Editorial

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Peter Trachtenberg in his recent *The Book of Calamities: Five Questions about Suffering and its Meaning* (Little, Brown and Company, NY, 2008) reminds us that much of human life on our planet is taken up with the struggle to endure and wrest meaning from the multiple calamities that befall us. His book is an eloquent witness to the ubiquity of human suffering in all times and places known to us. It could be argued that our deepest religious insights emerge from the courageous reflection upon and response to this tragic history of human suffering. Moreover, we have the great religious traditions among us to remind us that how and why we live our lives as we do is never self-evidently given and never without question, especially when our human projects and our taken-for-granted worlds are shattered by the presence of calamity.

All of the articles in this issue of the *Journal of Religion and Health*, directly or indirectly, point to the presence of calamity and the suffering such calamity causes. We see this, first, in the continuation of reports that have appeared periodically in the pages of the *Journal* on the calamity of the HIV/AIDS crisis (The most recent statistics indicate that in 2007, 33 million people in the world are living with HIV/AIDS, 2 million of them children, 2.7 million of them newly infected, and 2 million dead from the disease. UNAIDS/WHO, July, 2008.). Shelley Francis and Joan Liverpool tell us that, though the AIDS epidemic in America has affected African-American persons disproportionately, there has been a significant increase and improvement within African-American faith-based communities in the development of HIV/AIDS prevention programs. Angela Kelly, as Kerry William Benton did for Protestant Christian communities in the same country (JORH, Vol. 47:3, pp. 314–325), explores the ways in which Roman Catholics in Papua New Guinea have begun to develop a theological understanding of the calamity of HIV/AIDS that has emerged out of the praxis of faithfully responding to the human suffering wrought by this disease in their country. In these two articles we see stories of people brought together by the power of their religious visions both to do what they can to help those afflicted with the HIV/AIDS virus and to reflect on the meaning of this particular calamity in their common lives.

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Kambiz Karimzadeh Shirazi and Mohammad Ali Morowatishharifbad make a convincing case that the teachings of the Islamic tradition regarding pre-marital sexual behavior play a protective role among Iranian males at risk for HIV/AIDS infection, by prohibiting pre-marital sex. The first case of HIV/AIDS was diagnosed in Iran, as it was in Papua New Guinea, in 1987. Yet, in the two countries, one predominantly Moslem, the other predominantly Christian, there is a significant differential in the statistical density of the disease in the two countries. While Iran has a much larger population than PNG, it is not suffering a generalized epidemic of HIV/AIDS as PNG is. These two articles suggest that religion may play multiple roles in addressing the human suffering caused by HIV/AIDS: a proscriptive role, which protects adherents against becoming infected by the virus and a motivational role, which inspires and empowers adherents to become actively involved in relieving human suffering.

Becca R. Levy and colleagues explore another realm of human suffering following a calamity, this one the extraordinarily destructive earthquake in 2004 that drove a tsunami wave that devastated the Sri Lankan coastline. A total of 32,000 persons lost their lives in this calamity and 500,000 persons were left homeless. Of those fortunate enough to survive the tsunami but most exposed to its anomic force, 56% suffered from PTSD and 36% reported poor to fair health. Dr. Levy and colleagues focused their research on the question of how we give meaning to such destructive events in our lives, especially through the cognitive category of causality. Since the population of Sri Lanka is largely Buddhist, the Buddhist concept of Karma was the subject of their research. As an instantiation of the category of causality, the concept of Karma would address the traumatized mind's need for explanation; yet, paradoxically, like a pessimistic explanatory style, it will predict for worse health and PTSD in those who experienced the calamity and survived. In Buddhism, it would seem, meaning, achieved through an instance of causal explanation, trumps health. I leave it to our readers to ponder this phenomenon as the dialogue continues regarding the complex questions of the relationship of religion to our physical and mental health.

Janice Bell Meisenhelder and John P. Marcum studied the impact of the American calamity, the 9/11/01 terrorist attacks on the World Trade Center Towers. Unlike Dr. Levy's study, Meisenhelder and Marcum interviewed over 1,000 persons affiliated with the Presbyterian Church, USA, who experienced the 9/11 attacks vicariously and at a distance. Although very few of the subjects in this study had personal connections with the victims of 9/11, 80% of the total sample manifested some symptoms of post-traumatic stress 2 months after the event. Testing not only for severity of symptoms of post-traumatic stress and level of perceived threat, the subjects were also tested for positive spiritual outcomes in relationship to positive spiritual (and non-spiritual) coping strategies. Not surprisingly positive spiritual outcomes were consistently correlated with positive spiritual coping strategies, which suggests, as the authors point out, a high level of effective coping among the respondents of this study with the calamity of 9/11.

