# Medical Discourses and Practices in Contemporary Japanese Religions

*Monika Schrimpf*

## ABSTRACT

In contemporary Japan, many religious actors engage in therapeutic practices with the intention of curing or preventing disease, whether in new religious movements and the Japanese New Age, in folk religion or in "established religions" (*kisei shūkyō*). Notwithstanding the prominent role of Buddhist scriptures, temples, and priests in medical practice and knowledge in premodern Japan, the introduction of a public healthcare system in the Meiji era (1868–1912) based on German medicine resulted in a functional and institutional differentiation between medicine and religion. Therefore, the question arises how contemporary religious actors offering therapeutic practices can legitimize their actions and position themselves in Japanese society. By choosing the example of a Nichiren-Buddhist priest's concepts of Buddhist medicine and Buddhism as medicine, as well as healing practices in a new religion called Perfect Liberty Kyōdan, two strategies of legitimizing and positioning therapeutic practices in the religious field will be described: the scientification of religious practice, and code-switching between the semantic fields of medicine and religion.

## 1 INTRODUCTION

This article explores possible ways in which contemporary religious actors whose religious traditions used to comprise medical or therapeutical techniques, react to a social and political environment in which religions are—at

least on a political level—deprived of medical authority. How can they legitimize engaging in therapeutical activities intended to cure or prevent disease, and how do they position themselves in a society where religion and medicine are functionally and institutionally differentiated? More specifically, the strategies introduced here illustrate religious responses to the relevance assigned to science in the process of medicalization,[1] i.e., to the replacement of religious views of man, body and illness by scientific models of physiological processes and conceptualizations of the human body as a multipartite organism. These strategies are not representative of Japanese religions in general; rather, they serve to illustrate possible ways in which religious actors make use of the alleged superiority of science-based medicine in order to legitimize their therapeutical activities and consolidate the social status of their religious community.

Although in premodern Japan, medical knowledge and practice were an indispensable part of Japanese Buddhism, public healthcare in contemporary Japan is provided primarily by biomedical institutions and experts whose scientific training and licensing is regulated by secular law. This medical system rests not only on the development of biomedical knowledge, practices, and institutions since the introduction of German medicine in the Meiji era (1868–1912), it also includes *kanpō* medicine or "Japanese traditional herbal medicine", the Japanese adaptation of Chinese medical traditions.[2] Whereas in the late Edo (1603–1868) and early Meiji eras *kanpō* medicine was the main rival of so-called Western medicine (*seiyō ijutsu*) (Oberländer 1995:

1 For the concept of "medicalization" cp., for example, Conrad 2007; Foucault 1973. Conrad provides a short definition of the term: "'Mecicalization' describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders." (2007: 4).

2 Literally, *kanpō* means "methods from Han-China" (206 BC–220 AD). Chinese medicine was introduced to Japan in the fifth century in the wake of the spread of Buddhism to the country. *Kanpō* medicine developed its specifically Japanese form during the Edo period (1603–1868), when the number of crude drugs used in decoctions was reduced to approximately 250 herbal plants and formulae, and Yoshimasu Tōdō (1702–1773) developed a particular abdominal palpation method (*fukushin*) for diagnosis. He also emphasized the practical, symptom-oriented focus of medical practice and de-emphasized the underlying theoretical concepts of the five phases, Yin and Yang etc. (Watanabe et al. 2010).

51), today it has been smoothly integrated into the medical system as a complementary herbal drug treatment.[3]

Notwithstanding the dominance of biomedicine and its incorporation of *kanpō*, other types of medical techniques, such as acupuncture and moxibustion (*shinkyū*) and massage therapy (*anma*), are also acknowledged as part of the public healthcare system and are subject to a training and licensing system regulated by the Ministry of Health, Labor and Welfare (MHLW).[4]

Outside the realm of officially recognized medical practices, religious actors, especially in the field of "new religions" (*shinshūkyō*) and the "new spirituality culture" (*shin reisei bunka*),[5] but also in folk religion or the so-called established religions (*kisei shūkyō*), provide alternative explanations for what causes illnesses and offer corresponding practices designed to heal[6] them. These forms of religious therapeutic knowledge and practice must be analyzed against the backdrop of a functionally differentiated society.

---

3 Therefore, a critical juxtaposition of these two as representing (reductionist) Western vs. (holistic) "traditional" or indigenous medicine, as suggested by Margaret Lock under the labels "cosmopolitan medical system" and "East Asian medical system" (1980: 3), is questionable for present-day Japan. Still, her study provides valuable insights into medical views and attitudes of contemporary *kanpō* doctors and patients.

4 For information on the licensing system for acupuncturists, moxibustionists and *anma* massage therapists, see the website of the Japanese Society for Acupuncture and Moxibustion (JSAM): http://en.jsam.jp/contents.php/020000RNSXjD/, July 4, 2018. Acupuncture, moxibustion, and *anma* massage or acupressure therapy are partly covered by national health insurance (http://apps.who.int/medicinedocs/en/d/Jh2943e/9.6.html#Jh2943e.9.6, July 4, 2018).

5 The term as coined by Shimazono Susumu designates the New Age culture of Japan as comprising imported elements of Western New Age, as well as specifically Japanese notions of spirituality and related activities, networks, i.e., the so-called "spiritual world" (*seishin sekai*) (2007: 46–57).

6 The term "healing" (*iyashi* as noun, *iyasu* as verb) as applied in the context of religions and the new spirituality culture goes beyond the meaning of physical curing. As Yumiyama Tatsuya states with regard to contemporary Japanese new religions: "Thus religious people speak not only of diseases that are cured through faith but of diseases that, uncured, occasion the realization of the true meaning of life or the perception of erroneous ways of thought." (Yumiyama 1995: 269).

Despite the historical relevance of therapeutic services in the Buddhist or new religious traditions, propagating them today requires legitimizing the religious claims of an authority that is assigned to medical institutions, knowledge and social practices.

## 2 TERMINOLOGICAL REFLECTIONS

The term biomedicine is applied here to denote a conceptualization of medicine based on the principles of the natural sciences, in particular biology. Notwithstanding multi-layered criticisms of the term as both a research perspective and a medical concept (Bruchhausen 2010), I prefer "biomedicine" to the alternative terms "Western medicine" and "modern medicine," which are often used in literature about Japanese medical history. Not only does "Western medicine" disguise the plurality of medical traditions in Europe and North America, it also ignores the developments that took place in Japanese biomedicine after its introduction in the Meiji era. Besides, both "Western medicine" and "modern medicine" are used as counter-terms in the realm of traditional, complementary, and alternative medicine, where they denote a symptom-oriented, science-based kind of medicine originating in the "West" that does not take the mental and spiritual aspects of illness into account. For example, on the website of the Japanese Society for Integrative Medicine, the basic distinction between symptomatic treatment (*taishō ryōhō*) and causal treatment (*gen'in ryōhō*) is used to characterize the differences between modern Western medicine (*kindai seiyō igaku*) and traditional, complementary, and alternative medicine (*dentō igaku, sōho daitai iryō*). "The kind of medicine practised in many medical institutions today builds on modern Western medicine with its focus on the treatment of symptoms" (http://imj.or.jp/intro, July 4, 2018).[7]

In contrast, the concepts of oriental medicine (*tōyō iryō*)[8], East Asian medicine (Lock 1980), and traditional medicine (*dentō igaku*) are often

7 This and all following English quotations from Japanese sources are my own translations.

8 See, for example, the website of the Japan Society for Oriental Medicine, which is dedicated exclusively to *kanpō* medicine (http://www.jsom.or.jp/index.html, January 29, 2018).

qualified as representing a holistic, individualistic, and natural approach to health and wellbeing. The Japan Holistic Medical Society explains the main principles of holistic medicine (*horisutikku igaku*) as a "holistic (wholesome) view of health" (*horisutikku (zenteki) kenkōkan*), reliance on "the therapeutic powers of nature as the source of healing," trust in self-healing powers, the combining of various medical methods to create the appropriate treatment for each case, and the conviction that realizing the inherent meaning of illness contributes to individual self-realization (http://www.holistic-medicine.or.jp/holistic/definition/, July 4, 2018). Traditional medicine is described by the Japanese Society for Integrative Medicine in terms of juxtaposing culture with science:

> "There are specific styles based on regional characteristics such as climate, food, ethnos, customs etc., and they have evolved as traditional medicine and folk medicine. In this sense, traditional medicine is clearly more of a culture than a science, and given this background it can be viewed as a medicine tailored to the patients' and clients' individuality." (http://imj.or.jp/intro/qa, January 29, 2017)

However, both societies advocate the combined use of biomedicine, Japanese traditional medicine, and CAM (Complementary and Alternative Medicine). This discourse also provides an important frame for proponents of Buddhist medicine.

