

The cultural diversity of healing: meaning, metaphor and mechanism

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This chapter reviews the great diversity of healing practices found around the world and represented in most urban centres. A general model of healing is presented that includes both the physiological processes central to biomedical theory and practice and the symbolic aspects of healing that have physiological, psychological and social effects. Work on the theory of metaphor in cognitive science provides a way to understand the transformation of experience across levels of sensory, affective and conceptual meaning. Healing rituals and other symbolic action can thus have effects on physiology, experience, interpersonal interaction and social positioning. Complementary medicine and traditional forms of healing are attractive to many individuals both because of the limitations of biomedicine and their metaphoric logic of transformation, which promises wholeness, balance and well-being. Participation in specific healing traditions may also contribute to individual and collective identity.

Introduction

Notions of healing are central to any system of medicine. Anthropologists have documented a rich array of healing practices employed in different parts of the world. The comparative study of healing systems has shed light on the universal elements of healing as well as culture-specific features. In the classic account of Jerome Frank, all systems of healing share some theory of affliction, defined roles for patient and healer, a circumscribed place and time for healing rituals, specific symbolic actions with healing efficacy and consequent expectations for recovery¹. Ethnographic studies reveal cultural variations in every aspect of this general framework. In the contemporary world, migration, telecommunications and mass media have made such cultural variations not simply a matter of intellectual curiosity, or a source of scientific hypotheses about the nature of healing, but a practical concern for clinicians seeking to provide effective care to an increasingly diverse population. Indeed, this is not only an issue for newcomers but a feature of the general population. In Canada,

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Australia, the USA and UK, various forms of complementary, alternative and traditional medicine are used by 20–40% of adults annually^{2–5}.

In this chapter, I consider a general framework for healing that includes both the physiological processes central to biomedical theory and practice and the symbolic aspects of healing that have physiological, psychological and social effects. This model allows us to consider the place of diverse healing practices in contemporary medicine. Clinicians need some understanding of these healing practices in order to consider their implications for biomedical treatment. Some practices directly challenge the assumptions of biomedicine; others may conflict with prescribed treatments. At the same time, healing traditions offer important resources for patients. Practitioners able to work in concert with these complementary medical systems and sources of healing will be better able to serve their patients.

The diversity of healing practices

The great diversity of systems of medicine is reflected in a comparable diversity of models and metaphors for healing. Some common systems of medicine are listed in Table 1 along with associated practices. Healing involves a basic logic of transformation from sickness to wellness that is enacted through culturally salient metaphorical actions. Common healing practices include: the use of medicines that are drunk, smoked, injected or otherwise taken into the body; methods of getting things out of the body by emetics, cathartics, purgatives, bloodletting or surgery; manipulations of the body through touch and gestures or with specific materials; diagnostic or divinatory practices that establish the nature of the affliction in terms of its causes, consequences or some other classificatory scheme; and the use of rituals and ceremonies incorporating words, music, costumes and other theatrical devices that may involve the afflicted individual or the healer alone, interaction between patient and healer, or the participation of a whole group or community.

At the heart of any healing practice are metaphorical transformations of the quality of experience (from feeling ill to wellness) and the identity of the person (from afflicted to healed). The metaphoric logic of specific modalities of healing often follows from the associated model of affliction. Where illness is understood as the result of mechanical or physical injury, specific physical measures may be taken. Where illness is attributed to spirit attack, shamanistic practices involving communication with or journeying to the spirit world and enlisting the aid of spirit helpers are employed⁶. When the spirit comes to dwell within or possess the afflicted person, it must be exorcized⁷. Where spirits or ancestors are offended, they must be propitiated through sacrifices and offerings⁸. Where illness reflects an imbalance, efforts are made to restore balance