We see in these studies of calamity and human suffering the power of religious faith and practice to help those afflicted cope with the terrible reality of human anguish, whether such faith and practice promotes or compromises our physical and mental health. It is with this theme in mind that Emily DeMoor's account of her personal journal through the calamity of Hurricane Katrina is most instructive. What we see there in a vivid and compelling narrative of self-transcendence in the face of the massive destruction of life structure, is the spiritual transformation of suffering into meaning and resilience.

One can imagine the personal stories of anguish that inform the remarks of Assistant Secretary of Defense for Health Affairs, Dr. S. Ward Casscells to the military chaplains of

the United States armed forces. Whatever history's definitive judgment will be regarding the war in Iraq, it can hardly be disputed that, like all war, it has been enormously costly to both the peoples of Iraq and the United States. It is those American soldiers, men and women, who return from the calamity of war shattered in body and mind for whom Dr. Casscells advocates in his speech. Somehow, in Dr. Casscells' asking the military chaplains for help in assisting those American soldiers suffering from PTSD and significant risk of suicide, we have one of the most human pictures of the war in Iraq that has been presented by the Defense Department. It is a picture of the Nation's concern for the healing and recovery of those men and women whose lives have been radically damaged by the calamity of war. If read carefully, it is also a picture of the attempt to deconstruct *the myth of the heroic warrior*, who must bear suffering alone and silently, which the soldier, historically, has consciously or unconsciously lived. This deconstruction is in the service of a new myth, which could be called *the myth of the wounded warrior*. In this latter myth, the wounded warrior is encouraged to ask for help, to face his/her trauma in dialogue with others, and, through grief and emotional healing, slowly rebuild what can be rebuilt of his/her life. Who knows where this new myth might lead us?

Helena Rocklinsberg offers one final example of the religious encounter with the calamity of illness and the profoundly complex questions raised by the relatively new branch of medicine, organ transplantation. She argues in her article that organ transplantation medicine inevitably and necessarily raises existential questions for both recipients and donors of organs for transplantation. These questions, she argues, can only be satisfactorily explored in relationship to one's view of life. Drawing upon data from focus groups on transplantation medicine in four European countries, Dr. Rocklinsberg shows that religion plays a complex role in the decision-making process of many persons considering organ transplantation. Thus, to achieve fully informed consent through "participative involvement," the religious views of recipients and donors must be taken seriously by those doctors who specialize in organ transplantation medicine. In coping with the calamity of organ failure, vulnerable patients have the same need for clarity and meaning as do persons coping with other kinds of calamity. For many, religion, especially in its views of life and the moral principles derived therefrom, address these needs for clarity and meaning. This quest for clarity and meaning in the face of the calamity of organ failure through the cognitive and symbolic resources of religion includes the capacity to explore the often hidden assumptions of the secular/scientific/technological paradigm of modern medicine. In such a process, again, calamity may give way to creative suffering of new meaning and new life.

Theo A. Cope introduces us to a model of psychotherapy based on the work of Dr. Nossrat Peseschkian, a Persian psychotherapist, who has been deeply influenced by the Ba'hai tradition. This model of what Peseschkian calls "positive psychotherapy," built as it is on the tradition of depth psychology and the philosophical resources of the Ba'hai movement, may be useful in this dialogue with calamity. Since Freud and Jung, we have been slowly and resistantly led to the idea that at least one form of human suffering rests upon the calamities of early childhood, and these calamities deeply trouble us, whether or not we have been assaulted by the calamities of disease, natural disasters, and the terror and violence of human conflict and aggression. This form of human suffering might be called the suffering of not knowing who we are and thus the suffering of not being deeply related to ourselves and others. For Freud, the calamity of early childhood is the experience of having and not having our first love, the emotional consequences of which are contained in the unconscious, deeply influencing us in ways we neither know nor understand. For Jung, in contrast, it is the calamity of the ego's irreversible separation from the source of

