuch: 139–203 [orig. 1910/11].

Ginzburg, Carlo 1992. *Die Benandanti. Feldkulte und Hexenwesen im 16. und 17. Jahrhundert.* Frankfurt am Main: Syndikat. [orig. 1966. *I benandanti. Ricerche sulla stregoneria e sui culti agrari tra Cinquecento e Seicento.* Turin: Einaudi].

Curare 42 (2019) 3+4

Arbeitsgemeinschaft Ethnologie und Medizin (AGEM)
Association for Anthropology and Medicine (AGEM)

VWB – Verlag für Wissenschaft und Bildung
ISBN 978-3-86135-848-0
ISSN 0334-8622

Ästhetiken des Heilens. Arbeit mit den Sinnen im therapeutischen Kontext
Aesthetics of Healing. Working with the Senses in Therapeutic Contexts

Herausgegeben von
edited by Helmar Kurz