## 3 DIFFERENTIATION OF RELIGION AND MEDICINE IN JAPAN

From ancient times, health care in Japan was provided by either officially trained physicians or Buddhist "priest-doctors" (*sōi*).[9] In ancient Japan, Chinese medical literature and the knowledge transmitted by Korean physicians provided the main basis for medical practice. From the ninth century, these writings were complemented by Japanese medical literature, starting with the *Daidōruijuhō* (806–810) and the *Ishinpō* (982–984) (Rosner 1989: 12–33). In addition, Buddhist priests relied upon Chinese (and to a lesser degree Indian) medical knowledge as passed on in Buddhist scriptures such as the *Sutra of Golden Light* (Jp. *Konkōmyōkyō*; Skt. *Suvarṇaprabhāsottama-sūtra*), the meditation manuals *Tendai shōshikan* ("Shorter Treatise on śamatha and vipaśyanā") and *Maka shikan* ("The Great Calming and Insight") by the Chinese monk Zhiyi (Chigi; 538–597), founder of Tian'tai Buddhism and many more.[10] From the Heian era (794–1185), Buddhist temples became places where commoners could find medical help. Paul Demiévielle's classification of three types of Buddhist healing practices corresponds to Buddhist medicine as practiced throughout Japanese history: Buddhist healing comprised "religious therapeutics (good works, and practices of worship, expiation; meditation etc.), magical therapeutics (mantras, incantations, esoteric ritual), and medical therapeutics proper (dietetics, pharmacy, surgery etc.). The lines demarcating these fields are not at all distinct" (Démieville 1985: 6).[11]

---

9 For general overviews of Japanese medical history, cp. Fujikawa 1911, Kuriyama and Yamada 1997, Rosner 1989, and the historical chapters in Siary and Benhamou 1994.

10 Beside Paul Démieville's fundamental article on Buddhism and healing (1985 in English, original 1937), Pierce Salguero has written extensively on the transmission of Indian and Chinese medicine in Chinese Buddhist scriptures (2013, 2012, 2010–11, 2009). See also Katja Triplett's introduction to Buddhist medical scriptures used in early and medieval Japanese Buddhism (2012).

11 Various authors have contributed to the study of Buddhist medical history in Japan: For early and medieval Japan see Cristoph Kleine (2012), Juhn Ahn (2008), Edward Drott (2010), Katja Triplett (2012), and Andrew Goble (2011). Pamela Winfield (2005) and Jason Ananda Josephson (2013) focus on the medieval and early modern Buddhist practice of "empowering prayers" (*kaji*) and their re-

From the late sixteenth century, Buddhist priest-doctors were challenged and complemented by medical professionals trained in *kanpō* medicine and frequently also in the Confucian and neo-Confucian classics (Josephson 2013: 125; Rosner 1989: 63–72). Starting with the arrival of European missionaries in the sixteenth and seventeenth centuries, both traditions were confronted with the gradual spread of European medical thought. With the publication in 1774 of Sugita Genpaku's (1733–1817) *Kaitai Shinsho* ("A New Book on Anatomy"), a Japanese translation of the Dutch translation of Johann Adam Kulmus' *Anatomische Tabellen* (1725),[12] European anatomical knowledge became increasingly known in Japan. In the Meiji era, concepts of the human body as a kind of independent organism gradually started to supersede hitherto prevalent views of the body as being influenced by the flow of *ki*, the relevance of its balance, and its effects on the internal organs.

In the wake of modernization, the new Meiji government installed a system of public healthcare that shifted responsibility for health from the individual to the state. Starting in 1874, a standardized system of medical examination was established, and from 1876 anyone aspiring to acquire a license as a physician had to study biomedicine as imported from Germany. The first decree issued in 1874 by the Ministry of Education regulated the training and licensing examination of physicians and pharmacists, as well as the control of pharmaceuticals (Oberländer 1995: 61). It was followed by various regulations (*kisoku*) and codified as a law (*fukoku*) in 1883 (Oberländer 1995: 61–62,140). Medical ideologists like the physician and politician Gōtō Shinpei (1857–1929) denounced premodern medical practices, such as *kanpō* or Buddhist healing prayers, as useless, obstructing modern medicine, and damaging the national body. In addition, in 1874 the Ministry of Doctrine (Kyōbushō) issued an ordinance specifically prohibiting religious healing practices: "Healing by means of magical rituals and the like are obstructing the government and are henceforth prohibited." (Josephson 2013:129–131, quote 131; Shinmura 2013: 283)

---

interpretation in the modern era. For the early modern period see Duncan Ryūken Williams' study on the medical activities of Sōtō temples in Tokugawa Japan (2005: 83–116), and Juhn Ahn on the relation between Zen, medicine and sword fighting (2012). See also Nihonyanagi's study on medicine in esoteric Buddhism (1997) and Shinmura's (2013) overview of Buddhist medical history in Japan.

12 The *Ontleedkundige Tafelen* or "Anatomical Tables", 1734.

The gradual implementation of this policy[13] was a blow especially to *kanpō* doctors, who in 1873 made up about eighty percent of Japanese physicians, and to Buddhist temples offering medical services. A Westernization of medicine took place, in which medicine was differentiated from religion as a separate sphere, regulated by the state authorities, and conceptualized as pursuing different goals.

As a result of these processes, biomedical institutions and practices have become the dominant form of medicine in contemporary Japan. Yet ever since the revival of *kanpō* medicine in postwar Japan, starting with the foundation of the Japan Society for Oriental Medicine (*Nihon tōyō igakkai*) in 1950, *kanpō* has become an integral part of the contemporary healthcare system.[14] It should be noted, however, that this integrated form of *kanpō* differs substantially from premodern *kanpō*: most conventional physicians do not practice the *kanpō*-specific type of diagnosis (*shō*)[15] but prescribe herbal drugs on the basis of conventional medical diagnoses. Moreover, most *kanpō* drugs are produced using industrialized techniques in which spray-dried granulate extracts have replaced the former decoction of crude drugs

13 Takeda Dōshō points out that the implementation of the health policy of licensing physicians and hospitals was slow and that the lower social classes had limited access to them. For him, the coincidence of this failure of public healthcare with numerous cholera epidemics in the 1880s and 1890s supported the popularity of religious healing practices offered by new religions such as Renmonkyō (Takeda Dōshō 1991; http://www2.kokugakuin.ac.jp/ijcc/wp/cpjr/newreligions/takeda.html, January 29, 2018).

14 For a detailed reconstruction of the *kanpō* revival movement in the twentieth century, cp. Oberländer 1995 and Hattori 2014. See also Margaret Lock's fieldwork study (1980) of the activities and conceptualizations of *kanpō* doctors and patients in the 1980s. Since 2001, *kanpō* has been included in the curriculum of obligatory medical studies, and conventional physicians are allowed to prescribe *kanpō* drugs, 148 of which are covered by national health insurance (Watanabe et al. 2011).

15 The typical *kanpō* diagnosis comprises "[…] investigation of the complaints and symptoms of the patient, including taking their temperature, examining sensation, weakness or sweating […]. The physical examination includes abdominal palpation, tongue inspection and pulse diagnosis." (Watanabe et al. 2011, 1.3 "Background of Kampo").

(Watanabe et al. 2011, 1.2, "Usage and Integration into Modern Medicine"). Notwithstanding these changes, *kanpō* is extremely popular in contemporary Japan.[16]

> "While Chinese medicine and acupuncture are looked on with doubt by some and there is certainly room for debate as to whether or not these therapies are seen by most as viable means of treating serious illness, as an overall trend, current attitudes towards *kanpō* and acupuncture are perhaps more positive than any time since the Meiji period." (Hattori 2014: 18)

Although *kanpō* is based on premodern medical practices which were a full-fledged alternative to biomedicine, today *kanpō* physicians and the Japan Society for Oriental Medicine tend to characterize it as a complementary form of medicine which compensates for the limits and deficiencies of biomedicine. In doing so, they have adopted the critical stance and semantics of Complementary and Alternative Medicine (CAM), emphasizing the holistic approach and the naturalness of *kanpō* medicine, its reliance on the patient's own self-healing powers, and its effectiveness in cases of chronic diseases (where biomedicine fails) (Oberländer 1995: 217–219). Oberländer explains this re-interpretation as resulting from the new educational system established since the Meiji era, which requires all *kanpō* specialists to be trained doctors of conventional medicine (1995: 219).[17] Thus, contemporary *kanpō* is an "invented tradition" (cp. Hobsbawm/Ranger 1983) which is semantically much closer to CAM than to its Japanese premodern predecessors.

Adding to the plurality of medical practices are the healing practices offered in religious communities and by agents of the "spiritual world" (*seishin*

16 In 2011, the Japan Society for Oriental Medicine counted 2,150 certified *kanpō* specialists practising in Japan, as well as 152,049 licensed acupuncturists and 150,812 moxibustionists (Hattori 2014: 18).

17 Besides, Osamu Hattori reconstructs the strong stimulus that postwar Japanese *kanpō* doctors and acupuncturists received from European movements in complementary and alternative medicine. Hattori diligently reconstructs how the mutual visit of a German physician (Heribert Schmidt) studying *kanpō* and acupuncture in Japan, and the subsequent visit of a Japanese *kanpō* doctor (Hiroshi Sakaguchi) to Germany in the 1950s influenced the *kanpō* and acupuncturist movements and the self-perceptions of their supporters in Japan (cp. 2014).