Table 1 Some common systems of healing

	Region	Theory of affliction	Healing practices
Ayurveda ¹²	Indian subcontinent	Imbalance of elements or humours (<i>dosas</i>)	Diet, purification, medicines
Chiropractic ⁵³	Europe and North America	Misalignment of spinal column	Physical manipulations
Christian healing ⁵⁴	Americas	Moral error, sin; demonic possession	Prayer, restitution; demonic exorcism
Divination ⁵⁵		Offending spirits or ancestors	Offering or propitiation
Homeopathy ⁵³	Widespread (orig. Northern Europe)	Life force out of balance	Administration of homeopathic remedies
Islamic medicine ⁵⁶	Widespread (orig. Middle East)	Disturbance of heart as centre of spiritual, emotional and physical experience	Recitation of Quran
Naturopathy ⁵³	Europe and North America	Weakened state of body	Strengthen body through diet, cleansing, 'natural' remedies
'New Age' (e.g. aromatherapy, crystal healing, light therapy, polarity therapy, Reiki)	Europe and North America	Energy imbalance	Use of materials and manipulations to 'rebalance' energy
Possession Cults (e.g. Candomblé, Zar) ⁷	Widespread (Africa, Asia, South America)	Offending spirits or ancestors	Possession by spirit allows propitiation
Psychotherapies	Widespread (orig. Europe)	Psychological conflict or maladaptive learning (behavioural, cognitive)	Corrective relationship, re-learning (through exposure, and cognitive or behaviour modification), insight
Shamanism ⁶	Hunter-gatherer peoples	Offending spirits, magical attack, accident	Shamanic healer travels to spirit world and with aid of spirit helper (usually an animal), redresses wrong
Traditional Chinese Medicine ^{9,57}	East Asia	Imbalance in energy (<i>chi'i</i> , yin/yang) or in five phases (air, earth, wind, fire, water)	Herbal and other medicines, diet, moxibusion, acupuncture
Unani medicine ⁵⁸	Indian subcontinent; Middle East	Imbalance in humours or life force	Herbal or mineral medicines

by supplying the missing element or augmenting the appropriate process, which may be physiological (e.g. humoral systems, hot/cold), or involve various subtle energies (*chi'i*, *ki*, etc.)⁹⁻¹².

Young has outlined a broad classification of medical systems as *internalizing* or *externalizing*¹³. Internalizing systems locate the causes, mechanisms and solutions to affliction inside the individual—although these processes may be bodily, psychological or metaphysical: something bad has gotten inside the person and must be neutralized, destroyed or removed (toxins, germs, traumatic memories, evil spirits); something is missing or depleted inside the person and must be added (vitamins, blood, vital energy); something is blocked inside the person

and must be unblocked and allowed to flow (energy, wind); something is out of balance within the person (yin/yang, dosas) and must be brought back into balance.

Externalizing medical systems, in contrast, locate the origins and resolution of affliction in processes outside the individual, and these are often interpersonal, social or spiritual. In consequence, they usually involve rituals in which the patient's family, entourage or community are engaged and the healing transformation may take place in the group rather than the individual.

From the perspective of biomedicine, authors have contrasted the physiological effects of physical healing and the psychological effects of rituals, ceremonies and other symbolic action. On closer inspection, however, this distinction is hard to sustain. Research on the many types of placebo effect makes it clear that symbolic stimuli and psychological attitudes and expectations can exert myriad effects on physiology, facilitating healing or aggravating disease. Of course, this symbolic efficacy is not limited to psychosocial interventions: any intervention will have psychological and social effects based on its meaning for the patient and others with whom they interact^{14,15}. Consequently, the material and symbolic effects of healing must be considered part of one interacting system.

At the same time, healing practices often involve physical interventions (*e.g.* the use of pharmacologically active substances in herbal medicines, physical manipulations in acupuncture, massage) that may have unintended effects or interactions with other treatments. For example, some of the most popular herbal remedies (*e.g. ginkgo biloba*, ginseng, St. John's Wort) have effects on cytochrome p450 and other enzymes that can significantly alter the metabolism of other medications¹⁶. Clearly, there are reasons to take seriously the physical effects of many forms of traditional healing.

