COMPLEMENTARY HEALTH AND HEALING:
AN EXPLORATORY STUDY

UNIVERSITY OF SURREY

PhD Submission June 2001

Freda Elizabeth Mold

ABSTRACT

The following thesis aimed to explore the beliefs and practices which emerged from complementary health therapies. The research hoped to examine these beliefs and question whether they constitute a religious belief system.

The secondary aim of the research was to explore whether health beliefs and practices impact on adherents' sense of identity.

The qualitative research was grounded on unstructured interviews with complementary health practitioners and their clients. These interviews were originally located at one Healing Centre in North West London. The research focuses on three specific therapy groups. By focusing on three specific categorizations of complementary health (cell groups) it became possible to compare health treatments and explore whether there was significant belief differentiation between health practices.

Several common themes emerged while undertaking this study. These were: beliefs in treatments, healing experiences, beliefs in healing energy, body, lifestyle and world-view perspectives and finally, concepts of change.

The thesis concludes by highlighting the differences between religious and spiritual belief systems and analysing the specific impact of complementary health beliefs on the individual adherents' sense of identity.

Contents

Appendices

ACKNOWLEDGEMENTS

There have been a number of people whom I would like to acknowledge and express my deepest thanks for their support throughout the production of this thesis. I would like to begin by thanking my family and friends for all their kindness and support they have given me over the years. A special thank you goes to Professor Michael Hornsby-Smith for his constant encouragement and immense patience. Finally I would like to acknowledge all interviewees who kindly dedicated their time to discuss belief and health issues.

CHAPTER ONE

INTRODUCTION

This thesis emerged from an interest in people who sought alternative sources of belief from those of the mainline religions. My interest in contemporary belief systems led me to explore the beliefs and practices which arise in complementary health and healing, and examine them in relation to conventional religion. In studying these commonalities and differences it became possible to explore whether health beliefs constitute a religious belief system. In undertaking this research another area of interest arose. This was the construction of ontological meaning and the consequence of health beliefs on one's sense of identity. In studying complementary health and healing, then, I hoped to explore an environment where expressions of contemporary beliefs emerged, and where ontological explanations were offered to everyday events.

Complementary health adherents have only very recently been seen as exponents of a specific belief system as previously many such practices had been accused of being narcissistic and, hence, of little investigative and academic worth. However, the gradual interest being shown in complementary health today can be seen through various disciplines. For example;

- medical science: by their experimentations into complementary health (as seen in the Clinical Reviews by the British Medical Journal, also see the recent journal series entitled 'ABC of Complementary Medicine'.);
- the proliferation of health literature and media interest (particularly literature concerning self-development and self-healing workshops, television programmes and internet pages);
- academia (expressed in new journal titles, for example the Journal of Alternative and Complementary Medicine, and the Journal of Contemporary Religion, as well as conference themes, which are slowly being seen as part of the mainstream, for example 'Contemporary & New Age Religion in the British Isles' which now takes place at The Open University, Milton Keynes, annually);
- products and services which have graduated into the mainstream (for example Boot's new range of Aromatherapy essential oils).

● Other indicators of this proliferation are found in government and association groups which monitor complementary health's practices (for example Parliamentary Reports);
● and finally even mainstream religious services (for example, healing services and healing prayer groups).

Recent interest in health and healing has proliferated to such an extent that a wide range of academic disciplines are now just beginning to consider the subject to be a fruitful research field (for example psychology, sociology, medical science).

Indeed, although there has been a gradual awareness of complementary health beliefs and practices my interest in this subject area arose from an obvious gap in the sociological field regarding contemporary expressions of belief. My aim, therefore, was to explore these beliefs and to shed some light on the somewhat neglected study of beliefs and the body. Previous sociological work, concerned with complementary health, has usually concentrated on subject areas such as: the client-practitioner relationship (Brody 1992, Piliuk & Parks 1986); whether certain therapies work (Janice Hopkins Tanne 1998); the history of complementary health (Saks 1992, Budd and Sharma 1994); types and categorizations of complementary health (Fulder 1985, 1988); practitioner professionalism and ethics (Beckford 1984); the popularity of modern health practices (Hamilton 1998a); to themes such as the spirituality of diets (Hamilton 1994, Hamilton et al 1995). The following research is not predominantly preoccupied with these questions, but rather the exploration of specific ideas which arise from particular complementary health therapies. Although I aim to contribute to the existing body of knowledge regarding contemporary beliefs this study will in addition address the lack of empirically-based sociological work regarding issues of health, the body, and belief.