*sekai*).[18] Whereas healing services provided in networks or so-called "client religions" are open to everybody, rituals specific to the new religions are usually accessible only to their members. In addition, recent initiatives propagate Buddhist places and practices as contributing to individual wellbeing, such as temple yoga or meditation as a means of stress-reduction (e.g. http://www.tera-buddha.net/project/spilit_body/, January 29, 2018).

## 4 TWO CASE STUDIES

The following two case studies are situated in the contexts of (1) traditional, complementary, and alternative medicine in a Buddhist setting, and (2) religious healing practices in new religions. The examples of the Nichiren Buddhist priest Kageyama Kyōshun and the new religion Perfect Liberty Kyōdan provide insights into two possible legitimation strategies used by contemporary religious actors offering therapeutic practices. They were chosen because they illustrate significant ways of relating religious and medical or scientific authority and not because they represent the main advocates of therapeutic practices in established Buddhism, TCAM or new religions in Japan. In accordance with Steve Bruce's observation that nowadays "only the fringes of religion" (2016: 640) propagate (or reject) therapeutic practices, both examples illustrate these fringes: Perfect Liberty Kyōdan as a new religion and Kageyama Kyōshun as a non-mainstream Buddhist priest, as we shall see below.

### 4.1 Buddhist Medicine: Kageyama Kyōshun

Despite the long history of Buddhist medical practice in Japan, contemporary advocates of Buddhism as a medical tradition are comparatively rare. Instead, Buddhist schools and individuals have recently become actively engaged in providing spiritual care or grief care,[19] especially for terminally ill

18 Cp., for example, Araya et al. 1995; Kubotera 2011; Tanabe/Shimazono 2002; Shimazono 2003.

19 Cp., e.g., the Vihara Movement and concepts of Buddhist counseling as developed in Jōdo Shinshū (Tomohisa 2010, 2013), or the cross-denominational Institute for Engaged Buddhism (Risshō Bukkyō Kenkyūsho; http://www.zenseikyo.

patients or in the aftermath of the triple disaster in Tōhoku in 2011.[20] In addition, the role of Buddhism in the contemporary Japanese healthcare system was the topic of a research project (1999–2001) headed by the Research Institute of Bukkyō University and entitled "Contemporary Problems of Modern Medicine—from a Buddhistic [sic] Point of View—" (Bukkyō Daigaku Sōgō Kenkyūsho 2013). The research adopted a critical stance towards biomedicine because of its alleged tendencies towards objectification, dehumanization, and superficial doctor-patient relations. In contrast, Buddhist medicine was advocated as a means to add a holistic and humanistic perspective to contemporary healthcare (Muraoka 2003: 4–5). In defining Buddhist medicine, Muraoka Kiyoshi, head of the research group, referred to a contemporary interpretation of the sixth century meditation manual *Maka shikan*, mentioned above, thus contributing to the construction of an "invented tradition" of Buddhist medicine.[21]

The same critical attitude towards biomedicine and the characterization of Buddhist medicine in accordance with the rhetoric of CAM is expressed in a recent publication on "Medicine and Buddhism" (*iryō to bukkyō*) in the Buddhist journal *Samgha Japan* (2018). Here, the depiction of Western medicine (*seiyō igaku*) in opposition to Eastern medicine (*tōyō igaku*), namely *kanpō*, acupuncture, moxibustion, and other *ki*-based healing techniques, is intertwined with a fundamental cultural critique of "the values of Europe and America" (*ōbei no kachikan*) as manifested in materialistic thought and an

---

or.jp/rinbutsuken/index.html, January 29, 2018). Practical examples in the Tōhoku area include the training of "Japanese-style chaplains" (*rinshō shūkyōshi*) at Tōhoku University (http://www2.sal.tohoku.ac.jp/p-religion/2017/cn8/pg37.html, July 4, 2018) and the Café de Monk run by Sōtō Zen monk Kaneta Taiō. On spiritual care, cp. Kamata 2014.

20 E.g. the earthquake and *tsunami* that hit the East coast of Japan on March 11th, 2011, and the subsequent meltdown at the nuclear power plant in Fukushima.

21 More precisely, he relies on Nagura Michitaka's rather selective summary of Chigi's medical approach in five guidelines: (1) care concerning clothes, food, accomodation, human relationships, and guidance; (2) overcoming emotions aroused by the five senses; (3) refraining from greed, hatred, anger, laziness, arrogance, and jealousy; (4) regulating food, sleep, exercise, breathing, and mental attitude; and (5) cultivating virtues such as positive thinking, perseverance, trust, wisdom, and a unified mind (Muraoka 2003: 6).

approach to medicine that objectifies the human being. In contrast, Eastern medicine is described as activating the person's own self-healing powers and striving for the harmonization of mind and body (Iryō to Bukkyō 2018: 4–5).

This way of combining the evaluation of different medical traditions with a critique of "Western" culture as opposed to conceptualizations of a superior Japanese or Asian culture is also characteristic of the writings of Kageyama Kyōshun (born 1951), the Nichiren-Buddhist head priest of the temple Shakaji in Kamogawa in Chiba prefecture. Kageyama is a graduate of Nichiren-Buddhist Risshō University (Buddhist Studies) and obtained his Ph.D. in Behavioral Sciences from the California Institute for Human Science (CIHS)[22] with a thesis about the psychological and physiological aspects of the Chinese Tendai monk Zhiyi's (538–597) meditation manual *Tendai shōshikan*. He has completed and guided the severe hundred-day ascetic practice of Nichirenshū (*aragyō*), is the vice-director of the Nichirenshū Research Center on Contemporary Religions (Nichirenshū Gendai Shūkyō Kenkyūsho) and has published several books directed at the public. The following analysis is based on three of his publications: *Buddhist Body Techniques: Relating "Calming the Mind and Insight" [Meditation] to Psychotherapy and Buddhist Medicine* (2007), *Healing Illness by Prayer* (2010), and *A Buddhist Life awakening to Spirituality: Contemporary Buddhism as Meditation Techniques* (2013).23 Whereas *Healing Illness by Prayer* is written in a rather simple style to advocate the healing effects of Buddhist

22 This institute in Encinitas, California, has been founded by Motoyama Hiroshi (1925–2015), parapsychologist and second head of the religious group Tamamitsu Jinja. It offers degree programs on BA, MA, and PhD level in "Psychology, Integral Health, Life Physics and Comparative Religion and Philosophy". Its academic interest is expressed in Motoyama's "President's message": "[…] conducting research on the healing applications of subtle energy by integrating science with spirituality. […] By experiencing the body-mind-spirit interconnection, as well as integrating science with spirituality, people can gain a deeper insight into the nature of reality, which will hopefully empower them to contribute to the improvement of society at large." (http://www.cihs.edu/index.php/about-cihs/presidents-message/, July 4, 2018) Motoyama Hiroshi also founded the International Association for Religion and Parapsychology (IARP, 1972).

23 These are my translations of the originally Japanese titles (see Bibliography).

practices, the other two books combine elaborate depictions of Indian and Chinese medical concepts transmitted in Buddhist writings with physiological explanations of the effects of Buddhist meditation techniques. In both his temple activities and his publications, Kageyama propagates Buddhism as a salutogenetic medical tradition and a Buddhist way of living as a guarantor of a healthy life. He argues (1) that Buddhist practice is simultaneously therapeutical practice, and (2) that "traditional" Buddhist medicine[24] represents the premodern "medicine of nourishing life" (*yōjō iryō*)[25] as a countermodel to modern "Western medicine" (*seiyō igaku*). For both arguments, he relies primarily on Zhiyi's meditation manuals, whether with regard to their explanations of the causes, types, and treatments of diseases, or as the ultimate authority for East Asian meditation techniques. For reasons of space, I will focus here on his second argument.

Kageyama defines Buddhism as meditation techniques (*meisō gijutsu*) that enable us "to live in a healthy way and face death in a healthy way" (2013: 300). In his understanding, meditation includes various forms of religious practice (*shugyō*), such as sitting meditation (*zazen*), walking meditation, sutra recitation, invocations of the Lotus Sutra's title (*daimoku*) or Amida Buddha's name (*nenbutsu*), or service to others (Kageyama 2010: 105; 2013: 28). He advocates Buddhist meditation as the appropriate way of overcoming the separation of mind and body as prevalent in modern, competitive societies: "As mentioned before, the main need of societies in which

---

24 Buddhist medicine for Kageyama denotes the transmission of Ayurvedic and Chinese medicine in Buddhist scriptures and its reception by Japanese Buddhists such as Nichiren (1222–1282).

