

## Healing narratives in the context of a performed life

*“Our spirit is the real part of us, our body its garment. A man would not find peace at the tailor’s because his coat comes from there: neither can the spirit obtain true happiness from the earth just because his body belongs to earth”*

Inayat Khan, <sup>1</sup>

*"The very fact of our existence is a prayer and compelling - "I am, therefore I pray - sum ergo oro." It is a quality of the Divine basis of existence while acknowledging our temporal material existence"*

Frithjof Schuon <sup>2</sup>

The natural science base of modern medicine, which in turn influences the way in which modern medicine is delivered, often ignores the spiritual factors associated with health. Health invariably becomes defined in anatomical or physiological, psychological or social terms. Rarely do we find diagnoses, which include the relationship between the patient and their God. The descriptions we invoke have implications for the treatment strategies we suggest, the way in which we understand how people can be encouraged to become healthy, and the policies that we implement to maintain that state which we call “health”. Patience, grace, prayer, meditation, hope, forgiveness and fellowship are as important in many of our health initiatives as medication, hospitalisation, or surgery. The spiritual elements of experience help us to rise above the matters at hand such that in the face of suffering we can find purpose, meaning and hope. It is in the understanding of suffering, the universality of

suffering and the need for deliverance from it that varying traditions of medicine and religion meet.

Important changes have been taking place in both the church and within medicine. Issues relating to health and well being are raised that question the fundamental practices of these institutions. Principally these issues are about the definition of health and who is to be involved in healing. These issues are not new. Such issues are raised at times of transformation when the old order, whether it be in church or medicine, is being challenged. The claim of healing abilities by lay practitioners is certain to inflame those practitioners licensed by the state. But, expectations of modern medicine can lead us to overreach ourselves. We promise to deliver a technology that frees us from disease, yet we know that those claims are partial. Chronic diseases are still a challenge. Mental health problems are recalcitrant.

What is important to make clear from the very beginning is that I am not proposing spiritual healing as an alternative to modern health care delivery. Modern medicine, and its complementary forms, is the basis of health care delivery in the Western industrialised nations<sup>3</sup>. What I am arguing for is that within that pluralistic system of health care delivery we accept some patients and practitioners will want to express their understandings of health, illness, recovery and treatment in terms that are spiritual, as well as physical, psychological and social. Further, some patients and practitioners will want to participate in forms of healing that include spiritual considerations within a pluralistic context of modern health care delivery.

There is a growing demand by health care consumers for involvement in health care issues and for initiatives promoting a healthy life style. Within the church too there are demands by the laity to be actively involved in the life of the church and for lay ministries to be recognised. Communities are eager to make decisions about matters which affect their daily lives and are no longer willing to abdicate the sole process of decision making to licensed and expert professionals who may be far removed from them in terms of educational background, social class and experience. This does not mean that there is a revolt against

expert health advice from health professionals or the clergy. What is proposed is that these experts become facilitators and informed advisers within a system of health care deliverers, providers and consumers. What we appear to be seeing is in wealthy industrialised nations, where basic health care needs are satisfied, that health appears as a commodity linked not to the survival needs of fresh water and drainage but to existential needs. This is not to say that health care needs are not threatened by the pollution of those basic services but the problem is one of glut rather than poverty.

### **Health as narrative performance**

Our stories are our identities. How we relate them to each other constructively, so that we mutually understand each other, is the basis of communication. What we do, or persuade others to do, as a consequence of those communicated stories is an exercise of power.

While we may have sophisticated instruments of communication for transferring data as information, the digital technologies of cellular telephone networks and the 'web', how we understand the meanings of others cannot be so easily achieved. Delivering data is no problem, understanding each other demands another level of involvement that is simply not technical.

People are focusing on achieving health, rather than on becoming ill, thus we enter a domain that is not practitioner bound. Consumers are making specific and informed demands of the expert practitioner and of the market that supplies health care. Of these health care activities, an orientation to the future, that links with the past and is achieved in the present, will be based not only on understandings but practices related to those understandings. If hope is an understanding of the future realised now, in the present, then we have a practical understanding of a spiritual activity. Hope, is a common term in our culture that appears to be acceptable to scientists, priests and laity. Hope, while based on belief, becomes manifest in action. It is what we do, that is as important as what we think and understand. Both are related. A major mental health problem throughout the industrialised nations is suicide, the tragedy of hopelessness<sup>4</sup>. Promoting hope will be a significant endeavour in living fully and expressed in action.

There are different methods to approach truth. If we accept that in a modern vibrant culture there is a pluralism of truth claims, then a major task will be for us to reconcile what may appear to be disparate ideas. The argument here is not for some kind of homogeneity of thought but for an acceptance of the tension between ideas as a creative arena that pushes us beyond what we know. Thomas Merton <sup>5</sup> writes in his journal for the 28th of April 1957,

*“If I can unite in myself, in my own spiritual life, the thought of the East and West of the Greek and Latin fathers, I will create in myself a reunion of the divided Church and from that unity in myself can come the exterior and visible unity of the Church. For if we want to bring together East and West we cannot do it by imposing one upon the other. We must contain both within ourselves and transcend both...”* (p87).

