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Religion and Spirituality

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Introduction

Why this article?

An American professor of physical medicine and rehabilitation tells of a patient born with spinal muscular atrophy, who underwent the usual evolving series of medico-therapeutic interventions while also pursuing her own spiritual quest for meaning and inward understanding of life, ranging from a Catholic Christian background to the major Hindu scriptures. Over many years, none of the rehabilitation services addressed what the patient considered “the most essential aspect of my being - my spirituality”. The patient and the professor fully agreed on this point, since they were in fact one and the same person (Nosek 1995). From a different perspective, a self-help group of Indian mothers bringing up children with significant intellectual disabilities in a very poor area of Delhi reached a similar conclusion about 'organised religion'. From Hindu, Buddhist, Muslim and Christian backgrounds, they found more help in their regular discussions with one another than in the paths suggested by various religious mentors, for coming to terms with their child's disability. Each battled on with a faith or philosophy that she had bashed into shape on the anvil of her own bitter experience (Balasundaram 2007).

Recent reviews of North American literature suggest that, in a dozen years since Nosek's comment, interest in 'religion and health' has been growing rapidly, while growth in the 'religion and disability' field is perceptible but remains comparatively scanty (Lee & Newberg 2005; Johnstone et al 2007; Zhang & Rusch 2005). In much of recorded history, religious practices and the healing, therapeutic or rehabilitative arts have been mutually supportive (Ebrahimnejad 2002; Sullivan 1987; Veith 1972, 10, 53, 215; Zysk 1998), and this may continue to be so in much of the non-urban, non-industrialised world today. The account by Katz (1982) of shamanic community healing among the Kalahari Kung, some of whose healers had serious impairments, conveys a sense of millennia during which humans lived 'between earth and sky', with minimal material possessions and an enhanced awareness of the threats and possibilities of spiritual existence. The global but mainly urban spread of modern, science-based medicine, psychiatry and rehabilitation has increasingly developed away from, and often in conflict with, traditional religious belief and indigenous healing or therapeutic practice. Yet governments with vast rural populations, such as China and India, have attempted some integration of traditional healers and beliefs in modern health services (Bray 1999; Leslie 1976; Wujastyk 1998, 9-10). Some scientifically-trained practitioners in developing countries find it useful to study the traditional methods, particularly in the mental health field (al-Habeeb 2002; Issa 2000; Khalili et al 2002; Patel et al 1995; Raguram et al 2002; Salib & Youakim 2001; Winkelman 2004); and in discovering and appropriating locally available materials, skills, techniques and philosophy (Adams 2002; Feierman 2000; Werner 1998). Some religious schools of thought have moved to bridge the gaps, modernising their approach, studying the mentalities of modern science, developing chaplaincy services and other responses. Many physicians, psychiatrists and therapists, whether personally atheist, agnostic or having religious beliefs, have understood that patients'

religious culture or spirituality can have significant effects on their reception and compliance with the therapeutic programme, the speed and extent of their (self-)healing and recuperation, and the beneficial participation of families and local communities in the rehabilitative process.

There is some concurrent movement to re-humanise the therapeutic encounter, to diminish professional masks and barriers, to cherish the non-measurable elements of human care and kindliness, and perhaps to learn something about making therapy a pleasant process (Halliburton 2003), part of the harmonious flow of life (Iwama 2005), from Asian cultures in which the science/religion debate has been approached more skilfully. An opposing tendency, toward designing rehabilitation facilities on the model of car factories, and trying to manage them for maximum efficiency, cost control, mechanised throughput and profit, might also be noticed. Some synthesis of trends may emerge in situations where people have a choice of rehabilitative therapies, and prefer to pay for those known to be scientifically effective, culturally palatable, and to wear a kindly face. It must also be remembered that a considerable proportion of people with disabilities have very little contact with the world of rehabilitation, healing or therapy -- their 'disability' is an unchanging bodily condition around which they construct a mostly normal human life. Their main requirement of society is to refrain from filling the built and the social environment with physical and attitudinal obstacles.

Reports from physicians, therapists and priests who themselves experience serious illnesses and disabling conditions can also bring some enlightenment, or at least a greater awareness of the complexity of thoughts, experiences and paradoxes in this area (Axelrod 2005; Boswell et al 2001; Klitzman & Daya 2005; Koss-Chioino 2006; Nosek 1995; Squier 2004). Personal involvement has produced deeper insights from artistic, literary, philosophical and theological sources, into the human experience and response to deafness and disability (e.g. Bragg 2004; Byrne 2000; 'David B' 2005; Oe 2001; Peloquin 2005; Yong 2007). It has also influenced anthropological discourses in this field (Haualand 2007; Ouertani 1999; Rösing 1999). A rising number of reports from therapists near the front lines of war, liberation struggles, natural disasters, and reconstruction, also brings the raw and bleeding edges of human society into the foreground, replacing the therapist's own safety, order and calm consideration of issues, with more urgent demands on their commitment, compassion and spirituality (Kronenberg, Algado & Pollard 2005; Werner 1998).

In the increasingly multicultural, multi-religious, anonymising and automatising modern city, the idea that professionals trained in rehabilitation sciences and therapies should somehow be 'addressing the spirituality' of their clients may sound like a leap into unknown depths, complicated relationships, and uncertain outcomes (Farrar 2001); yet some professionals are aware that their practices need to be better informed both in the area of spirituality and in the diversity of cultural and religious backgrounds (Faull et al 2004; Stone 2005; Yamey & Greenwood 2004). This article sketches some of the background, complexity and potential resources in religious text and practice, for the often uneasy, yet sometimes rewarding, interface between religion, spirituality, disability, and rehabilitation. In particular, it brings into focus some resources of religion in Asian, Middle Eastern and African countries, where encounters between modern and traditional approaches to disability are not identical with 20th century western experiences. (For a recent article on similar topics with more of a western focus, see Gaventa & Newell, 2006).

Religion and spirituality

In contrast with scientific terminology that is closely defined for use in the rehabilitation field, words such as '*religion, religious*', and '*spiritual, spirituality*', and their equivalents in many languages, form part of everyday speech. Referring to beliefs and experiences that are not strictly definable or measurable, they are less amenable to being captured by science and employed with precision. Such words also acquire a variety of inflections and nuances in different languages and cultures, and have had a wide historical range of meanings. In English, for example, '*the spirituality*' was once a collective term for all the bishops, priests, deacons, nuns and others in the church hierarchy, while '*religion*' has sometimes been used as a term of dislike for an outbreak of dedicated participation at mosque, temple or church: “he was a fun-loving guy until he got religion!” Current trends in English seem to reflect a reversal from those two examples. 'Religion' is now more often used for formal creeds, doctrines, and organised communal activities, while 'spirituality' more likely signifies the personal quest and inward engagement of a participant or seeker in any of the religions or philosophies of transcendence. 'Spirituality' was recently described as “an intricate, enigmatic, abstract, and ambiguous concept”, in a study of its current status in health literature (Sessanna, Finnell & Jezewski 2007).

Religious words will appear below, with some of these current flavours. Reference will be mostly to major religions such as the 'Abrahamic' monotheisms (Judaism, Christianity and Islam), the religions or philosophies in which *karma* and rebirths are prominent (Hinduism, Jainism and Buddhism), with briefer references to African traditional religions and major religious philosophies of East Asia (Confucianism, Daoism, Shinto, and some schools of Buddhism). Arguably, the range of teaching and practice within Hinduism is so vast and diffuse that it cannot properly be regarded as one religion: it is an ocean of religious belief, philosophy and practice. Yet a comparably vast range and diversity may be noticed in worldwide Buddhism and Christianity. For present purposes, such debate will not be pursued. To address any of these religions or philosophies of transcendence through the medium of English, French or Spanish is also to risk introducing some shifts of meaning and emphasis, away from the mother-languages of their origins. Users of the European languages should tread lightly across the grass.