25 *Yōjō* (Chin. *yangsheng*) denotes "a broad array of practices aimed at nourishing and prolonging life, including breathing exercises, dietetics (especially abstention from grains), sexual practices, meditation and visualization exercises, pharmaceutical prescriptions, and methods of 'guiding and pulling' (導引) vital pneuma or *qi* 氣 (Jp. *ki*)" (Drott 2010: 254). Originating in China, *yangsheng* theories and practices spread in Japan through Chinese medical writings. They were adopted and complemented by Buddhist and other authors, such as Myōan Eisai (1141–1215), Kaibara Ekken (1630–1714), and many more. See Drott's (2010) analysis of *Kissayōjōki* (1211) and *Chōseiryōyōhō* (1184), and Ahn's (2008) study of Kaibara Ekken's *Yōjōkun*. For Kageyama, *yōjō* medicine was transmitted by Buddhism, and its core is the medical chapter in Zhiyi's *Maka shikan* (2013: 169).

mind and body are separated is liberation from stress, and this can be realized by means of meditation techniques which unite mind and body" (2013: 4). Accordingly, Kageyama calls his temple a Buddhist Meditation Center (*Bukkyō meisō sentā*) and offers not only the usual ritual services, but also yoga classes, meditation and consultation sessions. In addition, his wife provides Ayurvedic treatment and macrobiotic meals.[26]

By means of these services and this self-representation, Kageyama's temple differs from most other Nichiren Buddhist temples. Given his strong criticisms of temple priests who restrict their activities to funerary rites rather than thinking of ways in which they can be helpful to contemporary Japanese,[27] one can easily imagine that he is a contested figure in contemporary temple Buddhism. Therefore, Kageyama could be said to exemplify religious advocates of medicine at the margins of mainstream religion.

## 4.2 Healing in New Religions: Perfect Liberty (PL) Kyōdan

Starting with the earliest new religions, such as Tenrikyō, Ōmoto, Konkōkyō etc., healing has been an important element in the practices of Japanese new religions. Nagai Mikiko distinguishes between forms of "magical healing" (*jujutsuteki na iyashi*), which are based on the performance of rituals or rely on supernatural powers, and "healing by self-cultivation" (*shūyōteki na iyashi*) (Nagai 1995: 97–98). Robert Kisala adds the category of "social healing" (*shakaiteki iyashi*), which refers to social engagement, i.e., "[…] to put it in strong terms, what we can see is the intention to heal the maladies of society as a whole" (Kisala 1995: 112). Like Yumiyama, Nagai emphasizes that healing in this context refers to individual perceptions of being saved, irrespective of whether physical curing has taken place or not (Nagai 1995: 97).

Healing practices in the new religion Perfect Liberty Kyōdan are an example of how magical healing and healing by self-cultivation overlap. Its followers are encouraged to engage in guided moral self-cultivation as a means to overcome disease, injuries, and other forms of misfortune.

---

26 http://temple.nichiren.or.jp/1031159-syakazi/; http://sunwork.her.jp/ayurveda/index.html, July 4, 2018.

27 Private conversation, September 2016.

Guidance, however, relies on god's saving powers as transmitted by the head of the group or its religious teachers (*kyōshi*).

Perfect Liberty Kyōdan (cp. Schrimpf 2018) has existed in its present form since 1946, but it goes back to the pre-war community of Hitonomichi Kyōdan (founded by Miki Tokuharu (1871–1938) in 1925) and its predecessor Mikatekyō Tokumitsu Daikyōkai (founded in 1912, renamed in Shintō Tokumintsu Daikyōkai in 1917). Already the pre-war religious movements had a strong focus on self-cultivation and healing, centering on the practice ofurikae as the temporary transference of illness to the head of the group (Serikawa 1972: 1–27). Although in Hitonomichi Kyōdan veneration of the emperor was strongly emphasized, in 1937 Miki Tokuharu and his son Tokuchika (1900–1983) were accused of lèse majesté and the group was ordered to dissolve (Serikawa 1972: 280–281; Kojima 2008). It was refounded as Perfect Liberty Kyōdan in 1946 by Miki Tokuchika.

PL Kyōdan has approximately 1.2 million members and is headed by Miki Takahito, the third "parent of the teaching" (*oshieoya*), whose uncle was Miki Tokuchika (http://www.perfect-liberty.or.jp/html/name-pl/kyouso.html, January 29, 2018). The doctrinal core consists of 21 "rules of living" (*shoseikun*) as guidelines for the moral conduct of life. As summarized in the slogan "Life is Art" (*jinsei wa geijutsu de aru*), salvation is conceptualized as perfecting moral self-cultivation. With its concepts of divine notices (*mishirase*) and divine instructions (*mioshie*) as essential tools of salvation, PL Kyōdan offers a religious interpretation of illness, and its religious teachers direct the believers in overcoming it. Illness, injuries, and misfortune are seen as divine notices (*mishirase*) indicating distortions of one's self-expression as manifest in inappropriate habitual behaviour or bad habits (*kokoroguse*) such as greed, obstinacy, arrogance, hurry etc. In order to reveal these distortions, so-called divine instructions (*mioshie*) are granted by god to the head of the group, the oshieoya, as someone who is in a "purely objective state" (*junsui kyakkan no kyōchi*) and "one with heaven" (*tenjin gōitsu*) (Miki 1979: 118).

These two examples differ in type of actor—Kageyama as an individual actor, PL religious teachers as collective actors—and data. In the case of Kageyama, analysis relies mainly on his publications. In the case of PL Kyōdan, the main data are the group's publications and instructions directed at the religious teachers (Pāfekuto Ribatī Kyōdan Bunkyōka 1991). In the following, the focus will be on the level of semantics, that is, on the ways in

which elements of the semantic field of medicine are blended into the semantic field of religion.

## 5 RELIGION AND MEDICINE AS STRATEGIC ACTION FIELDS[28]

Strategic action fields are social orders that provide a conceptual and practical frame for the interaction of individual or collective actors. This term, coined by Neil Fligstein and Douglas McAdam, designates "a constructed mesolevel social order in which actors (who can be individual or collective) are attuned to and interact with one another on the basis of shared (which is not to say consensual) understandings about the purposes of the field, relationships to others in the field (including who has power and why), and the rules governing legitimate action in the field" (Fligstein/McAdam 2012: 9). The "shared" but not necessarily consensual understandings refer to (1) "what is going on in the field, i.e. what's at stake"; (2) the existence of a set of actors possessing more or less power; (3) the nature of the rules governing possible, legitimate and interpretable actions; and (4) interpretive frames applied to the actions of others" (Fligstein/McAdam 2012: 10–11).

In our cases, both types of actors clearly position themselves within a subfield of religion, either Japanese Buddhism or PL Kyōdan. Both act according to their perceptions of the rules governing legitimate action in their respective fields. Neither Kageyama's nor PL Kyōdan's religious teachers perform medical practices in a technical sense. Kageyama propagates religious practices such as meditation techniques, prayers, recitation of the Lotus Sutra or invocation of its title (*namu myōhō rengekyō*), as well as moral practice and body practices, such as breathing exercises, physical exercises, dietetics, hygienic routines etc. (Kageyama 2010: 156–173). PL religious teachers guide their believers toward a moral conduct to which they ascribe healing effects. In PL Kyōdan, acceptance of the differentiation between the two fields is also manifest in the clear distinction between the practice of moral guidance on the one hand and medical activities in the PL Hospital

28 I thank Nina Rageth for inspiring me to apply Fligstein and McAdam's concept of the strategic action field (2012). As a consequence, these authors figure prominently in both our articles.

(http://www.plhospital.or.jp, July 4, 2018) and the health centers in Tokyo (the PL Tokyo Kenkō Kanri Sentā; http://www.pl-tokyo-kenkan.gr.jp, July 4, 2018) and Osaka on the other hand. These institutions rely completely on biomedical expertise and modern medical technology. Accordingly, religious teachers who accept and forward requests for *mioshie* are urged to emphasize that *mioshie* does not primarily have curing functions but is a means to realize moral conduct in accordance with one's nature (Pāfekuto Ribatī Kyōdan Bunkyōka 1991: 184–185).

In sum, since both types of actor propagate religious or moral practices based on the authority of their religious status (Buddhist priest, religious teacher, head of PL Kyōdan) and act in religious spaces (Buddhist temple or PL church), they can be said to position themselves as actors in their respective fields, namely Japanese Buddhism and PL Kyōdan, or in the wider field of religion.

From this position, however, they claim that their religious or moral practice has therapeutic effects in a practical, not a metaphorical sense. In Kageyama's case, this claim is clearly aimed to redefine the purpose of the field of Buddhism and to (re-)establish Buddhism as a medical tradition, hence integrating medical functions into the religious field. In contrast, PL Kyōdan publications emphasize that healing is just a side effect, not the intended goal of moral practice. In both cases, however, therapeutic claims are supported on the level of semantics. Kageyama's writings and PL Kyōdan's communicative practices are both characterized by particular ways of switching between "religious language" and "medical language", understood here as the vocabulary, idioms, or linguistic registers (i.e. ways of talking and writing) of the respective semantic fields of medicine and religion. Based on these observations, I will introduce two forms of strategic action that aim to legitimize claims to therapeutic authority: (1) Scientification and (2) Code-switching between the religious and medical semantic fields.