The unsolved problem in classical accounts of symbolic healing is just how the narrative movement or change in symbolic representation is translated into a change at the level of bodily experience or physiology. Levi-Strauss argued that the transformations of healing involve a symbolic mapping of bodily experience onto a metaphoric space represented in myth and ritual¹⁷. The narrative structure of the ritual then carries the participants into a new representational space, and with this movement, transforms their bodily experience and social position. Dow built on Levi-Strauss's account to suggest that symbolic healing involves mapping a personal problem onto a collective mythic world through emotionally charged symbols. The emotion evoked by the symbols then insures that manipulating the symbols within that mythic world will lead to corresponding transformations of patients' illness experience¹⁸.

Recent work in cognitive science on the centrality of conceptual metaphor in human thought offers further insight into the mechanisms of

healing. The ability of metaphor to link sensory, affective and conceptual aspects of experience allows us to construct a model of healing transformations that can begin to explain how symbolic processes influence bodily experiences of pain, the pathophysiology of disease, and the emotionally charged meanings that give suffering its bite^{19,20}.

Metaphor, meaning and mechanism

Metaphor theory grounds abstract conceptualizations in the processes of sensory-affective imagery and bodily action^{21,22}. Abstract reasoning is built on a scaffolding based on basic bodily experiences through metaphorical projections from concrete to more abstract domains²³. Fauconnier and Turner have shown how conceptual representations involve constructing spaces that blend properties from different conceptual systems²⁴. Metaphorical concepts are interpreted as instructions for constructing and operating on an appropriate conceptual space.

This general perspective on the metaphorical nature of conceptual thought can be applied to understand the ways in which healing rituals construct and transform illness experience^{25,26}. The context and symbolic actions of healing provide a metaphorical re-interpretation of illness. Illness experience is mapped onto a symbolic space created by the models and metaphors of the medical system. This mapping imbues illness with specific meaning for both clinician and sufferer. Even the application of a diagnostic label has metaphorical connotations that can change the meaning of suffering and illness experience²⁷. Elaborating implications of the metaphorical representation or the adoption of new metaphors yield new ways of thinking about and experiencing illness.

As described, this process of metaphoric transformation seems to be entirely cognitive and although this can account for changes in conceptual frameworks or attitudes, the link to physiological processes may not be obvious. However, metaphorical thinking conjoins sensory, affective and motivational levels of representation in ways that can help account for psychophysiological effects of symbolic interventions. Imagine a hierarchy of mental representational 'spaces' in which the lower levels correspond to the processing done by phylogenetically older parts of the brain involving sensory qualities and basic motivational valences, whereas other levels or layers correspond to representations of experience in terms of emotional states and more abstract conceptual structures. Metaphors transform our perceptions and representations by moving them through sensory, affective and abstract conceptual spaces²⁸. According to how this movement occurs within these independent spaces, any communication gives rise to multiple interpretations. These hierarchically stacked levels of

meaning are text and subtext, literal and metaphorical strands of meaning in communication and action. Importantly, these multiple levels of interpretation go on in parallel and may reinforce each other, giving experience profound depth and resonance, or contradict each other creating complex experiences of irony, ambivalence and ambiguity.

We can apply this notion of a hierarchy of metaphoric spaces, through which multiple levels of meaning are generated, to the range of symbolic healing practices. Figure 1 depicts some of the many processes involved in symbolic healing²⁹. In the central column of the figure, these are arranged as a hierarchy of levels of organization, first within the central nervous system (CNS), then on to family and to the larger levels of community, the physical and social environment, and the spiritual world. Each of these levels has its own metaphorical logic and dynamics corresponding to specific neuropsychological, interpersonal, social, political or ecological processes.

These levels of organization within a biopsychosocial hierarchy require different languages of description. The description of the activity of the brain, structured by salient environmental and social events, requires the language of physiological psychology. The lowest level depicted here is the brainstem which includes reticular formation, usually held to be the locus of 'nonspecific' responses to the arousing or activating effects of stimuli. Healing actions and agents working at this level serve to change the overall level of arousal, making the individual more or less sensitive and active in response to many stimuli. Healing practices that employ touch, massage, some aspects of placebo response, and other phenomena of classical conditioning may work in part by manipulating endogenous control systems for arousal, autonomic function, and pain control^{30,31}. For example, the expectation that one is receiving an effective analgesic activates endogenous pain control systems using endorphins^{32,33}. This phenomenon of placebo analgesia operates equally when one receives a pharmacologically active medication and can account for some of the individual variability in response to analgesics³⁴.