wholeness from which it derives. The ego's "fall" into space and time brings with it the struggle of the ego to achieve a functional form of self-integration, the accomplishment of which carries with it the "forgetfulness" of the wholeness which the ego has lost. The fate of the ego, for Jung, in its particularity, is to absolutize its own knowing and doing, and to experience the source from which it has come as a threat to its autonomy, self-sufficiency, and ontological solidity. This calamity, too, is lost in the unconscious for the ego. The unconscious suffering of these calamities, ultimately, for Freud and Jung, can only be healed by freely and courageously exploring the contents of the unconscious. According to Dr. Cope, his mentor, Dr. Peseschkian, builds on this depth psychological imperative to explore the unconscious by understanding it as a system of capacities, basic of which are the capacity to know and the capacity to love. For Peseschkian, we explore the contents of the unconscious to find ourselves and others through the discovery of our capacities, actualized and unactualized. We explore our painful inner conflicts, driven by the contrasting capacities within ourselves, as they "call" us to bring them more fully into conscious awareness through our capacity to know and, more fully into life, through our capacity to love. It could be said that Peseschkian's model of psychological existence, dynamically and teleologically, points to the calamity of un-lived life within us, as we suffer the inner conflict the opposites of the actual and potential generates. For Peseschkian, the wound of not knowing and not truly being ourselves is healed through a holistic form of knowing and loving he finds in the epistemology and praxis of Ba'hai. Here we see how the traditions of depth psychology and one of the world's great religious traditions have inspired, through the a mind at play in the field of *theoria*, a new model of the psychospiritual work to which many of our readers are called.

Ann Belford Ulanov, former Editor-in-Chief of the *Journal of Religion and Health* and now a member of our Editorial Advisory Board, writes as an experienced and accomplished Jungian psychoanalyst about this imperative to explore the unconscious with the purpose of healing the calamitous wounds of childhood. In her article, she gives an important focus to our capacity to love, to eros within the analytic relationship, which is, for depth psychology, the privileged and sacred space within which to explore the contents of the unconscious. Her question is what it means for the analyst to be passionately and deeply loved by the patient ("patient" means literally the one who suffers). This is the question of countertransference, and it points to the profound emotional and spiritual claim that analytic work makes upon both the analyst and the patient; for rarely are two people ever so vulnerable to each other as when the erotic field opens within and between analyst and patient. As Dr. Ulanov observes, for the erotic transference to activate in the patient, the analyst brings his/her own erotic energy to the relationship, which she understands as the opposite of the oedipal love the patient brings, namely, the parent's erotic feelings for the child. However, from her Jungian perspective, Dr. Ulanov sees that, once the erotic field is constellated, usually as an indication of the depth of the analytic relationship, the work of eros leads beyond the mere reliving of the parent-child relationship. As the erotic transference, creatively received and contained by the analyst, leads the patient into his/her own depth, the analyst too is confronted with the work of love in his/her own process, facing his/her own wounds as aroused by the patient's suffering perhaps, and living courageously the ways that eros may be opening him/her to greater life as mediated by the patient's love.

Eros seeks to reunite with what was lost, what is separated, what is seeking to come into existence as new being, new relationship, new emotional truth. By taking the risks of love, the analyst serves the purpose of eros as does the patient. And this is not just work on behalf of the patient or merely about the drama that is unfolding between the patient and

the analyst. If Jung is right, this work of eros, which both patient and analyst must suffer in the quest to heal the calamities of life as they have left their marks upon us, is for the whole of human kind. The healing work that is done in the microcosm of the analytic relationship, infinitesimal and subject to caricature as it is, is also a *magnum opus*, a tiny offering to the macrocosm that the calamities we suffer are somehow being faced and reckoned with on behalf of all of us, the whole human family.

Finally, a note about change and an acknowledgement of loss. With this issue of the *Journal of Religion and Health*, we begin a new chapter in its history. Having been under the creative sponsorship of the Blanton-Peale Institute of New York since 1972, the *Journal* is now under the ownership of its publisher for many years, Springer Science + Business Media. Springer's Publishing Editor, Carol Bischoff, has worked closely with Blanton-Peale and the Editor-in-Chief of the *Journal* over the years, and she will continue to impart her invaluable experience in helping guide the *Journal* into this new chapter in its life. We make this transition into the future with both a sense of excitement about continuing opportunities for the *Journal's* growth and development and a deep sense of gratitude to the Blanton-Peale Institute of New York for having provided a home for the *Journal* for these many years.

It is my sad duty to report the death of one of the members of our Editorial Board, Dr. Andrew Weaver. Dr. Weaver served the *Journal* well for several years as a distinguished scholar and Board member. He will be missed by his colleagues in the *Journal of Religion and Health* community and his memory will be held with great esteem by all of us who knew him and worked with him.