## 5.1 Forms of Strategic Action: Scientification

### 5.1.1 Kageyama Kyōshun

Scientification here denotes reference to scientific knowledge, institutions, and practices by religious actors in order to legitimize religious knowledge and practices. This strategy is a main characteristic of Kageyama Kyōshun's

writings. His justification for a scientific explanation of Buddhist practice contains a harsh critique of the forced separation of medicine and Buddhism in Japan's early Meiji era and of the prevalent mode of knowledge as represented in the academic culture. Due to the Westernization of Japan in early modern times, he argues, the emotional culture (*kansei no bunka*) of Japan as manifest in the premodern medical tradition of "nourishing life" (*yōjō iryō*) has been replaced by the rational culture (*risei no bunka*) of the "West" as represented in modern biomedicine. For him, emotional cultures are characterized by a mode of knowledge in which tradition is transmitted via emotion: "How are matters of tradition felt, how are they reflected in oneself?" (Kageyama 2007: 24). In constrast, in a rational culture, the dominant mode of knowledge rests on intellectual understanding and explanation, as well as on empirical knowledge (Kageyama 2007: 21–23). As a consequence, although Buddhist culture represents the original emotional culture of Japan, nowadays it is perceived as a primarily textual tradition—Buddhism has lost its "physicality" (*shintaisei*) (Kageyama 2007: 24). Therefore, although Buddhist truth can only be grasped through experience, Kageyama must refer to the language of the sciences in order to explain the essence of Buddhism (Kageyama 2007: 31).

In considering the appropriate science, Kageyama argues that Buddhism was originally not a scholarly tradition, but a form of psychotherapy. "At present, Buddhism is approached as philosophy, but considering that Buddhism actually aims at resolving people's sorrows and sufferings, it is not philosophy but rather psychotherapy." (Kageyama 2013: 19) The psychotherapeutic and general medical quality he ascribes to Buddhist practice results from the fact that, at its core, Buddhism is practice (*shugyō*) and experience, rather than a tradition of scholarship. It must therefore be approached through mental and physical experience, that is, by means of sensory perception and the emotions aroused by it.[29] Consequently, a science which provides appropriate tools to explain Buddhist practice must consider both the physical and the intellectual aspects:

29 "Emotional cultures such as Buddhism must be approached via a mode of knowledge in which someone knows by experience; by means of one's body, i.e. one's senses, someone knows how he feels and what mood arises" (Kageyama 2007: 24).

"Because in this sense Buddhist practice is the attempt to master (*taitoku*) true knowledge by means of mind and body, physiological-psychological research into methods of Buddhist practice represents a research attitude in accordance with the metaphysical particularities of Buddhist thought." (Kageyama 2007: 35)

For example, he introduces Hans Selye's (1907–1982) theory of stress reactions and the concept of homeostasis as developed by physiologist Walter Bradford Cannon (1871–1945) to clarify the physiological conditions of stress before explaining how the methods of "calming the mind and insight meditation" (*shikan*, Skt. *śamatha* and *vipaśyanā*) impact upon them by calming the body, the mind, and breathing (Kageyama 2013: 28–48). He also compares these meditation techniques to autogenic training as expounded by psychiatrists Johannes Schultz (1884–1970) and Wolfgang Luthe (1922–1985) (Kageyama 2013: 93–117). In more concrete terms, Kageyama explains and graphically illustrates the measured correlation of time spent in meditation with the frequency of brain waves and heart rates and links it to four temporal phases in autogenic training (2013: 118–123). In this argument, the slowing down of the heart rate and brain waves measured ten minutes after starting meditation is said to coincide with inducement of the meditative state of *zenna* (Skt. *dhyāna*), in which one sits in quiet observation of one's own self-reflection (Kageyama 2013: 156). Finally, the changed self-perception (the expansion of consciousness) in *shikan* meditation is compared to Stanislav Grof's notion of transpersonal experiences and Abraham Maslow's concept of self-actualization (Kageyama 2013: 134–139)[30].

Similar to Mikael Rothstein's observation concerning how and why new religions emphasize their scientific character, Kageyama's choice of the "physiological-psychological" sciences reflects his agenda of supporting religious authority vis-à-vis scientifically based authority claims in the field of medicine. "It is, as we shall see, religion, not science, which defines the standards in the interaction between the two systems: Science, in the scientific sense of the word, has been largely substituted by a mythological rendering of the same concept." (Rothstein 2004: 101) Although Kageyama's concept of science is by no means mythological, his choice of scientists, including proponents of transpersonal psychology, serves his aim of providing

30 See Stephanie Gripentrog's analysis of religious elements in Maslow's and Grof's contribution to Transpersonal Psychology in this volume.

scientific proof of the physical, psychological, and ultimately medical impact of Buddhist practice very well.

This interpretation of Buddhism brings Kageyama's concept of "Buddhism as meditation techniques" close to what Lorne Dawson calls "the new religious consciousness" (2006: 183)[31] as a kind of "cultural […] resource pool" (Robbins/Bromley as cited in Dawson 2006: 186), parts of which are actualized in different social settings. Similar to this notion of an individualistic, experience-based religiosity resting on a holistic worldview, Kageyama emphasizes experience as the only way of grasping the essence of Buddhism and advocates Buddhist practice as a means to re-establish the unity of mind and body. This topos of mind-body unity is a basic concept in the associations of integrative or holistic medicine mentioned above, as well as in the context of the California Institute for Human Science: its basic principles include "To Understand Human Existence from the Total Perspective of Body, Mind and Spirit".[32] As such, mind-body unity is a modern rhetoric projected back on to premodern forms of medicine. Neither in Buddhist medicine nor in Japanese kanpō does the juxtaposition of mind and body play any role.

In sum, Kageyama's strategy of scientification serves a double aim: (1) to legitimize his claim that Buddhist practices have medico-therapeutical effects by expressing them in scientific terms; and (2) as a consequence, to upgrade Buddhism as a tradition serving not only the religious goal of awakening, but also the physical goal of a healthy body and mind. His concept of Buddhism as a religion serving "this-worldly" interests, such as a healthy life, creates a counterimage to the negative image of Buddhism in Japanese public; the widely used term "funeral Buddhism" (*sōshiki Bukkyō*) implies that many priests see their main function in providing expensive funerary

31 Dawson describes this kind of contemporary religiosity as a cultural resource manifest for example in new religious movements, new religious networks, client religions etc. To him, it is characterized by religious individualism, emphasis on experience, i.e., "intense experiences of themselves and the sacred" (2006: 183), authority based on "skill development" rather than scriptures or revelation, tolerance of other religious perspectives, a holistic worldview, and "organizational openness" (2006: 184).

32 http://www.cihs.edu/index.php/about-cihs/principles-of-cihs/, July 4, 2018.

rituals to increase their wealth.[33] Therefore, the use of scientific language is applied here as a means to advocate and legitimize a new concept of Buddhism that defies its public image. As noted by Rothstein, it is a kind of legitimization that no modern religion can avoid: "No religion of the modern world will successfully be able to claim authority without some kind of scientific legitimization." (Rothstein 2004: 102)

### 5.1.2 Perfect Liberty Kyōdan

For the same reason, I argue, the value of science, especially of the medical and natural sciences, is strongly emphasized in the case of Perfect Liberty Kyōdan. As explained in its introductory guidebook for believers, "the unity of religion and science" (*shūkyō to kagaku wa itchi suru*) is a basic conviction propagated in the community. Accordingly, PL Kyōdan runs several scientific and medical institutions; a General Research Center (*PL sōgō kenkyūsho*), the PL Hospital (*PL byōin*), and two PL health centers (*PL kenkō kanri sentā*) in Tokyo and Osaka. The tasks of the General Research Center comprise "analysing psychic sources of injuries and illness, providing a database concerning doctrines and propagation, [and] rationalizing and increasing the efficiency of office work" (Pāfekuto Ribatī Kyōdan Bunkyōbu 2008: 27). At the same time, its aim to scientifically prove doctrinal statements is emphasized:

> "In the field of medicine, we conduct research on the topic of bad habits and illness (*kokoroguse to byōki*), based on the truth of divine notices (*mishirase*) and divine instructions (*mioshie*); and in the field of education, we conduct research on the topic of parent-child relations and human relations, based on the teaching that children are a mirror of their parents." (Pāfekuto Ribatī Kyōdan Bunkyōbu 2008: 27)

As these quotes indicate, scientific institutions and scientific knowledge are highly valued both as a means to support the religious organization and to prove its truth claims, and they are said to rest ultimately on religious truths. This linking of religious and scientific truth is also reflected in the short text introducing the PL hospital:

---

33 For an analysis of the role scholarship has played in the emergence of the popular image of a corrupt, degenerate temple Buddhism, see Covell 2005: 11–22.