A second level of the brain depicted is the limbic system, those phylogenetically older structures of the forebrain and limbic system, characteristic of mammals, that have been implicated in emotion³⁵. These regions of the brain are involved in the encoding and decoding of emotional meaning, empathy and in the regulation of attachment—the making and breaking of affectional bonds³⁶. Healing interventions aimed at this level work through the evocation of emotion and the dynamics of interpersonal attachment.

Higher cortical functioning adds two further levels in this hierarchy of representations: language and imagery. Therapeutic action at this level aims to elicit and transform conceptual models of experience. Most cognitive and psychodynamic therapy is concerned with this level. Ultimately,

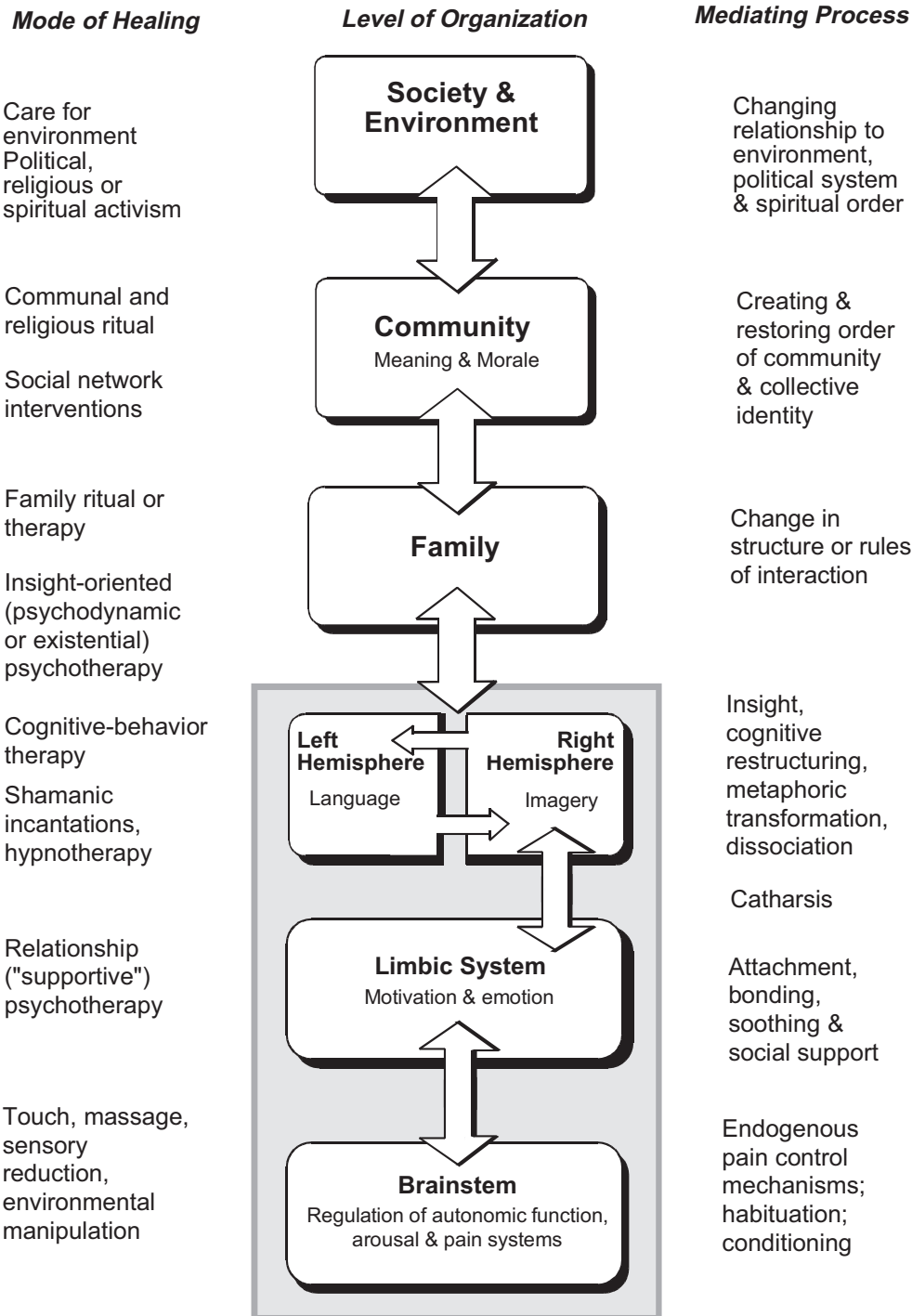


Fig. 1 A hierarchy of healing mechanisms. Adapted from Kirmayer²⁹.

psychotherapy aims to transform the individual's conceptual models of self and other to achieve better emotional regulation, cognitive flexibility, and adaptability in social roles.

Much experimental evidence supports a specific role for the nondominant hemisphere in elaborating imagery. The nondominant hemisphere also appears to have stronger neuroanatomical and functional links with the limbic system, which is specialized for the processing of affective meaning. Modes of healing that use imagery, reverie or trance may work with this level of organization.

For example, emotional catharsis involves both the imagery-based evocation of emotion and the linguistic framing of the experience to create adequate cognitive 'distance' so that the reliving of traumatic experience is not itself so intense and immediate as to constitute a fresh trauma³⁷. The concept of aesthetic distance is crucial to the cathartic process. The painful experience is relived but with an added awareness that it is not really happening, the context has changed, it is *only* a memory, *only* a movie. Catharsis depends on an optimal experiential distance. If the distance is too great, the person may remain unmoved by the performance or memory. If the distance is too small, he may experience raw motions that are too intense, and hence, tension building, painful or even traumatic. At optimal or 'aesthetic' distance, the