Conflicts, internal and external

Apart from problems of definition, religions in practice are well known for internal and external divisions and conflict. Within every religion there is diversity of belief and practice, sometimes derived from conflicting doctrinal schools, sometimes from differing preferences among the adherents, e.g. toward communal religious ceremonies as against individual, inward piety; or toward practical action to relieve the poor and oppressed, as against withdrawing from involvement in a world perceived as evil. While mostly preaching love, peace, and the brotherhood / sisterhood of humankind, there have also been sharp conflicts between representatives of the different religions, exacerbated when religious difference coincided with ethnic identity, caste or class boundaries. Advocates of religious beliefs have also found themselves in conflict with secularising movements and scientific ideologies. The latter may represent the wave-front of change and modernisation, challenging religious discourse and trying to break the mould of earlier rules and prohibitions (Dennett 2007). Yet secular, modernising movements, under banners such as 'scientific progress', or 'revolutionary socialism', have also attracted critical scrutiny, as they too may involve rigid paradigms of belief that stifle thought, or may be enlisted or implicated in environmental degradation, food

pollution, or bloodshed comparable to earlier 'religious' wars. Developments involving science and information technology have contributed to massive social change, and continue to generate difficult ethical and moral issues, without perhaps providing any obvious increase of politically credible solutions. Religions have been traditional custodians of the terminology of ethics and morality; yet religion-based terminology may sit uneasily with the kind of ethical decisions demanded in fast-moving biomedical developments.

Globally shifting fields

The human world, once imaginable as a deck of cards neatly arranged by race, family, colour, religion, social hierarchy, increasingly looks like a deck randomly shuffled, and from which many of the markings have been erased (Geertz 2005). Along the city street, or seated in the physical therapy clinic, neighbours may be a kaleidoscope of individual ethnic and religious backgrounds, age-bands, educational levels and social expectations. Perhaps all have painful shoulders, their backs hurt, and their bodies all have capacity to respond to the same physiological processes of treatment. Yet the personal meaning and the social implications of the symptoms and impaired functioning will vary across a wide spectrum, involving beliefs about the origin and meaning of the pains, and different cultural packages of body image and perception. Those factors can affect whether clients actually come for treatment, give accurate information about their daily living activities, the circumstances in which their problem arose, and any therapies they have already undergone; and then accept the formal treatment offered, comply (or not) with recommendations about home exercises or dietary restrictions, have an experience of healing, and report back accurately on the outcomes. The spectrum may be different again in clients with lifelong disabilities, seeking treatment for an adventitious ailment or new impairment.

Within different age groups in a single urban family, there are often two or more significantly different sets of cultural perceptions and terminologies of the body and its functioning; and these perceptions are changing over time, under various influences, both local and global, rational and irrational (and points in between). A television documentary on a particular kind of therapy or healing, a religious leader's pronouncement on a bioethical issue, a blogger's critical opinion, a medical journal article, news of a film star's cosmetic reconstruction, may ripple out and cause a shift in one person's body concept on the other side of the world within days, and move their neighbour's concept five years later in a different direction. The rapid rise and global dissemination of knowledge, with echoes and distortions all along the way, generates a still vaster growth of fuzzy and inaccurate information, with cultural diffraction through a thousand filters and translation gateways. Variety may sometimes be beneficial; but the person in need of relief and healing may be less likely to meet a therapist who shares, or can even imagine, her conceptual world.

Urban therapists and practitioners get accustomed to a continuing problem: they need to understand at least a little about their clients' lives, beliefs and activities, to be able to respond appropriately and to customise the therapies on offer; yet the diversity of those lives, beliefs and activities is growing and shifting erratically, while each month's issues of the therapy journals report further changes and challenges to professional practice. The major religions are also in a process of change and updating. Some factions in each religion adopt and others vigorously reject each new feature, with ripples and echoes across the world as leaders and religious scholars respond to modernising pressures, and adherents make their personal choice of updating, reacting, suspending judgement, or avoiding the issues.

How Major Religions Have Addressed Disability

The Textual Basis

The major religions and religious philosophies all have revered historical texts that are used to underpin doctrine and the behaviour of adherents, and to challenge individual and social behaviours. They also have mechanisms for custody, interpretation and transmission of texts. Adherents of each religion or spiritual path usually vary along a spectrum, from those for whom a traditional interpretation of the revered texts is supremely authoritative, to those who privately or publicly allow themselves some choice in what they accept, reject, adjust or reinterpret from the text and from the custodians and official interpreters. Further, it is seldom easy or straightforward to make a confident assertion that “the Torah says X” about disability, or “the Qur'an says Y about rehabilitation”, or “the Confucian teaching on intellectual impairment is Z”. The journey from ancient texts to modern formulations of belief or rules for conduct has involved complex processes of historical transmission, translation, interpretation and belief. The complexity of the processes actually provides room for some flexibility, and opens the way for updating; yet this is often highly sensitive and conflictual.

Approach

The notion is attractive, yet hardly tenable, that one can adopt an entirely dispassionate, neutral and unbiased approach toward the world's revered texts, viewing them as distant objects through a telescope, or dissecting a specimen text under a microscope. Adherents of religion often view their own texts as divinely given authorities, addressing and admonishing all of humankind, while the texts of other religions may be admitted to have some merit, but basically are flawed. To disagree with such assertions, or to wish to modify them, is already to move from disinterested neutrality. Militant atheists may regard all religious texts as packets of dangerous nonsense, responsible for much of the world's bloodshed, while more moderate non-believers may perceive a few enlightened moments amidst a web of superstition and frankly incredible statements. These are all personal positions capable of being advocated with evidence and argument, but no more capable of conclusive demonstration or scientific proof than are the religious positions. Even to read a substantial amount of the world's religious scriptures (in translation) with an orthodox exposition by scholars of each text, requires a large investment of time and involves some personal response or reaction to the claims made for them and by them.

The approach taken here, in describing texts and interpretations relevant to disability and rehabilitation, has some acknowledged bias and intention. It begins from a widely held view that the world's disabled people, throughout history, have faced difficulties arising directly from their impaired condition, and those difficulties have often been made much worse by environmental barriers and by adverse attitudes, legal restrictions, prohibitions and over-protection, imposed on disabled people. Some of the adverse attitudes can be found in religious texts, and have been supported by religious teaching; while other factors more favourable to people with disabilities, supporting respectful and considerate behaviour, encouraging therapies and healing, can also be found in religious text and teaching. The major religious texts can be regarded as a *common cultural heritage* of humankind, in which many people find support and motivation for their more positive and desirable behaviour, or may find justification for their discrimination against and persecution of minorities.

Human choice is involved in whatever is found in the texts, and in which parts are emphasized and taught to succeeding generations. That choice is exercised mostly by scholars and teachers in each religion. Yet as people of all the major religions and philosophies increasingly are literate, live in closer proximity, and run up against one another's different beliefs and practices, there are greater opportunities to learn some of the more attractive sides, as well as noticing some of the less attractive practices. We (the human race) seem to have a long way to go before achieving in practice the high ideal of a world in which the vast majority of people with disabilities have a reasonable chance of enjoying a life of worth and dignity, and of making their own best contribution to society, by whatever definition. So it is useful to learn and share the more beneficial resources from every culture, religion and philosophy, as well as from the worldwide endeavour of scientific knowledge-creation. Perhaps 'we' may also assist one another to let go of some practices which may have had their justification in earlier times and circumstances but are no longer useful, or may actually be harmful, in current perceptions of life.