"No matter how well we are equipped with excellent technical devices, and how much we improve medical techniques, since we are human beings we cannot avoid mistakes. Therefore, those in a position to take care of other peoples' lives cannot but conduct medical treatment with the following praying mind: 'We do our best to make sure, and we do what is humanly possible, but beyond this we rely on god with all our hearts.'" (Pāfekuto Ribatī Kyōdan Bunkyōbu 2008: 27)

Obviously, in this introductory guidebook, the relationship between science and religion is evaluated from a religious perspective. By addressing a religious audience, emphasizing the superiority of god's actions over human actions, and stressing the scientific truth of their religious doctrines, the authors are acting in accordance with the rules of legitimate action in the religious field. Relating science to religion in this way is a communicative strategy with the intention to strengthen the authority of religion by and in relation to science. By means of this strategy, an ambiguous relationship between the two fields is created. On the one hand, the legitimizing power of science is accepted; on the other hand, the superiority of divine action over human action is claimed, thus reversing the relationship.

This strategy is not applied in the context of medical institutions. The website of the PL Hospital addresses potential patients rather than PL members or the religious in general. The language of the website conforms to the norms of communication in the field of medicine with regard to both, its contents and its use of medical terminology. As on any other hospital website, the hospital units and their recent activities, the technological equipment they use, their medical services, ethics in dealing with patients etc. are described. The only reference to religious concepts is made in the section on "Hospital guidelines," where one finds not only an extended version of the PL motto "Life is Art", namely "Life is Art—So is Medicine" and a commitment to the ultimate reliance on god when men reach their limits, but also the statement that "medical treatment rests on PL principles" (http://www.plhospital.or.jp/contents/gNavi4/hosin.html, July 4, 2018). Although the connection with PL Kyōdan as a religious group is clearly stated, the actual meaning of the "PL principles" and their relevance for the hospital remain vague. In this institutional context, the purpose of the medical field is acknowledged and its rules are applied with regard to medical practice as well as language use.

Both cases show that religious actors pursue a strategy of scientifically validating therapeutical claims, thus supporting Mikael Rothstein's judgement, mentioned above, that every modern religion needs scientific legitimization in order to claim authority for itself. In the case of PL Kyōdan, scientification as a means of legitimization is complemented by its attempt to establish itself institutionally in the medical field. However, representatives of these institutions act as medical actors, thus complying with the semantics of the medical field.

## 5.2 Forms of Strategic Action: Code-switching between the Religious and Medical Semantic Fields

Another strategy I observed among religious actors is a kind of code-switching between the semantic fields of religion and medicine in order to create a functional hierarchy. Although linguistically code-switching denotes "the juxtaposition of elements from two (or more) languages or dialects" (McCormick 1994: 581), it is used here in a wider sense as switching between semantic fields. By semantic field, I refer to specific vocabulary, idiomatic expressions, and linguistic registers, such as special terminology, as well as codified ways of speaking or writing, for example, between doctor and patient, religious expert and believer etc.

Semantic fields in this sense are understood as part of the tool kits of the strategic action field of religion or the subfields of Japanese Buddhism and PL Kyōdan, and medicine. Tool kits are defined by Ann Swidler (1986) as habits, skills, meanings, linguistic repertoires etc. that are available to actors in their respective social contexts. Individual and collective actors develop strategies of action by selecting from these cultural repertoires and by interpreting their actions in specific ways (Swidler 1986: 281–283).

In the two cases discussed here, the question arises why religious actors select from the linguistic tools of the semantic field of medicine and combine them with elements of their own religious linguistic repertoires. Do they want to position themselves as actors in the medical field? I argue that, rather than positioning themselves in another field, they apply this strategy as a means of strengthening the position of their own field in relation to that of medicine.

Let us look first at the case of Perfect Liberty Kyōdan. The procedures of asking for divine instruction (*mioshie*) concerning a disease, injury or other

physical affliction involve religious semantics as well as medical semantics. If a member asks for *mioshie*, he or she hands over a standardized "plea for *mioshie*" to the local church. Beforehand, he or she will have prayed in a ritualized way and promised to apply the contents of the divine instruction in his or her daily life. The religious teacher who receives this plea inquires diligently about the member's marital status, family members, job, duration of membership etc., and describes the symptoms and course of the disease in great detail (Pāfekuto Ribatī Kyōdan Bunkyōka 1991:183–186, 195–279).

This comprehensive information is then sent to the headquarters in Tondabayashi, where Miki Takahito, the head of PL Kyōdan, or those religious teachers who are able to receive *mioshie*, write down the specific divine instruction and send it back to the local church. Again, the member has to pray in formalized words before receiving the envelope with the *mioshie* from a local religious teacher. After three days of reflecting about the meaning and the individual application of the *mioshie*, the member visits a religious teacher to ask him for his assessment (*kaisetsu*) and to discuss possible ways of realizing the *mioshie* in everyday life (Pāfekuto Ribatī Kyōdan Bunkyōka 1991: 186–189).

Notwithstanding the ritualistic language register manifest in prayers and formalized phrases when receiving the plea and handing over the *mioshie*, code-switching to medical language occurs in the religious teacher's detailed recording of the symptoms, the course of the disease, the diagnosis by a physician, and the prescribed treatment. The manual for religious teachers illustrates how the symptoms of various diseases are to be described in great detail and how their location is to be marked on a drawing of the human body. For example, in the case of a rash, the person is asked whether she or he experiences hot flushes at night, and whether the symptoms increase when the person is exposed to cold wind; in case of sinusitis the believer is asked how the nasal mucus smells, how it affects the sense of smell, and whether it causes headaches; in case of an accident, the course of events must be described precisely etc. (Pāfekuto Ribatī Kyōdan Bunkyōka 1991: 231–239).

In this communication, religious teacher and believer imitate a conversation between a doctor and a patient. Whereas previously their communication was in line with the linguistic registers of religious believer and teacher, they now switch into the communicative mode of a medical anamnesis performed by a doctor with a patient (Pāfekuto Ribatī Kyōdan Bunkyōka 1991: 183–185). By using this kind of medical communication in order to document the

symptoms of a disease or injury and by framing it using religious concepts that explain the occurence of the symptoms, different functions are assigned to medical and religious language respectively: medical language serves to label and locate the symptoms physically, whereas religious language serves to explain the actual causes of the disease and to indicate ways of healing it. Thus, a hierarchical relationship is constructed, in which religious concepts are assigned a superior position.

A similar strategy is followed by Kageyama in his explanations for actual diseases. On the general level, he ascribes the increase of so-called lifestyle diseases such as metabolic syndrome, diabetes, cerebrovascular diseases, heart diseases, cancer, allergies, rashes, high blood pressure, eating disorders etc. to the separation of mind and body as characteristic of contemporary "competitive societies" (2013: 36). This separation creates stress, the main cause of all the diseases mentioned above, and can be countered by meditation techniques which reinstate the unity of mind and body (Kageyama 2013: 28–36). In explaining actual diseases, he sometimes blends religious concepts with physiological effects in a way that assigns them different functions. The following is part of his explanation for what causes chronic rheumatism and rheumatic arthritis, a disease that afflicts mostly women in the second half of their lives.

"In the minds of women who suffer from rheumatic arthritis, suppressed contradictory emotions are hidden. In Buddhism we call these "dust accumulating passions"; this expression describes a state in which the mind, which is originally as pure as the Buddha nature, in the process of its development has been polluted by dirt. This aggressive karma (*gō*), in neurophysiological terms, stimulates the sympathetic nervous system and manifests itself in a muscular tension. By suppressing this strong impulse in order to stop it, the tension of the adversary muscle which is connected to the originally tense muscle is also intensified. As a consequence, the contraction caused by the tension of the adversary muscle group damages the joints, and the physical basis causing rheumatism is revealed." (Kageyama 2010: 111)

In this example, medical terminology and explanations are used to describe a disease as a physiological process, whereas religious terminology—the concepts of passion (*bonnō*), Buddha nature (*busshō*) and karma (*gō*)—are applied to explain its real cause. To Kageyama, a woman's contradictory urges to dominate and to protect cause aggressive karma. Buddhist prayers

(*kitō*) and invoking the title of the Lotus Sutra are advocated as means to purify this negative karma, resulting in a relaxation of the muscles and a stabilization of the vegetative nervous system (Kageyama 2010: 114).

As in the case of PL Kyōdan, medical terminology is incorporated here and assigned the inferior function of explaining organic processes and relationships, in which it is framed by religious concepts which provide an explanation for what causes these physical effects in the context of a Buddhist notion of man and fate. In this way, religious knowledge and practice, whether Buddhist or new religious, is depicted as superior when it comes to understanding the causes of diseases.

## 6 CONCLUSION

Neither Kageyama nor the religious teachers in PL Kyōdan make use of the linguistic tool kit of the field of medicine or apply scientific reasoning in order to compete with medical actors in their respective field. Kageyama does not challenge medical experts by setting up an institution of alternative medical practice or by actually becoming involved in contemporary medical-scientific discourses. PL Kyōdan does have its own medical institutions, but they operate according to the rules of the medical field. Here, the specifically religious interpretation and subsequent treatment of illness are considered to be complementary practices.