Complementary health's beliefs and practices are frequently categorized under the somewhat broad title of the 'new age'. The term 'new age' commonly represents the differing bodies of networks, groups and centres which aim to stand apart from conventional meaning systems, and promote an alternative perspective for an individual's lifestyle, world-view and personal belief system. These world-views can range from health, well-being and self-growth, spiritual traditions such as shamanism, wicca and witchcraft, divinatory practices, ecology and environmental movements to feminism and animal rights. The roots of this new age consciousness stem from the

youth counterculture of the 1960s and 1970s where emphasis was laid not so much on wealth and materialism but on personal growth through a heightened sense of the individual consciousness, or 'self', and beliefs concerning the harmonization of individuals.

The proliferation of complementary health therapies can be seen as one fragment of the new age network which concerns itself specifically with the search for self-development and total well-being. Complementary health's popularity today can be argued to be due to its message that good health and ultimate well-being can be accessible to everyone. It is this belief which encourages adherents to closely scrutinize their own body, and enable them to assess all positive and negative factors which are present in their life. This introspective analysis thereby provokes adherents to re-define their sense of self-identity. By studying the impact of complementary health beliefs on adherents' sense of identity it therefore becomes possible to explore modern sources of meaning.

While exploring the characteristics of complementary health it became evident that common beliefs emanated from all health practices under study. By analysing these common issues it became possible to study the impact of complementary health beliefs on the individual's sense of identity. In exploring these beliefs it was also possible to question whether health and healing notions go further to form a belief system of their own which can be interpreted as religious. It is by investigating contemporary health beliefs that we are able perhaps to indicate areas of further study as well as identifying the future evolution of conventional religious beliefs. Indeed, although this study addresses just one area in a whole network of contemporary belief systems it does hope to represent the indicative movement of modern beliefs and practices. The importance of studying contemporary beliefs rests on the principle that if we are knowledgeable concerning new expressions of religiosity and belief, we are then more capable of understanding the cognitive actions and meanings which adherents apply to their everyday lives. This, in turn, could potentially hint at the future development of conventional religion. By identifying the principal themes of complementary health beliefs we are therefore able progressively to move towards greater understanding of many interrelated contemporary beliefs. It is with this aim that I hope to contribute to

the body of knowledge concerning new age beliefs. The following research is located centrally within the Sociology of Religion. However, due to relatively new developments concerned with alternative meaning systems, other disciplines may also be touched upon when discussing this subject area.

The research was principally designed to investigate the ideas which arose from complementary health treatments. Due to the diversity of health treatments available today many treatments are frequently brought together in one holistic health environment, such as a health and healing centre. It was therefore decided that by studying one centre I would be able to explore the health beliefs which were reflected from the wider health environment. By studying one microcosm of the health milieu, then, I could perhaps explore beliefs which occur in, and are mirrored by the surrounding health network. The study therefore focused on therapies and beliefs which emanated from one health and healing centre. In addition, by fully integrating myself into the one environment I was also able to participate in treatments and related social events, for example workshops, open days and fairs. Consequentially, I aimed to create a degree of close proximity with the research environment and its participants.

The formulation of the research began by focusing on one particular healing centre in North-West London in early 1995. The study was not designed to be a case study but rather the exploration of qualitative interview and ethnographic material based initially in one health environment. The methodology employed was primarily the focused interview with health practitioners and their clients. This method was chosen due to the nature of the study area. By discussing sensitive subjects such as personal belief and health it was expected that an intimate and revealing conversation would evolve. The depth and detail of these interviews would have been impossible to achieve by other methodologies, for example by surveys or structured interviews. In addition, by studying both therapists' and clients' accounts of health treatments I also hoped to explore whether there was a separation of knowledge and beliefs, between adherents, and whether a degree of belief transference occurs between therapist and client groups.