Caution with Texts

While almost all religions and philosophies have texts that are revered or normative, usually some parts of those texts have effectively dropped out of doctrine, as they no longer correspond with current thinking and practice; and other parts are still taught, but with radical reinterpretation. Similar tendencies can, of course, be noted in medical science. Texts derived from Hippocrates, Galen and Ibn Sina, or Susruta and Caraka, were definitive authorities for 'modern medicine' through many centuries, but have now disappeared from most of the world's medical colleges. The older texts are useful for reflecting on how humankind has approached disability and rehabilitation in the past, and also on the speed with which our current perceived wisdom may give way to something quite different. For the future, it seems likely that the 'textual' medium of religion may cede more ground to multi-media communications of spirituality and religious faith, possibly with a broader intelligibility and attractiveness.

Care is also advisable, when using historical texts, to avoid missing major features simply because they are called something other than what one might expect in the 21st century. Historically, 'disabled people' (or 'people with disabilities') were seldom known by a generic or 'umbrella' term directly equivalent to the modern phrase. They were often collected within a broader category indicating 'the poor and suffering', which might include widows, orphans, barren women, elderly people without family support, along with 'the blind and the lame' (Iliffe 1987, 7-14; Rispler-Chaim 2007, 3-5, 123-124). Most religions have exhorted followers to compassionate practical action toward these 'poor and suffering' people, as a major pillar of religious practice, both individual and communal; but this might not appear if one merely searches ancient texts for modern 'disability-related' terms. It may indeed appear, only for the 'good works' unexpectedly to be dislocated, as by the Bhakti teacher Allama Prabhu: “Feed the poor / tell the truth / make water-places / for the thirsty / and build [water-] tanks for a town - / you may then go to heaven / after death, but you'll get nowhere / near the truth of Our Lord” (Ramanujan 1973, 167).

Categorisation, Metaphors of Abuse

Some revered texts provide quite detailed lists of impairment categories, which shed light on how disability was perceived in earlier times. Lists are sometimes given explicitly to exclude

people with those impairments from participation in some benefit, activity or employment; for exempting some from religious obligations that would be difficult or impossible; or to protect them from harm, or reduce their liability to punishment. Examples appear in Hindu, Buddhist, Jaina, Jewish and Christian religious law codes, as shown below. From the ancient scriptures to the later ones such as the Qur'an, and the Adi Granth of the Sikhs, disability terms are repeatedly used as metaphors or similes, as humankind is rebuked for 'deafness' to the deity's voice, or 'blindness' and 'idiocy' when confronted with the spiritual realm and its rules of correct conduct; or is threatened with disabilities as a punishment for mass disobedience. (English translations of the major scriptures now appear on the internet in searchable format, from which such metaphorical use may readily be found). Sometimes there is an extended set of metaphors in which moral decay and depravity are so intertwined with the torture of disabling disease that it is hard to tell which set is being used as a metaphor for the other, i.e. whether the unbridled lusts of flesh and mind are being shown as a punitive or biological cause of impairment; or impairment is considered a warning signal of moral degradation; or both (Growse 1876/1987, 711; Taraporewala 1922, 216-242.)

Major disability categories are discussed in the *Upanishads*, a cumulative 'religious philosophy' curriculum from India some 2800 to 2500 years ago, in debate about which 'sense' is most important. The list, i.e. hearing, sight, touch, speech, breath, mind, is familiar, though not quite what a modern philosophy class might use. The theoretical-empirical method -- each sense is imagined taking leave for a year, then returning to see how the others got along -- is comprehensible, and the astute reader may guess the outcome (Hume 1931, 158-160, 226-228). It is also asserted that each imagined situation, i.e. being without sight, without hearing, without mind, corresponds with the familiar experience of people who are blind, deaf, intellectually impaired, or whatever. In everyday observation of such people, their life goes on, even without one sense (though not, of course, without breath).

Attempts to influence social attitudes also appear early in history, in the context of detailed impairment lists. A Jaina writer pointed out that people having those impairments get annoyed and hurt when they are addressed with the name of their impairment (“Hey, Cripple...”). Therefore, since religion teaches you not to hurt or annoy other people, do not use such names! (Jacobi 1884, I: 54, 152-154). Similar admonitions appear in other religions in different periods. Priests or laity of the early Christian Church were threatened with expulsion if they ridiculed someone with a disability (Schodde 1885). One early refinement was the use of ironic or 'reverse' terms. In Akkadian, some 2300 years ago, a *blind* person might be known as *Beautiful Eyes* (Marcus 1980). That tendency was penalised in the South Asian *Arthashastra* of Kautilya: one could be fined for calling people by a physical attribute they actually had; and the fine was doubled if the attribution was false, and doubled again if a sarcastic term was used (Rangarajan 1992, 470-473).

Prohibition, Restriction, Protection, Kindly Care

Prohibition / Restriction

Religious law at different times prohibited some disabled people from becoming king, priest, royal counsellor, a witness in court, or from inheriting property; or placed other restrictions on their participation. Detailed exclusion lists appear in the ancient texts of Hinduism and Buddhism, as well as Jainism, Zoroastrianism and Judaism, in translation (Raghavachariar 1965, 485-486; Bühler 1886, 76, 106-108, 119-120, 239 etc; Telang 1898, 319-321; Rhys

Davids & Oldenberg 1881, 191-225; Jain 1947, 174; Darmesteter 1895, 17; Danby 1933, 538-539; Wood 1926). Exclusions often extended to all women, children, people without education, and people not born into the ruling class or priestly caste, i.e. more than 97% of the population. How far any of the exclusion lists was implemented in everyday life is now very hard to tell. For example, the framework of India's vast epic *Mahabharata* involved the fact that King Dhritarashtra was blind, and so should not have become king; yet he does appear as king. Sometimes 'worthiness' triumphed over impairment: Ethiopian Christians preserve an early tradition that worthy men may become bishops of the Church even if lame or one-eyed, for "a defect of the body does not corrupt him, but a defect of the soul [does]." Yet a worthy man could not become bishop if he were deaf or blind, not from any imputed unworthiness in these conditions, but on pragmatic grounds: it would be harder for such a man to see for himself what was going on, or to hear all sides of a story (Schodde 1885).

Protection / Kindly care

In the same (or later) law codes having religious authority, people with disabilities often benefitted from some protection against legal penalties, along with women and children, being deemed weaker and having less responsibility than able-bodied adult men (Shamasastry 1923, 268). The prophet Muhammad personally mitigated punishments for men who were ignorant, mentally disabled, or small and weak; he even reportedly shortened the prayers, out of consideration for weak and aged people and mothers with small children (Baghawi 1990, 99, 232, 697, 763). Much later in China, disabled or weaker members of society were exempted from torture to extract their confession of wrongdoing (Jones et al. 1994). People born deaf, along with those having serious mental disabilities, might be deemed to have no moral or legal standing and therefore could not enter legal contracts, nor could they be punished for breaking the law, though their family might be held responsible for failing to supervise them (Woodbridge 1939).

Adults had presumably noticed and differentiated some major impairment categories very early in the development of human communal living; but the origins of what might be called moral, communal, altruistic or religious approaches are hard to discover. Skeletal evidence on the survival of adults or children with severe impairments in small African communities, dated up to 12,000 years ago, suggests periods of years during which people provided food for disabled group members who very probably were, or became, 'useless' in terms of individual or group survival (Dastugue 1962; Goodman & Armelagos 1989, 238-239). Their motivations are impossible to know. Earlier claims of 'compassionate care' for disabled people at the 'Shanidar' excavations in Iraq have met with some scepticism (Dettwyler 1991). Links with religion, spirituality or morality are also tenuous. Possible evidence of religious thought may be dated back 30,000 to 40,000 years in archaeological studies of the burial of human bodies with material items that might 'accompany' the dead in a postulated further existence, or at least might signify ongoing respect for, or fear of, the dead by those burying them. Yet attempted reconstructions of prehistoric human behaviour, belief or morality remain highly speculative (see e.g. debates in Katz, ed., 2000). The past two centuries of academic speculation on human histories and destinies serve mainly to suggest "how purposes already embraced shape the way one chooses to make use of the science" (Murphy 2006), or indeed of the philosophy or theology.