Rather, Kageyama and PL Kyōdan's religious teachers use medical or allegedly scientific language to legitimize, within the religious field, their claims that religious practice also fulfills therapeutical functions. In this sense, Kageyama and PL Kyōdan both represent one way of bridging the gap between scientific medicine and their own therapeutic practices. They advocate an understanding of "the purposes of the field" (Fligstein/McAdam 2012: 9), which includes the goal of a healthy body and mind in the literal sense. By doing so, they re-claim a premodern or 'pre-differentiated' understanding of religions and their "purposes" in which medical care was a fundamental task of their respective religious communities. However, they do not propagate to simply return to this previous state and replace scientific medical authority by religious medical authority. Instead, they qualify their therapeutical techniques as compatible with science, thus acknowledging the

superiority of scientific medicine, while at the same time dissolving the boundaries between it and their own activities.

In this sense, scientification and code-switching between medical and religious language are used to strengthen the position and influence of religions in contemporary Japanese society. They aim to re-establish the relevance of religious traditions as (complementary) medical traditions via illustrating their compatibility with scientific-medical knowledge and the superiority of religious over medical explanatory models.

The strategies of scientific legitimization and code-switching applied in the two examples also shed light on possible ways in which religious actors may conceptualize the relationship between the two fields. On the one hand, the religious field—assuming it includes medical functions—is seen as being in a dependent relationship (Fligstein/McAdam 2012: 18–19) with the medical field. Although Kageyama extensively describes premodern Buddhist medical knowledge in times when medicine and religion were not yet differentiated, this traditional knowledge gains relevance for the present only if it is validated by contemporary medical-scientific knowledge. This conceptualization clearly reflects the relationship on the social level, where medical experts do not require religious legitimization, but religious actors cannot claim medical authority without referring to the tool kit of medicine. Or, in Rothstein's terms: "Religion has the ability to transform science into something useful for its purpose, while science usually is deprived of the possibility of transforming religion into something scientifically meaningful" (2004: 102).

On the other hand, in the internal discourse, an interdependent relationship is conceptualized by means of functional hierarchization according to which religious doctrines are claimed to provide the ultimate explanation of what causes illness. In this way, the one-sided dependence of religion on the social level is counteracted.

## BIBLIOGRAPHY

Ahn, Juhn Y. (2008): "Zen and the Art of Nourishing Life: Labor, Exhaustion, and the Malady of Meditation", in: Japanese Journal of Religious Studies 35 (2), pp. 177–229.

Ahn, Juhn Y. (2012): “Worms, Germs, and Technologies of the Self: Religion, Sword Fighting, and Medicine in Early Modern Japan”, in: Japanese Religions 37 (1&2), pp. 93–114.

Araya, Shigehiko新屋 重彦/Shimazono, Susumu島薗 進/Tanabe, Shintarō田邉 信太郎/Yumiyama, Tatsuya 弓山 達也 (eds.) (1995): Iyashi to wakai—Gendai ni okeru CARE no shosō癒しと和解—現代におけるCAREの諸相, Tokyo: Hābesutosha ハーベスト者.

Bruce, Steve (2016): “Differentiation”, in: Michael Stausberg/Steven Engler (eds.), The Oxford Handbook of the Study of Religion, Oxford: Oxford University Press, pp. 635–645.

Bruchhausen, Walter (2010): “‘Biomedizin’ in sozial- und kulturwissenschaftlichen Beiträgen. Eine Begriffskarriere zwischen Analyse und Polemik”, in: NTM: Zeitschrift für Geschichte der Wissenschaften, Technik und Medizin 18, pp. 497–522.

Bukkyō Daigaku Sōgō Kenkyūsho 仏教大学総合研究所 (2003): Gendai iryō no sho mondai—Bukkyō herusukea no shiten kara 現代医療の諸問題—仏教ヘルスケアの視点から. Contemporary Problems of the Modern Medicine—From a Buddhistic Point of View, Kyōto: Bukkyō Daigaku Sōgō Kenkyūsho 仏教大学総合研究所.

Conrad, Peter (2007): The Medicalization of Society. On the Transformation of Human Conditions into Treatable Disorders, Baltimore: The Johns Hopkins University.

Covell, Stephen G. (2005): Japanese Temple Buddhism: Worldliness in a Religion of Renunciation, Honolulu: University of Hawaii Press.

Dawson, Lorne (2006): Comprehending Cults: The Sociology of New Religious Movements, Oxford: Oxford University Press.

Démieville, Paul (1985): Buddhism and Healing. Démieville’s Article on “Byō” in Hōbōgirin. Translated by Mark Tatz, Boston: University Press of America.

Drott, Edward R. (2010): “Gods, Buddhas, and Organs: Buddhist Physicians and Theories of Longevity in Early Modern Japan”, in: Japanese Journal of Religious Studies 37 (2), pp. 247–273.

Fligstein, Neil/McAdam, Doug (2012): A Theory of Fields, Oxford: Oxford University Press.

Foucault, Michel (1973): Die Geburt der Klinik. Eine Archäologie des ärztlichen Blicks, München: Carl Hanser Verlag.

Fujikawa, Yu (1911): Geschichte der Medizin in Japan. Kurzgefasste Darstellung der Entwicklung der Japanischen Medizin mit besonderer Berücksichtigung der Einführung der Europäischen Heilkunde in Japan, Tokyo: Kaiserlich-Japanisches Unterrichtsministerium (reprint).

Goble, Andrew Edmund (2011): Confluences of Medicine in Medieval Japan: Buddhist Healing, Chinese Knowledge, Islamic Formulas, and Wounds of War, Honolulu: University of Hawaii Press.

Hattori, Osamu (2014): "European Homeopathic Medicine and the Rise of Kanpō in Postwar Japan", in: Nanami Suzuki (ed.), Healing Alternatives: Care and Education as a Cultural Lifestyle. Senri Ethnological Report 120, pp. 17–52.

Hobsbawm, Eric/Ranger, Terence (1983): The Invention of Tradition, Cambridge: Cambridge University Press.

Iryō to bukkyō 医療と仏教. Medicine and Buddhism (2018), Special Issue of Samgha Japan サンガジャパン Vol. 28 (2018–1), Tokyo: Sanga サンガ.

Josephson, Jason Ananda (2013): "An Empowered World: Buddhist Medicine and the Potency of Prayer in Japan", in: Jeremy Stolow (ed.), Deus in Machina: Religion, Technology, and the Things in Between, New York: Fordham University Press, pp. 117–141.

Kageyama, Kyōshun 影山教俊 (2007): Bukkyō no shintai gihō—Shikan to shinriryōhō, bukkyō igaku 仏教の身体技法—止観と心理療法、仏教医学, Tokyo: Kokusho Kankōkai国書刊行会.

Kageyama, Kyōshun 影山教俊 (2010): Inori de byōki ga naoru 祈りで病気が治る, Tokyo: Kokusho Kankōkai 国書刊行会.

Kageyama, Kyōshun 影山教俊 (2013): Supirichuaritī ni mezameru bukkyō seikatsu meisō gijutsu toshite no gendai bukkyō スピリチュアリティーにめざめる仏教生活—瞑想技術としての現代仏教, Tokyo: Kokusho Kankōkai 国書刊行会.

Kamata, Tōji 鎌田東二 (2014): Supirichuaru kea スピリチュアルケア, Sagamihara: Bingu Netto Puresuビイング・ネット・プレス.

Kisala, Robert (1995) "Shinshūkyō no shakaiteki iyashi" 新宗教の社会的癒し, in: Shigehiko Araya新屋重彦/Susumu Shimazono島薗進/Shintarō Tanabe田邊信太朗/Tatsuya Yumiyama弓矢達也 (eds.), Iyashi to wakai—Gendai ni okeru CARE no shosō 癒しと和解—現代におけるCARE の諸相, Tokyo: Hābesutoshaハーベスト者, pp. 111–128.

Kleine, Christoph (2012): "Buddhist Monks as Healers in Early and Medieval Japan", in: Japanese Religions 37 (1&2), pp.13–38.

Kojima, Nobuyuki 小島伸之(2008): “Tokubetsu Kōtō Keisatsu ni yoru shinkyō jiyū seigen no ronri—Kōdō Ōmoto to Hitonomichi Kyōdan ‘fukei jiken’ no haigo ni aru mono—” 特別高等警察による信教自由制限の論理—皇道大本とひとのみち教団「不敬事件」の背後にあるもの, in: Shūkyō to shakai 宗教と社会14, pp. 69–86.

Kubotera, Toshiyuki 窪寺俊之 (ed.). 2011. Iyashi wo motomeru tamashii no kawaki—Supirichuariti to wa nani ka 癒しを求める魂の渇きースピリチュアリティとは何か, Ageo: Seigakuin Daigaku Shuppankai聖学院大学出版会.

Kuriyama, Shigehisa栗山茂久/Yamada, Takako 山田慶兒 (eds.) (1997): Rekishi no naka no yamai to igaku 歴史の中の病と医学, Kyoto: Shibunkaku shuppan思文閣出版.

Lock, Margaret (1980): East Asian Medicine in Urban Japan: Varieties of Medical Experience, Berkeley and Los Angeles: University of California Press.