My hope is that we can go some way to uniting the “East” and “West” of thinking in spirituality and science such that there is a reunion of thought about healing and the possibility of transcendence. This perhaps is the basis of healing and the core of hope. As Merton suggests, one cannot be imposed upon the other, it is containment within ourselves that brings the change. I am not arguing against modern health care delivery, nor scientific methods, but for the development of an applied knowledge that relieves suffering and promotes tolerance.

### *Knowledge gained*

At the heart of our understanding of the world is knowledge. If there are various ways to the truth, then there are varying ways to achieve knowledge. What we know influences what we do. What we do influences the way in which knowledge is acquired. While modern medical science is predicated upon empiricism and knowledge through the senses, there is another source of knowledge through contemplation and meditation. The plea of this book is that both reason and intuition be considered. In a world where often loud aggressive activity appear to be the most convincing evidence of personal surety, then the knowledge that comes from out of the silence may appear to have little influence. But, it is to this knowledge

that we may have to return, it is from here that the soul cries out to us in its suffering. If *gnosis* is the source of knowing, then for the future of our health care endeavours we may have to broaden the sources of knowledge to include both the scientific and the spiritual in a reconciliation that is complementary. From such a reconciled basis of knowledge, we can enrich both *diagnosis* and *prognosis*.

Perhaps an example from clinical practice will illustrate what the inclusion of spirituality may bring for the benefit of the patient.

### **Eva**

A woman came to see me in distress. She was referred by her general practitioner who was concerned for her mental state. Her husband had recently died. She had become suicidal and my task at that time was to research into suicidal behaviour. As she talked about what had happened over the previous year, it became increasingly clear that the woman had faced a series of tragedies in her life leaving her increasingly alone and distressed. However, both in the way that she talked about her problems concerning those varying life events and in the symptoms she presented, there seemed to be no obvious elements of mental illness. Nor did my psychiatrist colleague find any such signs. On asking Eva about what the central problem was, she said it was that she had lost her relationship with her God. Her husband was dead, her family estranged, her body was failing her and she saw no reason to live. These were all signs for her that God had abandoned her.

This presented me with a dilemma because instead of the conversation staying within a predictable framework of life -events and symptoms, or even florid descriptions of a supernatural world. The woman sitting before me was giving a clear account of an existential world that had lost its meaning. Her purpose for living had gone. Not solely in the loss of her husband, that had been a massive blow in itself, but in the sequelae of that loss. The question remained about how to approach this problem, as surely she needed a priest not a research-psychologist? And here lay the crux of the problem. For whenever she had talked about the nature of her problem as the loss of her relationship with God, that living

made no sense to her, she was either passed on as mentally unstable by her general practitioner, who like me felt unable to locate her problem within his own sphere of competence, or misunderstood by the priest who prescribed prayer. Either she was stigmatised, in her eyes, by her doctor or she was asked to do something impossible by her priest, pray, to whom she had already said she had lost her faith.

In a previous book <sup>4</sup> I have described this escalation of distress and how it may be compounded by the cycle of failed attempted resolutions, in this case referral or prayer. She saw referral to a psychologist and psychiatric services as an act of rejection and humiliation. In her own eyes, she was not crazy but suffering. Her priest offered a solution that was as untenable as being labelled as mentally ill. He asked her to pray to a God in whom she no longer believed, in a church where she no longer felt at home, and before a symbol of the crucifixion that both reflected and exacerbated her suffering. Fortunately, I had trained with a colleague who had left the priesthood, in a crisis of faith, and became a social worker. He offered to talk with her and, despite another referral, she eventually found a partner with whom she could begin to make sense of her existence in spiritual terms but without the confines of a religious context.

We see here how distress is manifested in a way that finds no immediate resolution within the framework of health care delivery. The woman is using a language about a spiritual need for which those of us in the various helping agencies had no vocabulary other than that of a potential pathology. Yet, this language is perfectly legitimate within a broader cultural context. In terms of her distress, where was she to find healing? Both bastions of culture, medicine and the church, were failing her in that we were deaf to the language in which she was expressing her dilemma. My concern is that such language is revived, and that legitimacy is restored to the notion of spirituality within our health care endeavours.