Flawed Gods, Kings, Super-crips, Prophets

Some African, Asian and European cosmologies have major or minor deities or spiritual

entities portrayed with impairments, having imperfect offspring, or specially concerned with disability. From Southern Africa, the sacred legend of the 'Tree of Life' portrays the Great Mother, Goddess of Creation, passing on physical imperfections to her creation. There follows the birth of the first deformed child, the call to destroy this child, and its mother's flight (Mutwa 1998, 5-41). In West Africa, the deity Orisanla (or Obatala) is believed to have created humans with impairments, possibly under the influence of alcohol; and there is some association with a tradition of disabled people being killed in religious sacrifices (Abimbola 1994; Bolaji Idowu 1962; Palau Marti 1964). The Azande in Sudan considered that during a woman's pregnancy God might be busy fashioning the growing foetus, and any disturbance to that work could result in some deformity. This led to a thoughtful ban on rousing pregnant women from their sleep (Bayoumi 1979, 40-41). A creation legend from Ethiopia showed the first man having a body with everything in place, yet inert or paralysed. God's wife suggested that the man should be given “speech medicine”. God had none, but brought breath and “then the man began to speak and move about” (Hallpike 1972, 226). The Wagogo people of East Africa tell a story of the High God rejecting appeals for help from several men, because in their journey to heaven they behaved scornfully toward disabled people. Finally a woman made the trip and obtained help, because God noticed her admirable respect and friendliness toward disabled people along the way (Cole 1902, 315-316). It is often hard to disentangle early traditions from later accretions which may have been given undue prominence by European ethnographers and interpreters; yet it seems that African traditional theologies have a fund of imaginative explanations involving God, creation and disability.

The Mesopotamian story of 'Enki and Ninmah', from the second millennium BC, depicts a range of human beings deliberately created with disabilities by one deity, as a kind of challenge to another deity who then proceeds to find some appropriate social and vocational role for each of them -- a blind man becomes a court musician, one without sexual parts serves as a eunuch at the palace, and so on (Black et al, 1998-2006; Bottéro & Kramer 1989, 188-198; Klein 1997). The significance of this tale for the ancient Sumerians remains a matter of speculation; yet it suggests some recognition that disabled people should be facilitated in making their contribution to society. In the major texts of Shinto, physical and behavioural abnormalities are prominently described in the process of Japan's creation (Aston 1896, I: 19-21, 62-63), though their significance is much debated by scholars. This peculiar cosmogony has been creatively reconstructed by a modern disabled Japanese poet, reflecting the continuing need for disabled people to navigate across the seas of rejection, indifference or conditional toleration they may encounter (Hanada 1998/2005). Some Asian cosmologies reflect adversely on procreation between closely related deities, for example the 'Father' creator fertilising his 'daughter' (who may be the Sky, the Dawn, etc), which may signal an early awareness of possible links between incest and impairments in offspring (Murakami 1988; O'Flaherty 1975, 28-35, 43-46). Various South Asian religious legends tell of gods and spirits who engaged in battle and sustained disabling injuries, but who continue to function as gods. Others were specialists at healing injuries (Daniélou 1964, 118, 128-129, 136-138, 184, 190, 196-197, 282, 309, 325, 364).

Religions accommodating a range of deities have some possible advantage in reflecting the spectrum of human experience, including variety in gender, skin pigment, sexual orientation and disability, which may appeal to particular groups of adherents, while the sole, supreme deity of the monotheisms has to work harder to fulfil the range of human demands and expectations. Christianity, while inheriting from its Jewish origins the deity's power, majesty

and separateness, also managed to find in the earlier prophets a paradoxical theme of vulnerability and 'brokenness' in God (or in God's servant), from which both the suffering and the healing capacities of Jesus Christ might be understood (Abraham & Abraham 2007), though this was seldom reflected in later Church power structures and hierarchies. The identity of Jesus as Healer was embraced also by Islam (based on Qur'anic surah 3: 45-49).

There are widespread legends of ancient male sages or minor divinities who were blind and came to see further and deeper then ordinary men, e.g. Homer (Umar) and the Vedic sage Dirghatamas; or had multiple impairments, e.g. Ashtavakra (eight-ways disabled); or who limped, e.g. Hephaestos, and Iron Crutch Li (one of China's Eight Immortals). A self-disabling theme runs through some religious literature, to enhance the devotee's focus. The plea of the 12th century South Indian social reformer Basavanna was: "Cripple me, father, that I may not go here and there. / Blind me, father, that I may not look at this and that." (Ramanujan 1973, 70, also 77, 78). Occasionally the 'wise disabled' archetype is female, e.g. Khujjutara, hunchbacked maid of an Indian queen. Khujjutara had been craftily misusing the queen's funds, but was converted by the Buddha's teaching and promptly confessed her thefts. As a result, she was asked to expound the Law to the female courtiers, and soon became an exalted teacher. A coda explains how, in an earlier birth, Khujjutara mocked a deformed holy man by imitating his stoop. She had thus earned a 'corrective' or 'educational' rebirth as a hunchback herself (Burlingame 1921, I: 281-82, 292), so that the progress of her soul should not continue to be impeded by wrong thinking and conduct.

There is a shared tradition among the major monotheisms that, at some time in their lives, the religious prophets of old experienced significant impairments or disabling diseases, e.g. Ishaq (Isaac), Yaqub (Jacob), Moise (Moses), Hiob (Job), and others (Artson 2007). The speech impediment of Moses has a particularly long and complicated literature among the monotheisms (Hamilton 1912; Tigay 1978). Sections on afflictions and treatments in Al-Bukhari's collection of well-attested sayings of Muhammad (Khan 1996, 934-945) broadly teach that disease and disability come from Allah, and believers who remain patient will have their sins forgiven and will be compensated by entering paradise. Of Muhammad himself, Aisha reported that she "never saw anybody suffering so severely from sickness as Allah's Messenger" (Khan 1996, 934). One of the earliest substantial and critical discussions of disability and public responses was by the 9th century Arab writer al-Jahiz, who experienced a range of disabling conditions during a long life. He drew on the same theme with an assertion that "disease and physical imperfections should not be considered to be social stigma, but rather signs of special divine blessing" (Trembovler 1993-1994).

Historical adjustments and facilitation

In 'Disability Movement' folklore, pre-20th century history is sometimes portrayed as a uniformly Dark Age in which disabled people either were killed at birth or were crushed under intolerable lifelong burdens heaped on them by callous kings, priests, physicians, lawyers and the able-bodied population. Yet a more nuanced picture may be drawn by careful consideration of historical evidence. People with disabilities have not always been isolated and helpless victims as they are sometimes now portrayed. Blind people in many Asian and Middle Eastern countries have been trained and respected musicians, and have memorised the revered texts of their community, playing a role in religious ceremonies (e.g. Matisoff 1978; Nagai 2002; Ragheb Moftah & Roy 1991). There is plausible evidence for deaf servants acting as a group in the Hittite royal palace in ancient Anatolia, c. 1300 BC (Soysal

1999), and for vigorous debate and concerted action by several hundred disabled people as far back as 330 BC in Persia (Miles 2003). The latter were released captives who had suffered various kinds of punitive amputation, and who attracted the attention of the warrior Alexander as he advanced on Persepolis. They received his promise of help, debated the options among themselves, then caused Alexander to cancel what he thought they should have and instead give them what they really wanted.