audience or participant becomes emotionally involved in the drama but with parallel awareness of being an observer. Here *distance* is a metaphor for the degree of absorption and the awareness of context, an awareness of artifice, safety or ritual sacredness that dilutes the experience of suffering and promotes an experience of release and relearning.

A similar notion of distance can be applied to understanding pain and suffering in other contexts. Metaphor can be used to explore the microdynamics of pain and suffering²⁰. Perceptual distance can be regulated by thought and image, bringing pain terrifyingly close or allowing it to recede. Again, metaphor structures the process of attention so that we can become detached from our wounds by 'just watching'—a strategy that can be learned through techniques of Buddhist meditation³⁸.

Some ethnographic accounts of healing use the notion of trance both as an explanation for performative power and therapeutic efficacy³⁹. Trance is a metaphor for states of absorption, concentration, distraction, or 'awayness' in which attention is turned inward or away from ordinary consensual external reality⁴⁰. Although trance behaviour has often been hypostatized as an 'altered state of consciousness,' this is true insofar as any period of focused attention or absorption can be viewed as a different state. Social psychological research has made it clear that trance behaviour reflects scripted social behaviour that unfolds according to the dramatic requirements of stage, setting and dialogue. Healing practices that are designed to carry the healer, the

patient or the audience into an absorbed or trance-like state, both mark off the event as special and allow participants to focus on images that can be worked on through the sensory, emotional and imaginative processes evoked by metaphor. The ritual use of trance then has more to do with specific meanings conveyed by the context and metaphors of healing than with any generic change in state. Relaxation, positive mood, and feelings of safety and self-efficacy are not intrinsic to trance but are evoked by specific images and self-descriptions. Of course, such changes in psychological state have significant effects on autonomic, endocrine and immune functioning with consequences for healing, health and well-being⁴¹.