While conventional religions are intended as vehicles for the teaching and expression of spirituality, my perspective is to attempt to understand spirituality as meanings that may not always be located in religious contexts. Eva was undergoing a crisis of faith, albeit presented in somatic and psychological symptoms to her general practitioner. No amount of

medication was going to resolve this crisis. But, a counsellor, who understood the crisis of faith and the dark night of the soul, could offer her a way to find resolution. Practitioners and researchers are not being asked to abandon the language of natural science, simply to accept that within our varying cultures there are complementary vocabularies and repertoires of healing that have their own validity and with which those people who come to us as sufferers narrate the performance of their own lives. To deny the validity of their language of expression as it is performed in the dramaturgy of their lives is to deny legitimacy to the identity of the sufferer, and that contributes further to the suffering <sup>4</sup>.

### **Narrative regained**

Health is a praxis aesthetic, the performed body located in social relationship belonging to a culture of shared understandings <sup>6</sup>. Spirituality is a change in consciousness brought about by ritual. Religion is the social context that offers forms of understanding and ritual practice made specific by culture. Spirituality brings about changes in consciousness that are transcendental and achieved through a higher power or connection with a greater unity. Such changes of consciousness, embedded in the social and embodied in the individual, bring about changes in health. The social is incorporated, literally “in the body”, and that incorporation is transcended through changes in consciousness, which become themselves incarnate. Through the body, we have articulations of distress and health. While health may be concerned with the relief of distress, and can be performed for its own sake, sickness is a separate phenomenon. It is possible to have a disease but not be distressed. Indeed, it is possible to be dying and not be distressed.

The body becomes an interface for the expression of identity that is personal and social. In a metaphysical tradition, the human being is considered as a self-contained consciousness, homo clausus; yet Smith <sup>7</sup> argues for an alternative model, homo aperti, the idea that human beings gain identity through participation in social groups. My argument so far is that this identity is performed, and that both personal and social are necessary, that the interaction of personal and social is circular, and the difference between them constructed. Bodies express themselves at the interface of the personal and the social. Using the body communicates to

others. Using the body achieves perception of the environment, and that includes those with whom we live. The body has been neglected in communication studies as we emphasise language, yet it is gesture that is pre-verbal and promotes thought. Posture, movement and prosodics in relationship provide the bases for communication. Through the medium of an active performed body, health is expressed and maintained. Here is the bodily form that guides communication and by which the other may be understood and has an ambiguous content, it is social. Language provides a specific content, it is cultural. We know that someone is suffering by their appearance, what the specific nature of that suffering is they need to tell us. We know someone is happy by what they do, what makes them so happy, they need to tell us. In addition, by moving as if we were happy, we may promote happiness. By moving as if we were sad, we may promote sadness. Thus the body, and a moved body at that, is central to a life amongst others. Putting hands together to pray, going down on our knees, bowing in deference, opening our hands to receive are all ritual postures that have communicative intent within ritual settings and have individual consequencesx.

Language is a means of performing an authored personal identity and this occurs through narratives that are located within a cultural context<sup>4</sup>. Narratives are not only related but heard. This is the social. Healing is concerned with offering social contexts for the expression of healing narratives. These social contexts are embodied in acts of “being for the other” and entail the performance of shared meanings. The performance of healing narratives is gestural as it is verbal, whether in conversation, the consulting room or the church.

### *Making sense of adversity*

Making sense of adversity is what we do when we are patients. We connect our illnesses to a specific biography. We weave together events and episodes from daily life incorporating the bruises and kisses together into a life story. A *potential* life story, for once we enter into the healing narrative that story is subjected to various interpretations according to the company we keep. The legitimation of those stories is crucial to the process of healing<sup>4</sup>. Thus while we will have self-authored identities, they are dependent upon dialogue.

Csordas <sup>8</sup> writes that it is not the removal of symptoms that is important from a healing perspective but an alteration in lifestyle and a change in the meaning of personal attributes related to illness. This is meaning-centred discussion rather than a disease-centred discussion. He writes *“Healing is treated as a discourse that activates and gives meaningful form to endogenous physiological and psychological healing processes in the patient. This discourse has three basic components: a rhetoric of disposition, a rhetoric of empowerment and a rhetoric of transformation. The net effect of therapy is to redirect the patient’s attention to various aspects of his life in such a way as to create a new meaning for that life, and a transformed sense of himself as a whole and well person”* (p360). Predisposition refers to an individual believing that healing is possible and the means of healing are legitimate. Empowerment is being persuaded that the therapy is efficacious and transformation is that change, however it may appear, is recognised.

#### *An authored identity*

Language is important for the way in which we author our identities and health is an important factor of identity, then the language options we have for “authoring” ourselves is vital. The language of spirituality enhances the repertoires of healing vocabularies that we have by transforming and transcending understandings. A vocabulary that includes hope, transcendence, forgiveness, grace will be important in how we author our identity. In religious terms, ritual provides a means of authoring identity through action and involvement with a given vocabulary and grammar. George Orwell demonstrated the totalitarianism inherent in the destruction of words that makes “the vocabulary smaller and the range of thoughts narrower” <sup>9</sup>. Including a spiritual vocabulary and the rituals in which it is used offers us a greater variety of options for constructing identities. If we lose the opportunity to exercise the language of spirituality, or the religious contexts in which such language is performed, then we are significantly impoverishing the healing cultures in which we live. More than that, with the loss of the language, we lose the concepts involved. It is the re-telling of lives, a performance in the company of others, invigorated by a spiritual understanding, that brings about a transcendental change in health.