The study of health beliefs, for practitioners and clients alike, also brought into question whether health beliefs and practices differed significantly between treatment styles. That is, although complementary health practices appear to have diverse treatment

methods they can, in fact, be categorized into three distinct treatment techniques. These treatment styles are classified as Physical, Psychological/Spiritual and Integral. In studying health notions by treatment style I hoped to explore whether certain therapies illustrate greater implicit beliefs than other treatment methods. This study was therefore intended to investigate how each treatment differed in the construction of a modern meaning system. In addition, although this thesis aimed to be primarily exploratory, rather than hypothetical in form, hypothetical notions were raised regarding health style differences. As we will see, then, once the research design had matured and data analysis had been performed, hypothetical and theoretical notions were raised.

The ethnographic data collected throughout this study were analysed using an analytical computer package entitled WINMAX Pro. Once all ethnographic data had been successfully imported into the program specific procedures were followed to code text segments, to organize segments into thematic categories, to search and retrieve data relating to a specific code or keyword, and to assess the relationship between coded text segments. In performing these tasks several core themes emerged. The principal themes were beliefs in treatments, therapist and client relationships, beliefs in healing energy, body, lifestyle and world-view perspectives, and finally concepts of change. These aspects will be argued to impact on adherents' sense of self and contribute to the construction of participants' sense of self-identity and personal growth. It is by examining how therapists and clients discover, understand and use beliefs present in complementary health that it became possible to analyse contemporary expressions of belief. These health beliefs will be questioned using Anthony Giddens's concept of 'ontological security' (1991:243) and Bryan Wilson's 'probabilistic inventory' (1990:279). The thesis aims to illustrate Giddens's notions of 'ontological security' by arguing that complementary health beliefs and practices assist in the construction of one's sense of self-identity. As such, complementary health practices will be argued to contribute to one's sense of identity by giving adherents the means to introspect on body and lifestyle issues. Bryan Wilson's 'probabilistic inventory' offers a comprehensive list of features which he believes are present in conventional religious beliefs. By questioning these aspects in relation to contemporary health beliefs it became possible to explore whether health beliefs resemble the characteristics of a religious belief system.

In order to draw together the ethnographic material present in this research, and the features present in Wilson's inventory, it will be necessary to analyse the prominent beliefs and practices which emerge in complementary health and highlight how these factors can influence health participants.[1] Interview extracts will be drawn on throughout the thesis to illustrate these factors.[2]

The thesis is divided into nine chapters. Each chapter will discuss and analyse central issues, or beliefs, which have emerged as a consequence of the research. The beliefs which emerge from complementary health practices are interdependent; as such, chapters will occasionally touch on common issues, and references to the relevant chapter will then be made. Chapters Four to Seven will explore practitioner and client beliefs, while Chapter Eight extends this exploration by distinguishing between beliefs which occur in each cell group. Indeed, the themes raised in each chapter cumulatively contribute to the theoretical development of the entire thesis.

The thesis begins by discussing *Complementary Health and Sacred Imagery*. The central characteristics of complementary health and healing, terminology and its divisions are made in order to distinguish the modern modes of health care from conventional health care systems. In outlining these differences and similarities three distinct categories within complementary health were identified. These were Integral (Cell A), Psychological/ Spiritual (Cell B), and Physical (Cell C). The table below illustrates these divisions.

		Physical	
		Positive	**Negative**
Psychological/ Spiritual	**Positive**	**Cell A**	**Cell B**
	Negative	**Cell C**	**N/A**

In undertaking this research certain aspects emerged to highlight how one's body

---

[1]In order not to pre-empt any findings, presented in Chapters Four to Seven, Wilson's inventory will be drawn upon in Chapter Nine to illustrate specific characteristics of both conventional religious beliefs and contemporary spiritualities.