McCormick, Kilian (1994): “Code-switching and Mixing.” In R. E. Asher (ed.), The Encyclopedia of Language and Linguistics, Vol. 2, Oxford and New York: Pergamon Press, 581–587.

Miki, Tokuchika 御木徳近 (1979): Watashi no rirekisho 私の履歴書, Tokyo: Nihon keizai shinbunsha日本経済新聞社.

Muraoka, Kiyoshi 村岡潔 (2003): “Bukkyō herusukea—Gendai iryō hihan no hitotsu kanōtai toshite” 仏教ヘルスケア～現代医療批判の一可能態として, in: Bukkyō Daigaku Sōgō Kenkyūsho佛教大学総合研究所, Gendai iryō no sho mondai—Bukkyō herusukea no shiten kara 現代医療の諸問題ー仏教ヘルスケアの諸点から, Kyōto: Bukkyō Daigaku Sōgō Kenkyūsho仏教大学総合研究所, pp. 3–16.

Nagai, Mikiko永井美紀子 (1995): “Shinshūkyō ni okeru shūyōteki na iyashi to jujutsuteki na iyashi” 新宗教における修養的な癒しと呪術的な癒し, in: Shigehiko Araya新屋重彦/Susumu Shimazono島薗進/Shintarō Tanabe田邊信太朗/Tatsuya Yumiyama弓矢達也 (eds.), Iyashi to wakai—Gendai ni okeru CARE no shosō 癒しと和解ー現代におけるCAREの諸相, Tokyo: Hābesutosha ハーベスト者, pp. 89–110.

Nihonyanagi, Kenji 二本柳賢司(1997): “Nihon mikkyō igaku to yakubutsugaku” 日本密教医学と薬物学, in: Shigehisa Kuriyama栗山茂久/Yamada, Takako 山田慶兒 (eds.), Rekishi no naka no yamai to igaku 歴史の中の病と医学, Kyoto: Shibunkaku shuppan思文閣出版, pp. 545–566.

Oberländer, Christian (1995): Zwischen Tradition und Moderne: Die Bewegung für den Fortbestand der Kanpō-Medizin in Japan, Stuttgart: Franz Steiner Verlag.

Pāfekuto Ribatī Kyōdan Bunkyōka パーフェクト リバティ教団文教課 (1991): Hokyōshi hikkei補教師必携, Tokyo: Pāfekuto Ribatī Kyōdan Bunkyōka パーフェクトリバティ教団文教課.

Pāfekuto Ribatī Kyōdan Bunkyōbu パーフェクト リバティ教団文教部 (2008): PL Gaido bukku PLガイドブック, Tokyo: Geijutsu seikatsusha 芸術生活社.

Rosner, Eberhard (1989): Medizingeschichte Japans, Leiden: Brill.

Rothstein, Mikael (2004): "Science and Religion in the New Religions", in: James R. Lewis (ed.), The Oxford Handbook of New Religious Movements, Oxford: Oxford University Press, pp. 99–118.

Salguero, Pierce C. (2009): "The Buddhist Medicine King in Literary Context: Reconsidering an Early Medieval Example of Indian Influence on Chinese Medicine and Surgery", in: History of Religions 48 (3), pp. 183–201.

Salguero, Pierce C. (2010–2011): "Mixing Metaphors: Translating the Indian Medical Doctrine *Tridosa* in Chinese Buddhist Sources", in: Asian Medicine 6, pp. 55–74.

Salguero, Pierce C. (2012): "'Treating Illness': Translation of a Chapter from a Medieval Chinese Buddhist Meditation Manual by Zhiyi (538–597)", in: Asian Medicine 7, pp. 461–473.

Salguero, Pierce C. (2013): "'On Eliminating Disease': Translations of the Medical Chapter from the Chinese Versions of the *Sutra of Golden Light*", in: eJournal of Indian Medicine 6, pp. 21–43.

Schrimpf, Monika (2018): "Perfect Liberty Kyōdan", in: Lukas Pokorny/Franz Winter (eds.), Handbook of East Asian New Religious Movements, Leiden: Brill, pp. 68–87.

Serikawa, Tei 芹川定 (1972 [1939]): Hitonomichi Kyōdan jiken no kenkyū ひとのみち教団教事件の研究, Kyōto: Tōyō bunkasha 東洋文化社.

Shimazono, Susumu 島薗進 (2003): 'Iyasu chi' no keifu—kagaku to shūkyō no hazama <癒す知>の系譜—科学と宗教のはざま, Tokyo: Yoshikawa Kōbunkan 吉川弘文館.

Shimazono, Susumu 島薗進 (2007): Supirichuariti no kōryū. Shin reisei bunka to sono shūhen スピリチュアリティの興隆: 新霊性文化とその周辺, Tokyo: Iwanami Shoten岩波書店.

Shinmura, Taku 新村拓 (2013): Nihon bukkyō no iryōshi日本仏教の医療史, Tokyo: Hōsei Daigaku Shuppankyoku法政大学出版局.

Siary, Gérard/Benhamou, Hervé (eds.) (1994): Médecine et Société au Japon, Paris: Éditions L'Harmattan.

Swidler, Anne (1986): "Culture in Action: Symbols and Strategies", in: American Sociological Review 51/2, pp. 273–286.

Takeda, Dōshō (1991): "The Fall of Renmonkyô and Its Place in the History of Meiji-Period Religions", in: Inoue Nobutaka (ed.), New Religions, Tokyo: Institute for Japanese Culture and Classics, Kokugakuin University. http://www2.kokugakuin.ac.jp/ijcc/wp/cpjr/newreligions/takeda.html, January 27, 2017.

Tanabe, Shintarō 田邊信太朗/Shimazono, Susumu 島薗進 (2002): Tsunagari no naka no iyashi—Serapī bunka no tenkai つながりのなかの癒し—セラピィー文化の展開, Tokyo: Senshū Daigaku Shuppankyoku専修大学出版局.

Tomohisa, Hisao 友久久雄 (2010): Bukkyō to kaunseringu 仏教とカウンセリング, Kyoto: Hōzōkan法藏館.

Tomohisa, Hisao友久久雄 (2013): Bukkyō to kaunseringu no riron to jissen—Bukkyō no oshie to kokoro no iyashi仏教とカウンセリングの理論と実践—仏教の教えと心の癒し, Kyoto: Jishōsha Shuppan自照社出版.

Triplett, Katja (2012): "Magical Medicine? Japanese Buddhist Medical Knowledge and Ritual Instruction for Healing the Physical Body", in: Japanese Religions 37 (1&2), pp. 63–92.

Watanabe, Kenji/Matsuura, Keiko/Gao, Pengfei/Hottenbacher, Lydia/Tokunaga, Hideaki/Nishimura, Kō/Imazu, Yoshihiru/Reissenweber, Heidrun/Witt, Claudia M. (2011): "Traditional Japanese Kampo Medicine: Clinical Research between Modernity and Traditional Medicine: The State of Research and Methodological Suggestions for the Future", in: Evidence-Based Complementary and Alternative Medicine, Published Online. https://www.ncbi.nlm.nih.gov/pubmed/21687585, June 22, 2018. doi:10.1093/ecam/neq067.

Williams, Duncan Ryūken (2005): The Other Side of Zen: A Social History of Sōtō Zen Buddhism in Tokugawa Japan, Princeton: Princeton University Press.

Winfield, Pamela (2005): "Curing with Kaji: Healing and Esoteric Empowerment in Japan", in: Japanese Journal of Religious Studies 32/1, pp. 107–130.

Yumiyama, Tatsuya (1995): "Varieties of Healing in Present-Day Japan", in: Japanese Journal of Religious Studies 22 (3–4), pp. 267–282.

## LINKS

http://en.jsam.jp/contents.php/020000RNSXjD/, January 29, 2017.
http://apps.who.int/medicinedocs/en/d/Jh2943e/9.6.html#Jh2943e.9.6, January 29, 2017.
http://imj.or.jp/intro, January 29, 2017.
http://imj.or.jp/intro/qa, January 29, 2017.
http://www.holistic-medicine.or.jp/holistic/definition/, January 29, 2017.
http://www.jsom.or.jp/index.html, January 29, 2017.
http://www.tera-buddha.net/project/spilit_body/, January 29, 2017.
http://www2.sal.tohoku.ac.jp/p-religion/2017/cn8/pg37.html, June 15, 2018.
http://www.cihs.edu/index.php/about-cihs/presidents-message/, January 29, 2017.
http://temple.nichiren.or.jp/1031159-syakazi/, January 29, 2017.
http://sunwork.her.jp/ayurveda/index.html, January 29, 2017.
http://www.perfect-liberty.or.jp/html/name-pl/kyouso.html, January 29, 2017.
http://www.plhospital.or.jp, January 29, 2017.
http://www.pl-tokyo-kenkan.gr.jp, January 29, 2017.
http://www.cihs.edu/index.php/about-cihs/principles-of-cihs/, January 29, 2017.
http://www.plhospital.or.jp/contents/gNavi4/hosin.html, January 29, 2017.