### *A performed identity*

Yet, there is another profound level of understanding that lies beyond, or before, verbal communication. Underlying an authored identity is the notion that we “do” who we are. We perform our very selves in the world as activities. This is a basic as our physiology and the grounds of immunology, a performance of the self to maintain its identity. Over and above this, we have the performance of a personality, not separate from the body, for which the body serves as an interface to the social world. We also perform that self amongst other performers, we have a social world in which we “do” our lives with others. This is the social self that is recognised and acknowledged by our friends, lovers and colleagues. This performed identity is not solely dependent upon language but its is composed rather like a piece of jazz. We are improvised each day to meet the contingencies of that day. And improvised with others, who may prove to be the very contingencies that day has to offer! We perform our identities and they have to have form for communication to occur. Such form is like musical form. Language provides the content for those per-form-ances. Thus we need an authored identity to express the distress in a coherent way with others to generate intelligible accounts <sup>8</sup>. We have a network of coherent symbols.

Prayer, meditation and worship will not simply be expressive ways of communicating with others in the world about ourselves, they are also means of understanding the world through others. But, those activities have to be performed and interpreted and are simply not cognitive activities alone. Prayer has its posture and movement too, and through its posture we understand and demonstrate. We need both *form* and *meaning*. Similarly, public prayer has its liturgy, and in the architecture of a liturgy then we have a cultural understanding that is performed and transmitted. That is the performative purpose of ritual, it provides both *form* and *meaning*. Csordas describes this too as a creative opportunity for achieving “the sacred self” <sup>10</sup>. Durkheim has already offered the idea that it is the social that provides form, as categories, by which the individual understands the world, and it is culture that elaborates those categories as specific understandings through individual action. It is individual bodies

that are the sites for the expression of the cultural in social relationship such that those sacred selves are realised.

Health identities are authored by individuals. There are, however, dangers in self-definitions of identity. We are open to an inherent narcissism. If this narcissism is combined with the omnipresence of globalised trivialities, then we reduce the alternatives of an actively lived healing repertoire still further. Furthermore, in the search for personal entitlements to health and the struggle for freedom of self-expression through self-fulfilment, then we are in danger of losing the social commitment that offers a transcending perspective. We may be free to fulfil ourselves according to our entitlements, rarely do we consider that such a fulfilment may be a loss or limitation if those entitlements are impoverished or trivialised. Egocentricity is itself a limited potential. The great spiritual traditions emphasise that there is more to us than we know. To develop a consciousness for a broader potential is a goal of spiritual and religious teaching. Spiritual teachings have emphasised that we may achieve a higher-self, a broadening of our current perspective, and this can be achieved through transformation. This transformation is facilitated by the relational contexts in which we have our daily lives. Health is this widening of potential to broaden the variety of possibilities for performing in the world. To elaborate our narratives we require an extensive gestural repertoire and a broad verbal vocabulary.

<sup>1</sup> I Khan, *The bowl of Saki* (Geneva: Sufi Publishing Co. Ltd, 1979).

<sup>2</sup> F Schuon, *Understanding Islam* (New York: Mandala, 1989).

<sup>3</sup> D Aldridge, "Making and taking health care decisions ," *Journal of the Royal Society of Medicine* 83 (1990): 720-723.

<sup>4</sup> D Aldridge, *Suicide: The tragedy of hopelessness* (London: Jessica Kingsley, 1998).

<sup>5</sup> T Merton, *A search for solitude: Pursuing the monk's true life*, ed. Lawrence Cunningham (New York: Harper Collins, 1996).

<sup>6</sup> D Aldridge, "Lifestyle. charismatic ideology and a praxis aesthetic," in *Studies in Alternative Therapy*, ed. S Olesen, et al. (Odense: Odense University Press, 1997).

<sup>7</sup> D Smith, "The civilizing process and the history of sexuality: comparing Norbert Elias and Michael Foucault," *Theory and Society* 28 (1999): 79-100.

<sup>8</sup> TJ Csordas, "The rhetoric of transformation in ritual healing.," *Culture, Medicine and Psychiatry* 7, no. 4 (1983): 333-75.

<sup>9</sup> I Markova, "Language and authenticity," *Journal for the Theory of Social Behaviour* 27, no. 2 (1997): 265-275.

<sup>10</sup> T Csordas, *The sacred self: A cultural phenomenology of charismatic healing* (Berkeley: The University of California Press, 1997).