Beyond these processes associated with levels of information processing within the CNS, it is useful to distinguish at least two further levels in biological organization: the social groupings of family and community. Families and other groups of people living together evolve implicit rules of interaction that may give rise to problems that are not reducible to psychological conflicts within one individual⁴². Consequently, the unravelling of such interpersonal conflicts demands a change in family structure or the rules of interaction. Family rules are rarely articulated as such. Instead, family members conceive of their group in terms of family myths and metaphors. So a change in metaphor, prescribed by a therapist and subscribed to by even one family member, can change the pattern of interaction in widespread ways.

The family unit is embedded in a community or larger social grouping with a collective history and way of life. At this sociocultural level of organization, people participate in the construction of institutions and shared symbolic meanings that confer an order, beauty and diversity that surpasses individual experience. Psychological healing at this level employs the extended metaphors of secular and religious ritual to create and restore the order of the community and the relationship to the environment, the larger cosmos and with it, the sufferer's experience of meaning and morale⁴³.

Healing also may be part of broader identity projects. Taking part in a ceremony, committing to a course of treatment, identifying oneself as someone who uses or receives a particular healing practice may come to occupy an important place in autobiographical narratives and in social positioning. For example, for many First Nations individuals in Canada, participation in pan-Indian spirituality and healing practices has become a way to cultivate and assert an Aboriginal identity in the face of rapid cultural change and forced assimilation⁴⁴. For some indigenous peoples, a return to traditional subsistence practices that respect the land and environment is a crucial element of personal and communal healing. Political activism, seeking to reclaim autonomy and control over their nations and communities is also understood as a form of healing both individual and collective wounds traced back to the violence of colonization.

Although Figure 1 assigns specific healing practices to specific processes, in practice, every therapeutic action or communication—whether drug, word, gesture, ritual or relationship—has effects simultaneously on all of these levels. These effects may be synergic or opposing. Thus, the same action has multiple meanings based on its effects at different levels in this hierarchy. Even when a specific model or theory of healing privileges a specific mechanism, its potential efficacy can be re-described in terms of other processes. In fact, there is little evidence to support the claims of particular schools of psychotherapy that a single mechanism like catharsis, insight, reinforcement or cognitive restructuring alone accounts for the efficacy of its practice. Nor is it very informative to speak of ‘nonspecific’ effects, like ‘mobilizing positive expectancies’ or ‘improving morale’, since each of these involves specific processes that can be explored with appropriate biological, psychological or social methods¹⁵. The picture of healing offered by any tradition is a limited portrait that selects certain ideologically important elements from the wide range identified by comparative research. Progress in understanding healing will come from more fine-grained analysis of a wide range of psychophysiological, biosocial and sociopolitical processes all of which are at play in even the simplest intervention.

The problem of efficacy

The key question with respect to any healing system or practice is ‘does it work?’ This would seem to be an eminently pragmatic and clear question that should admit an unequivocal answer. However, efficacy and effectiveness can be assessed against many different outcomes. Although we recognize diverse practices as forms of healing by their common concern to alleviate suffering, prolong life and reduce disability, the effectiveness of healing is judged against its ability to achieve goals that vary widely across different settings and traditions. The definition of efficacy raises epistemological, ethical and aesthetic issues. The epistemological concern is with how we can know that something works. More fundamentally, notions of efficacy depend on ethical and aesthetic values about what constitutes a positive change, improvement, health or well-being. What counts as a good outcome may range from change in a discrete behaviour viewed as troublesome, or improved ‘quality of life’, to the restoration of harmony between body, social order and the cosmos. Clearly, the epistemological issues and value-laden aspects of determining efficacy are thoroughly entwined in these outcomes. In addition, healing systems may interpret their own outcomes in ways that are self-confirming. Clinicians and patients may invoke different definitions and criteria for a successful outcome.

The effectiveness of a healing practice is embedded in a larger cultural system that identifies different types of malady or affliction and prescribes appropriate interventions. For example, a healing intervention may be deemed successful for quite disparate reasons: (1) the afflicted person recovers (recovery may be judged in terms of improved function or reduced symptoms and suffering); (2) the afflicted person does not recover but others in their family, entourage or community are helped; or (3) the system of medicine itself is affirmed (by engaging others in their roles as patients and participants in the healing ritual).