Writings of the Daoist philosopher Chuang-tsu (now usually: Zhuangzi), rather than focusing on bodily impairments, displayed an active interest in disabled people and what they actually did with their lives, giving examples of some whose personality or spirituality so attracted ordinary people that their impairments were hardly noticed (Graham 1981, 46-47, 64, 73-81). Similarly, the 3rd century BC philosopher Xunzi debunked the belief in physiognomical lore, which attempted to judge character and fortune from physical appearance and was popular at that time and later. Rejecting it, Xunzi gave examples of people of peculiar or deformed appearance who achieved fame by their character and actions (Knoblock 1988-1994, I: 196-211, 293-299). In Indian antiquity, some relief was introduced into the religious ceremony of *upanayana*, to make it feasible for young people with intellectual or communication disability, so they could at least get married and acquire adult status (Kane 1974, II (i) 297-299). Some corroboration of these facilitative adjustments is provided by reports that some people opposed them.

The Jewish teacher Moses ben Maimon (1135-1204), can be seen making more room in his own thinking about disability. He upheld the traditional ban on priests with visible blemishes giving the blessing in public, because their deformity might cause people to gaze at them rather than being conscious of God's presence; yet he allowed that if the priest were well known, and people were accustomed to his appearance, he might give the blessing (Abrams 1998, 201). Similarly, some 350 years later, the Christian reformer Martin Luther (1483-1546) was asked whether a chaplain with one weak hand could allow another person to hold an infant while he poured the baptismal water with his stronger hand. Luther agreed to this variation, provided that the chaplain's preaching was good, and the common people were not offended by the manoeuvre (Luther, Weimar edition 1883-1983, Tischreden 5: 264, No. 5588).

In a 16th century East African kingdom, the ruler who had any physical impairment was traditionally supposed to commit suicide because his body was imperfect and therefore could not properly represent his people before the deities and ancestors. Yet a visiting Portuguese priest (Dos Santos 1609, in Theal, VII: 193-195) found a ruler there who had shrugged off this rigid and inexorable religious duty. He had informed his people that it was a lot of old nonsense: he had lost a front tooth, he was still king, and he would continue to rule very well! In a comparable way, the purely legalistic approach to Islam was strongly rebutted by the historian Ibn Khaldun (1332-1406). He remarked on the spiritual insight of people with intellectual impairments, who were not deemed capable of dealing with earthly affairs but were equipped by Allah to report on things that could not be seen by the clever of the world (Ibn Khaldun 2005, 86). Modern scholars of Islam have now begun to report and discuss the detailed and nuanced historical debates by which earlier Muslim jurists and teachers worked out the place of disabled people within the everyday life of Muslim communities (Ghaly 2008; Rispler-Chaim 2007).

Similar items of 'rehabilitative' adjustment, easement and facilitation can be found in religious and secular histories across the world, suggesting that attitudes and behaviours towards disabled people have often been a mixture of pleasant and unpleasant, as can also be seen in the world today. They also suggest a human tendency to load other people with rules and regulations to be carried out 'religiously', while providing some loopholes in case laws prove inconvenient to the rulers charged with upholding them.

Stance, Updating & Reaction

Passions and Compassion

Schools of Jainism and Buddhism within Asia have had some very longstanding differences of practical approach to the sufferings and disabilities of the masses. Perceiving (along with some schools of Hinduism, Judaism and Christianity) that most suffering results from human ignorance and passionate human longings and strivings for vain things for one's 'self', some have emphasized the individual pursuit of salvation, in which all such passions are to be overcome by mental concentration and religious practices designed to dispel ignorance and eradicate foolish desires. Having 'compassion' on fellow humans may then also be one of the passions to be overcome. To be emotionally affected by people's diseased and deformed bodies is a mistaken perception; trying to fulfil the longings of others may merely confirm those people in a mistaken way of living, becoming also a process of self-delusion with evil results. So it is right to offer the teaching of Jainism or the Buddha's way; but not to set up health and social service units. Other schools of Buddhism moved to different conclusions, inaugurating some of the world's earliest organised healing services (Zysk 1991), practising the realisation of oneness among sentient beings (the pains and joys of others are my own pains and joys), and itinerating among the people with both healing and religious teaching, while remaining mindful of the many snares and pitfalls. These contrasting paths have developed and interacted through two millennia. Yet a modern Korean Buddhist philosopher, describing “Buddhist ways of overcoming suffering -- a mental approach and its criticism by 'socially engaged' Buddhists in contemporary Asia”, now discovers in the debate a radical innovation: “The world has changed. The causes of suffering have to be found, not in the individual, mental defilements, but in the intricate nexus of collective, structural or organizational evils.” (Jae-Ryong Shim 2001, 20) Relocation of the 'problem', from the individual mind or body to the community or society, and problematic issues of interventions, motives, compassion and empathy, have parallels in many other changed or changing regions of the world, and are reflected in the updating of religious doctrine.

Including deaf people (or not)

Histories of various disabling conditions also show considerable variations in religious responses and social rehabilitation at different times and places. The difficulties of tracing movement, reaction, and long-term synthesis are exemplified by the status of deaf persons in the Christian church. A slow succession of increasingly positive or permissive statements can be found about sign language and deaf people's comprehension, and rulings on their inclusion in church ceremonies, from the 3rd century to the present, from authorities such as the Apostolic Canons, Augustine, Jerome, Pope Innocent III, and Martin Luther. Yet most of these rulings failed to become widely known, or were bypassed, misinterpreted or argued against by people who thought they understood the issue better (Gewalt 1986; Zillman [1938]). The opposers believed it was their overriding duty to protect important church rituals from being 'diminished' by the participation of people who did not, in their opinion,

understand the meaning. It was the priest's reasonable duty to exercise some judgement about the level of fitness to participate, for example, by temporarily restraining people when they were inebriated, drugged or acting wildly, while welcoming them when sober and behaving with some consideration for other people. This exercise of discretion was sometimes over-generalised, in the belief that someone prelingually deaf had a seriously and permanently diminished capacity for understanding or communicating, and so was excluded automatically, without further investigation. The Pope at Rome in 1206 issued a positive ruling about deaf people's capacity to understand and to communicate by signs; but the local priest far away in his own parish, if he ever heard of it, might think that such a ruling included people who lost their hearing later in life, after they had clearly understood the meaning of the holy ceremony, but could not refer to those prelingually deaf. The weakness of the permissions granted by the religious leaders may be in some contrast with those found in the *Hedaya*, an influential 12th century guide to Islamic law, which gave some recognition to deaf people's sign language (Marghinani 1870/1975, 707-708), following similar recognition in the Jewish Talmud (Marx 2002, 117-118). However, the extent to which any law or advice was known, widely implemented or discarded in historical practice remains rather speculative.