Although only the first is usually considered in biomedical theory, in many systems of medicine, afflictions are understood to involve a wider social network and healing practices address that larger system⁴⁵. Thus, success in resolving communal tensions—or even in reducing the threat that affliction presents to the social order, may be deemed real efficacy. The healer and the system of medicine stand for central social values and every episode of affliction that falls outside expected or desired patterns constitutes a threat to the social order.

In many cases, the healing practice is conducted in a way that its performance already implies a kind of closure, completeness and success. The completion of the ceremony means that, symbolically at least, everything has been restored to its proper place. This is an end in itself, even if the person continues to feel ill, they may take comfort from the way in which shared values, moral rightness and aesthetic balance have been enacted, affirmed and restored. Aesthetics provides criteria for what constitutes the successful performance of a healing ritual. The performance itself has causal efficacy, since it changes a social state of affairs. Hence, an aesthetically satisfactory performance provides its own warrant of effectiveness that may triumph even when the individual's suffering persists.

This triumph of ideology over experience occurs in biomedicine as well. For example, it is not uncommon for surgeons who have done a technically correct (even 'beautiful') procedure to blame persistent symptoms on a patient's personality. Biomedicine defines physiological parameters and aspects of healthy functioning independent of the person's experience or global state of being; it is thus possible for a treatment to work (*e.g.* correcting blood levels) even though the person continues to be ill. This focus on physiology in biomedicine leads to the radical dissociation of notions of technical efficacy from the lived experience of the afflicted person.

Evaluations of outcome are always made with reference to specific problem definitions, hierarchies of values and contextual frames. Hence, there may be discrepancies between how healers and patients judge improvement, because of personal, professional and cultural differences in the calibration of health and illness. For example, in a study in Hunan, China, Kleinman found that most patients diagnosed with

shenjing shuairuo (neurasthenia, lit. 'nervous weakness') could also be diagnosed with major depressive disorder⁴⁶. When he treated them with antidepressants, most showed significant symptomatic improvement. However, many patients insisted they were still sick with the same illness because they understood and experienced it as a loss of energy, motivation and direction in their lives. Their feelings of enervation could be traced to the suffering they had experienced during the Cultural Revolution. A treatment that appeared effective for some aspects of their distress failed to address what patients' experienced as the core of their illness and hence, seemed largely ineffective.

People may use and endorse specific forms of healing not because of any demonstrable efficacy but because the healing practice is part of a larger system of values or a way of life they are invested in or simply take for granted. Faced with the challenge of evidenced-based medicine, practitioners of traditional medical systems fall back on claims of pragmatic knowledge and on identity politics⁴⁷: the system works because it appears to work and has 'stood the test of time,' and, in any event, it cannot be challenged because it is central to an ethnocultural group's history and identity. These responses side-step important issues of safety and efficacy. Contrary to the claim one often hears that a treatment must be effective if it is time-tested, rooted in a venerable tradition, and has been prescribed for hundreds of years, treatments may be popular and persist because they fit with important cultural values, institutions and powerful interests, even if they are, in fact, harmful or maladaptive in other respects. Of course, this applies equally to biomedicine. In place of a blanket endorsement or rejection of biomedical or traditional systems of healing, we need a critical approach, based on real knowledge, that examines the tradeoffs involved in any specific treatment.

The social context of healing

The classic accounts of healing rituals in anthropology have appealed to the grounding of symbolic in core values, well-learned and lived daily in local worlds that reflect a coherent and well-integrated social system⁴⁸. More recent accounts take note of the constant flux and change of cultures and the ways in which historical ruptures present important contexts for healing^{49,50}. In these accounts as well, new healing practices address core values and concerns in which individuals and communities have a profound stake. In multicultural urban settings, however, we face situations in which many people have only a shallow connection to a tradition and healing practices themselves undergo creative change and hybridization.

Globalization has increased the pace of cultural confrontation, challenge and change. The contemporary world presents us with a new situation in

which the coherence of traditional systems of healing and their links to an underlying culture and worldview are challenged and strained. Systems of healing that were rooted in a particular cultural tradition, community and way of life, have been uprooted, packaged and made available in a global marketplace. This has important implications for the efficacy, ethics and politics of healing practices.

To the extent that a healing practice depends on a shared cultural background or acts through communal networks, its efficacy may be reduced. Older theories of the fit of healing practices with ethnophysiological, sociomoral or religious systems of meaning are insufficient to address the common predicament of the person moving between cultural worlds. We need new models to understand the potential effectiveness of culturally based healing in a world in which cultures are in constant flux, transformation and hybridization. This new level and intensity of change means that individuals do not have the same degree of enculturation through childhood building up intense and effective associations and also that social groups do not have the same degree of cohesion. Thus, they may not have had the developmental experiences and tacit knowledge that give symbolic actions their specific meaning and associated efficacy and positive expectations. At the same time, the appeal to a traditional form of healing which may serve to reinforce a valued ethnocultural identity, may not have this same value for patients who are in transition, caught between cultural worlds, and ambivalent, at times, about both the old and the new. People are increasingly encouraged to adopt new values and approaches to health, both because of the novelty seeking and acceptance of the “new and improved” that are part of consumer capitalism and, ironically, because disaffection with contemporary institutions leads to a romantic idealization of the exotic as “traditional” and “holistic” and hence, as able to restore lost values of harmony and community⁵¹.

In traditional healing, healers are part of small communities and their credibility and reliability is judged by others close to them. When healing practices are divorced from the local communities or cultural systems in which they developed, the communal methods of regulating the authority and practice of the healer are replaced by the dynamics of the marketplace or by struggles for power among professional guilds. This raises unsolved problems of regulation and public safety.

Conclusion

Migration, mass media and telecommunication have exposed everyone to diverse healing traditions that promise effective or integrated treatment

of conditions that remain poorly understood or managed in biomedical care. In urban centres, people from many different backgrounds make active use of the wide variety of healing traditions available. Complementary and traditional systems of healing are widely used in the general population, although specific forms may be more or less popular among particular ethnocultural groups⁵². This is a function of dissatisfaction with contemporary biomedicine as much as it is confidence in any alternative system. The understanding of illness and healing within biomedicine tends to be narrowly conceived in terms of physiological processes and does not always attend to powerful psychological, social, moral and political dimensions of medical interventions. These wider dimensions have demonstrable physiological effects as well as involving psychological and social processes, which are important in their own right for individual well-being and recovery from illness.

There is a close link between definitions of efficacy and theories of mediation. Indeed, there is a tendency to move the problem of efficacy back to some facet of its theoretical mediation or some facet of the therapeutic activity itself so that merely carrying out the effective procedure is *prima facie* evidence of efficacy. So any account of efficacy must include an analysis not only of what, how and why things work, but of more basic or anterior questions of what it means for something 'to work', what it is supposed to be working on, and toward what end. This takes us far into the material circumstances of healing practices, which include not only physiology and behaviour but also social and political institutions and ideologies.

Systems of healing are part of local worlds of meaning and power. The meanings conferred by healing practices include the personal, social, religious and moral significance of affliction and recovery. The forms of power invoked in healing include personal feelings of efficacy and self-control, the professional and institutional authority of healers, and larger forms of economic, political or spiritual power. The quest for meaning and power in healing cannot be entirely disentangled: sometimes achieving power is enough to foreclose any further search for meaning; more often meaning is offered as a salve for the powerless.

Disentangling the different levels of efficacy in healing practices may allow researchers to identify specific mechanisms and evaluate outcomes. This in turn will provide a knowledge base to inform public debate on the place of complementary and traditional healing practices in pluralistic health care systems. Recognizing the diversity of healing practices should encourage clinicians to inquire about patients' use of alternative sources of help. Ultimately, it may inspire clinicians to undertake collaborations with other healers or develop their own hybrid approaches to address the range of their patients' concerns.

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