Leprosy ambiguities

The status of 'leprosy' has also been seriously confused through much of civil and religious history. The wide range of symptoms now attributed to *Mycobacterium leprae* probably did exist in South and East Asia more than 2000 years ago (Emmerick 1984; McLeod & Yates 1981). A person probably having leprosy (recognisable by modern criteria) is depicted very early in South Asia having stones thrown at him by fearful villagers, in the Buddhist *Jataka* no. 516 (Cowell 1895-1907, V: 38-41). Yet leprosy was confused with various other serious skin diseases through two millennia across Asia and the Middle East, and probably was not the 'leprosy' for which stringent public health regulations were prescribed in the Torah (Abrams 1998, 64-65, 94-95; Hertz 1952, 461-469; Hulse 1975). Ambivalent views about people with 'leprosy' are found in early Muslim teaching, based on several hadiths of the prophet Muhammad (al-Baghawi 1990, 98, 397-99, 526, 619, 955-56, 1221, 1379), and later legal formulations (Rispler-Chaim 2007, 56-58); yet the segregating principle embedded for centuries in Judaeo-Christian practice seems to have been avoided in early Islamic texts (Dols 1983). Comparable ambiguities in status and aetiology have accompanied epilepsy in religious and scientific viewpoints over the centuries, ranging from 'spirit possession' to various neurological hypotheses (Temkin 1971; Devinsky & Lai 2008; Ismail et al. 2005).

Duty and dignity

Some early debates within the monotheistic faiths showed a sensitive concern for the human dignity of disabled people, and the ongoing difficulty of accommodating this within workable laws. For example, in orthodox Jewish tradition, dignity is conferred on men by the effort to obey the laws given by the deity; consequently, those people deemed to have some exemption or lesser obligation to keep all parts of the law, i.e. women, minors and people with disabilities, could appear to have less dignity and less means for it to be conferred. Through different Rabbinic opinions, Jews with disabilities in some places might be excluded or exempted from some obligations in religious law, either by legal purists ('they can't do it'), or by the kind-hearted ('they need not do it'), or perhaps by the pragmatic ('let's not be stupid about this'), with some risk of diminished dignity. In another location, some might be included in the obligations, whether by legal purists ('they are not exempt'), or by the fair-

minded ('to exclude them might suggest contempt'). The range of Rabbinic opinion, on blind people's inclusion in legal obligation, “varies from complete exemption, in Rabbi Judah's view, to almost total obligation ... in Rabbi Meir's view” (Marx 2002, 106-107). A comparable division of opinion over human dignity arose among Muslim Jurists in the 9th century CE, on the 'weak-minded' or 'prodigal' person's right to have full control of his property in adulthood. Some considered that, as he might waste or be cheated of his property, it should remain under guardianship. Acknowledging the risk, other lawyers argued that still greater injury would be done to the man by continuing to treat him as a dumb animal, lacking all reason (Marghinani 1880/1975, 526-527).

Many of the 'inclusive' points noted above in ancient religious texts have been rediscovered or given renewed emphasis at various times in Asian and Middle Eastern history. They were again discovered, updated and refined by European and American disabled people during the later 20th century, in the Disabled People's Movement, and in the 'Deaf World', the 'Social Model' of disability, and calls to remove 'discriminatory' terminology. Development of the “Impairment - Disability - Handicap” distinctions in the 1950s (Riviere [1970]) aimed to replace adverse labelling, and was adopted by the World Health Organisation in 1981. A further conceptual leap took the terminology to “Impairments - Activities - Participation” (WHO 2001). It remains to be seen how far human activities in the mass media and at street level can respond positively to the proposed more 'inclusive' jargon.

Noticeable Patterns

Origins of Suffering

The major European and Asian philosophies and religions have all contemplated questions of suffering, its origins, possible meanings, reality or unreality, and possible connections with the progress of the soul (if any). Disablement has often entered the picture as a kind of 'permanent state of suffering'. Models of suffering (and therefore of disablement) needed to accommodate beliefs on the following broad patterns (Miles 2002a, revised).

1. We live one earthly life, followed by
   A. nothing;

or by: B. a long-lasting spirit existence, the quality of which will have some relation to rights and wrongs in the earthly life;

or: 2. We each live many lives, the conditions in each successive life depending on conduct in the earlier ones.

And: 3. The one life, or many lives, is/are influenced or controlled by:
   c. genetic / social / environmental influences, but no external transcendental power(s);
or by: d. an external transcendental power or powers;
or by: e. internal interactions of a transcending Whole within which we are atoms.

Middle Eastern and European civilisations during the past 1,500 years mostly favoured explanations involving a version of beliefs [1.B + 3.d]; and more recently in parts of Europe [1.A + 3.c]. Such beliefs have also been present in Asian civilisations, but beliefs [2. + 3.d] or [2. + 3.e] predominated. Explanations based on the latter beliefs have varied enormously as

they balanced ideas of good and evil, fair and just reward or punishment, the possibility of progress toward final liberation from the cycle of lives, etc. Within these variations the observable fact that some people live with a life-long or adventitious severe impairment of body or mind has often been interpreted as an inevitable outcome of personal misdeeds in earlier lives; and this understanding has shaped the immensely variable doctrines of *karma*. In both 'western' and 'eastern' beliefs, the element of ascribed personal responsibility did not necessarily preclude the idea that society as a whole was rotten, e.g. the ruler misbehaved, the people failed in religious duties, so 'monstrous' babies were born to de-monstr-ate divine displeasure, or perhaps as rebounding ill-effects within the interconnected Whole.

Disability as 'Given'

An associated pattern in religious beliefs at many times and places has been that a person's disability is 'given', by an agent, sometimes with purpose. The origins and logic of the 'giving' may tentatively be analysed as follows (Miles 2002b, revised):

4. Punishment
5. Inescapable consequence
6. Statistically probable consequence
7. Casual or incidental outcome

of: (a) the disabled person's own
(b) their parents'
(c) their society's
(d) humankind's

(i) sinful actions
(ii) ignorance and foolish actions
(iii) accidental actions
(iv) mistaken beliefs

(w) in the present life.
(x) in a previous existence.
(y) in earlier ages.
(z) since the human race began.

Clearly there are many possible combinations available in the above sets (though some, e.g. {5.a.iii.z} are hardly intelligible). The 'giver' or 'originator' in the above cases is usually understood to be the deity, fate, *karma*; or sometimes a lesser force such as the offended spirits of ancestors, or microbial agents such as polio viruses, to which insufficient respect has been offered; or recessive genes, e.g. {6.d.iii.y} which have recently appeared as explanatory 'origins'. A different range of views on 'given' disability may be expressed as follows (Miles 2002b):

8. an open-ended challenge for strengthening a person's soul.
9. a specific lesson to be learnt, to enable the soul to progress.
10. a challenge to the disabled person's family or other carers.
11. an occasion for the deity's power or love to be demonstrated.
12. an opportunity for individual or neighbourhood charitable action.

These last five perceptions might appear more 'positive' than the views depicted above; yet they have also come under strong attack in recent decades from Western disabled people's groups and they may be rejected vigorously by some in almost any country. There are also systems of thought or belief in which disability is not purposefully 'given'; it merely occurs randomly, or from the complex interplay of many factors, as suggested in combinations {6. or 7.} d.iii. {w. or y.} Having occurred, the disability can be perceived as an individual challenge; or interpreted as a form of oppression by a 'disabling' society, which must be resisted.

Scepticism, practical concerns, postmodern patterns

Explanations of the world, whether religious or secular, are increasingly purveyed by mass media simulacra and are 'spun' and packaged for political effect. Scepticism toward such explanations, and a perceived loss of meaning in key terms, are also probably rising in the more educated sector of each country, with a parallel and conflictual intensification of the desire for comforting or inspiring beliefs, formulae and metanarratives, experienced both communally and individually. These confusing trends in beliefs impinge upon the disability and rehabilitation fields in various ways.

For example, conflicts persist between disability identity politics and programmes for eliminating disability by scientific means. Smallpox used to be the physiological cause for a significant amount of blindness, and eventually a global drive was made to eradicate smallpox, and consequently to reduce the number of people losing their sight in youth or middle age. The package of health-promoting measures in which smallpox vaccination was included also contributed to rising longevity across the world, with a concurrent rise in old-age vision impairment and blindness. (Much of this unintended outcome is attributable to cataracts, which can be removed surgically at modest cost; but surgery still requires skills, finance, equipment, and individual trust, belief, consent, attendance, cooperation and aftercare. Those factors have proved much harder to organise, on the massive scale, than were the smallpox vaccination drives). There were no noticeable protests by blind people's organisations against the various measures to reduce blindness. On the other hand, various measures to eliminate deafness from infancy onward have been contested by some Deaf people, as a form of 'genocide' against people who consider themselves to have no disability but merely a different form of communication. There are ongoing and intricate ethical debates about the rationale for, and legitimacy of, using scientific means to avoid the conception and birth of people with significant impairment, or difference from a supposed 'norm' (see e.g. Anstey 2008, for a recent critique of some arguments).

Another unexpected outcome of scientific medicine in much of the world, countering some of the confidence in 'progress', is that 'modernisation' is often associated with the presence of far more disabled people in the community: infant mortality falls, far more infants with significant impairments and disabilities survive, greying populations also live much longer with increasing disabilities (Helander 1999, 19-32). Over one or two decades a large, unexpected population thus tends to emerge, of young, middle-aged and elderly disabled people with unmet needs for education, training, work opportunities, specialised health and care services; and also with hopes for some worthwhile and meaningful roles in their community or society.

The processes of modernisation are often accompanied by a rhetoric of universal 'rights' and of freedom from unwanted duties and obligations imposed by traditional religion and social custom. The 'rights' discourse has become popular in the modern western disability field, and has had some serious academic discussion (e.g. Silvers 1998). In other parts of the world, it is in some conflict with the traditional notion that families (or more precisely, female members of families) and local communities would or should voluntarily provide basic care for the needs of their members. However, in modernising economies with growing urbanisation, girls are more likely to go to school, and women to find paid work outside the home, becoming less available in traditional roles as unpaid carers for disabled and elderly relatives. New stresses have thus been generated in the ambient 'moral discourse' of many Asian populations (Cohen 1998; Ngan & Kwok 1992; Traphagan 2007), while the availability of unpaid care in many African countries has been reduced by the impact of HIV/AIDS on populations. 'Rights' are of practical use mainly in the rather few countries with well-functioning legal systems accessible to the weak as well as the strong, and with organised availability of paid 'carers'. In much of the world, disabled people (like everyone else) will continue to depend to some extent on the goodwill of their families and fellow villagers or citizens, some of whom will voluntarily make an extra effort to be helpful, while others will not do so even under legal compulsion. Probably the balance of willingness and unwillingness may be influenced by law, by religious or moral exhortation, by spiritual motivation, by appeal to cultural traditions, by various socio-economic changes and other factors; but these are difficult and unpredictable areas for government intervention, planning or service provision.

Conflicts over 'healing'

The universal human experience is of birth, life, and death, usually preceded by decline, with ailments and impaired abilities along the way. Modern science describes many remarkable bio-mechanisms by which the mind-body continually fights off decay and heals itself, until finally weakening and collapsing. There are also many historical claims that illness or impairment has been reversed or removed in a singular way, often with the intervention of a healer and in a context of religious belief and practice. The mechanisms in such reported events have usually not been described, measured or investigated scientifically, as they are not replicable in controlled conditions. Scientific and religious observers may be equally sceptical about event reports that are outside the normal human experience, where there is a history of such claims being fabricated or greatly exaggerated.

Scepticism is often justified, but sometimes creates barriers to rehabilitation progress. For many centuries, it was 'common knowledge' that people born deaf were also mute, and incapable of rational thought, understanding or moral responsibility. Any evidence that might seem to contradict this 'knowledge' was dismissed as a pretence or delusion. The *Encyclopaedia Judaica* notes a “first breakthrough in the attitude previously adopted”, when a Jewish scholar visited the Vienna 'school for deaf-mutes' during the 19th century, and discovered deaf children being taught, and giving evidence of comprehension. His report was slowly joined by similar evidence, and a century later scepticism gave way to the weight of experience, in Jewish teaching (Rabinowitz 2007; cf Marx 2002, 114-117, and Abrams 1998, 168-190). Luther in the 1520s similarly had personal acquaintance with one deaf young woman who gave evidence of understanding the Christian message; so he directed that she and other deaf people showing such evidence must be accepted as full participants in the church ceremonies (Luther, edition 1883-1983, vol. 6: 377-378). Some detailed recent

religious rulings by Saudi Arabian authorities, translated by Rispler-Chaim (2007, 97-134), while in many ways kindly and enlightened, seem hardly aware of several centuries of development in deaf education, or other capacities of modern disabled people in a well-designed environment. A willingness exists to engage in legitimate updating of religious law; but the process remains slow.

Scientific scepticism about reports of 'miraculous' healings has some evolving religious counterpart in the Roman Catholic office that investigates such reports in connection with the canonization of saints. Apparently, in 1088, eye-witness reports alone were required; in 1588, medical and legal opinions were also needed; after 1948, a Medical Council was established, with strict criteria for establishing the pre-existing medical condition and its prognosis, the claimed healing event, and evidence of the outcome, by a group of specialists in each category of disease (M. di Ruberto, reported in Falasca 2004). In the Coptic Church, reports of miraculous healings may also be closely scrutinised (Godron 1991). The further sceptical gaze of anthropologists has focused on western scientific investigations of non-western treatments having a medico-religious basis, where one outcome may be to determine and extract a possibly effective biochemical agent, to eliminate the 'magical, mysterious, religious' trappings, to test 'scientifically' the bits that can be tested, and to get the results patented and legally approved for mass marketing. This kind of interface between, for example, North American medical science, Tibetan healing treatments, multinational pharmaceutical companies, and a global public eager for cures tinged with ancient wisdom, displays a formidably complicated mixture of motives, beliefs, passions and conflicting epistemologies (Adams 2002).

Occasionally a different kind of scepticism has led to the proposal of an innovative therapy, in which people with serious disabilities are called upon not to be 'healed' from bodily or cognitive disability, but to participate in the acceptance of disability and the healing of one another's wounded hearts and lives. Examples have been recorded in “L'Arche” households, a modest presence in more than 30 countries, where a few disabled people create a communal home with some volunteer 'assistants', working together for mutual acceptance and tolerance across all barriers of race, religion, normality or abnormality: small signposts toward a radically different valuation of the human being (Einsle 1982). This movement is one of rather few that has given a higher value to people with intellectual or cognitive impairments, taking as its working rule the Beatitudes of Jesus -- “Blessed are the poor! Happy are the innocent in heart!”, and similarly flagrant contradictions of 'street smartness', which are not easily subjected to randomised controlled trials. Starting from that Judaeo-Christian base, l'Arche communities in Asia and Africa seem to have touched the string of reverence for innocence and harmlessness that resonates in the other major religions, as well as uncovering the worldwide abuse and oppression of those who must live their lives with greater vulnerability, without the 'normal' human defences of cunning and mistrust. Comparatively little study has been made of the self-reported spiritual experiences of such people (Shogren & Rye 2005). Their possible value as 'barefoot therapists' in the neighbourhood, and 'practitioners of difference' in a world of conflict, inevitably evokes scepticism; yet it has traces of recognition in the world's folk wisdom and 'kitchen theology' (Hawkins 2004; Ibn Khaldun 2005; Miles 2007; Shoshun 1998).

Postmodern skepticism

In characteristic postmodern thought, the metanarratives of religion, science, or any other

large epistemological systems, are subjected to sceptical gaze. The worldwide religious heritage on disability issues, while generating some well-tried and orderly patterns of thought and behaviour, remains a very mixed bag with slow responses to changing conditions. Some critical observers certainly think it would be better to throw out all the 'old junk' and start afresh with simple, evidence-based therapy and rehabilitation, in close consultation with disabled people's organisations and other interested parties. Yet religious belief and practice has very deep roots throughout the world, which show signs of decay in some places but continually break out in new growth and adaptation, usually avoiding very abrupt reversals. 'Science', as another heritage of philosophy and belief, with a worldwide urban distribution, observes and constructs more orderly and testable patterns of response to disability, yet has short roots and even those are frequently pulled up for critical examination and modification. Scientists of each decade often appear to reject the findings (or at least the interpretations) of scientists of previous decades, and can expect their own to be similarly short-lived, with some loss of public credibility in the outcomes of the game. While many solid products of modern scientific technology sustain the everyday life of the 'modern world', others are imbricated with global warfare, environmental destruction, new disease pandemics, and the activities of multinational companies dedicated to maximising shareholder profits, without very clearly generating much increase in human wisdom or motivation to manage the threats. A case may be made for enlisting resources of science, religion, philosophy, and other repositories of human knowledge, while using the analytical powers on each side to identify and diminish their harmful side-effects.

Some Implications for Rehabilitation

Noticing “my spirituality”

The challenge mentioned above, that rehabilitation systems should take some notice of “my spirituality”, remains difficult in the confused, shifting, secularising and fragmented modern sector of every country. Yet it can also be an attractive challenge and goal, for rehabilitation personnel who would like to develop their professional knowledge and offer service that is more humane, more resourceful and culturally more appropriate (Underwood 1999). Whether they personally may have no religious beliefs, ambiguous beliefs or strong beliefs, the possibility is open to develop a better understanding of the spectrum and 'range of movement' in other people's thoughts, beliefs, spirituality and religious practice. Some 'cultural diamonds' found in the religious, spiritual and philosophical heritage may be recut and polished to shed new light, or illuminate from a different angle, the human experiences of disablement, rehabilitation and gaining social space to lead a satisfactory life with some unusual features. The issues and problems were being discussed and recorded far back in history and remain unresolved today; yet the earlier discussions and adjustments have their uses. Modern developments may be proposed, not as radical innovation with 'dangerous' secular ideas, but as retrieval of the world's ancient wisdom, reconstructing or refreshing it for a new generation.

Research on the 'religious/spiritual uplift'

Increasing numbers of studies have been undertaken (listed in the standard academic databases of medicine, social science and religion) to discover whether there is evidence that religious or spiritual factors may have a *measurable influence* on illness, disability and rehabilitation, whether by increasing or diminishing patients' participation and compliance, affecting the speed of decline, improvement or recovery, improving the personally reported

quality of life or of community responses. (Lines of research opening up in neuropsychology and other fields would require detailed discussion and expertise which cannot be attempted here, but may be mentioned elsewhere in the Encyclopedia). Not surprisingly, there have been great difficulties in defining relevant factors and producing measurements that are valid, to the extent of being broadly credible. Where the investigators hope to show a positive correlation between religious belief and physical or mental improvement, no doubt the experimental design would benefit from the sceptical gaze of intelligent atheists before the event, rather than merely encountering their incredulity afterwards. Where investigators hope to identify a neurological mechanism that correlates with reported religious activity, they too should welcome the scepticism of religious believers toward any reductionist claim to have located the 'god reflex' or 'god gene'. The prominent atheist philosopher Daniel Dennett (2007, 272-277) has outlined such a collaborative endeavour, and apparently is quite open to finding evidence that religion might be 'good for your health', though of course anticipating that the benefits accrue from physical or psychosomatic mechanisms that require no divine origin or intervention.

Ethical convergence / divergence

In the histories of responses to disability and disabled people there is considerable common ground between various world religions and philosophies. At some points they are able to make a common presentation of support for what is currently deemed 'enlightened and inclusive' behaviour or rehabilitative practice. There is likely also to be a continuing measure of divergence, as it becomes clear that some religious theories, which modern intellectuals periodically dismiss as old and moribund superstitions, are neither disappearing nor are up for negotiation. The complex theories of *karma* and a cycle of rebirths probably fall into this category, and have continuing relevance to thoughts about disability. Such theories seem sufficiently reasonable and logical to perhaps half a billion adults, whether in a traditional rural context (Sharma 1973) or among urban intellectuals having considerable education and knowledge of modern western sciences and philosophies (Potter 1983). Scientific accounts basically deal with statistical probabilities having no intrinsic moral content or 'meaning for living', whereas *karmic* accounts are intended to relate specifically to the moral and spiritual content of people's lives and behaviours. Each type of account has some flexibility, deals with invisible forces and entities, responds to some aspects of the human search for patterns in the events of life, and appeals to people who have grown up in a conceptual world that supported this kind of account.

Holistic, friendly rehab?

In some parts of the urban world, a long tradition of hands-on rehabilitative treatment has been relegated to the margins, and trainee therapists instead learn to place clients inside an expensive machine. If the city electricity supply is on, and the machine has no broken parts, it applies some invisible form of radiation to the client's body. Practitioners may even customise their machine by strategic internal attachment of a small, battery-operated red light bulb producing a warm glow, which reassures clients that they really are getting their money's worth of advanced technology. (Practitioners may realise that the bulb functions quite well when the main electricity supply fails, or the machine breaks down; so the cost of replacing broken parts can also be saved). Belief seems to be the key to this story: belief in technology, belief in beneficial rays, eliminating the messy, fallible, personal, human touch; belief in the placebo effect; belief in fulfilling clients' superficial expectations; belief in maximising profits.

Against such devices and deceptions, there is some recognition that the strange spectrum of mind and body may do most of its self-healing, or perhaps be more open to unseen beneficial forces, if the practitioner offers a personal response of kindliness and encouragement. This may entail building the clients' hopes, resilience and immune system; patiently listening to their beliefs and nodding at those parts that seem positive or harmless; being the kind of healer that each person seems to need; recognising each person's human dignity, while gently guiding them toward evidence-based practices of therapy, diet, exercise, rehabilitation, social participation. Trained practitioners will be well aware of the ethical sanctions against imposing their personal beliefs or philosophy on clients, especially those who may be in a particularly vulnerable period of transition in their lives. Yet this does not mean hiding the human presence behind a professional mask, but offering the human presence with some reticence, respect and consideration.

The prudent remark attributed to Muhammad may also be cited: “Trust in Allah, and tie your camel's leg” (or perhaps a modern equivalent, “Believe in God, and get your child immunised”). If rehabilitative treatment continues for some time without apparent benefit, and the question of results becomes more insistent, the practitioner (with whatever personal beliefs) may suggest other kinds of therapies or adjustments. Yet to be honest, and to respect the economic realities of many clients' lives, the practitioner may also need to explore with clients how their life might go on with the present or increased impairment or suffering, and what adjustments and resources for relief may be available. Personal belief, age, experience and life-stance inevitably enter the equation. To the older, atheistic patient, for whom life is basically a stream of electrons making transient patterns in a meaningless void, the friendly response might be no more than to listen to what sort of 'transient patterns' that person has found worthwhile and enjoyable in life. For the client living within a religious context, there is in most religions some more hopeful strand of belief, in which suffering can be seen as submission to the deity, as sharing in the common lot of humankind, as a testing of the soul, as preparation for a future spiritual existence, or some other construction that enables it to be borne with dignity and courage. Returning to Nosek (1995) on spirituality and rehabilitation: “Both are paths towards defining who you are, how you relate to your universe, and where you are headed.”

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Note: An annotated bibliography of 460 historical and current items on disability and religion in the Middle East and Asia, including many of the following references, appears at: http://www.independentliving.org/docs7/miles200707.html

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