[2]Quotes have been sourced from the WINMAX Pro program. These extracts are therefore contextualized within the surrounding narrative.

and one's sense of self are irrevocably tied together. Complementary health practices are argued to be a means through which one can recognise and become aware of the distinct features of one's human form, the changes which could assist in one's possible transformation, the identification of one's surrounding social influences and beliefs in possible transcendental forces, and the interaction which occurs between practitioner and client. These features are all significant to one's sense of personal awareness and, as such, become the means through which one's identity and belief are formed. In viewing these aspects it became possible to argue that complementary health practices provide significant answers, meanings and explanations to everyday events.

By emphasising the particular beliefs associated with complementary health, questions emerged as to the meaning associated with the terms 'religion' and 'spirituality'. Thus, in reviewing both the functional and substantive definitions of religion it becomes possible to emphasise the differences and similarities present in the terms 'religion' and 'spirituality'. One of the main features which differentiates between conventional and complementary belief systems is complementary health's emphasis on self-exploration through identification with divine healing forces. The individuals' belief in sacred forces is expressed by means of divine communicative experiences relating to the body. The individual is therefore brought closer to their image of the divine by means of experiencing and interpreting transcendental forces imposed on the body. Hence, it is argued that although both religiosity and spirituality share concepts of the sacred, complementary health places these beliefs specifically within the personal, private domain. Modern expressions of the sacred have, then, taken shape within complementary health by placing greater emphasis on the individual's relationship with, and personal exploration of, such sacred forces. It is with these differences in mind that an outline of the terms religion and spirituality is offered. Complementary health has defined its role in modern society by offering adherents direct access to divine experiences. The receptacle for these experiences is the human body. The body therefore becomes sacralized for it is the vessel through which divine experiences can take place and the means through which one's sense of self, one's body, beliefs and lifestyle can be changed. Indeed, the sacralization of the body emerges as one consequence of modernity for it contributes to the search for a contemporary meaning system. It is through the

sacralization of the body, then, that an enlightened sense of self emerges offering meaning and relevance to everyday events.

Chapter Three outlines the *Methodology and the Research Process.* This chapter discusses the related themes which cumulatively illustrate the evolution of the research. In order to address the neglected issue of belief and the body in ethnographic literature it became necessary to design and develop a research project which enabled health adherents' sense of faith and belief in complementary health practices to emerge. As such, it was essential that both therapists' and clients' beliefs were addressed and a method designed which enabled the examination of these notions. My aim, then, was to recount the specific beliefs which emerge for both therapists and clients in the healing process. By commenting on the initial development and design of the research, then, it became possible to ground the subsequent research methods and illustrate their subsequent fruition. Factors such as sampling and pilot fieldwork, design and style of interview questions according to therapist or client status, gaining interviews and participant observation access, the interviewing of twenty-one health practitioners and twenty of their clients, participant observation in healing workshops and specific therapy sessions, and finally transcription, analysis and grounded theory were all addressed to demonstrate the processes involved in gathering the research material. In order to explore fully the recurring themes present in the interview transcripts the qualitative software package WINMAX Pro was employed to assist in the analysis of research material. The organisation, structure and accurate retrieval and querying of data were all undertaken with the assistance of the WINMAX Pro program. By using WINMAX Pro, therefore, the commonalities and distinctions between therapist and client groups and between cell groups could, more easily, be explored.

What became increasingly noticeable while undertaking the research process was health adherents' beliefs in treatments, their healing experiences and, of course, the therapist and client relationship. It is their preoccupation and attention to these factors which initially grounded adherents' sense of faith in the treatment and encouraged them to define a sense of self. Chapter Four therefore discusses practitioners' and clients' *Healing Experiences and the Therapist/ Client Relationship.* This chapter suggests that adherents turn to complementary health practices in order to alleviate illness conditions

and to attain a sense of hope in finding possible solutions to their ailment(s). Concepts of faith are therefore explored by focusing on adherents' sense of hope and trust in the treatment. Health experiences were also seen to influence the construction of faith in health treatments. By deciphering healing experiences adherents were seen to undergo a process of reflectiveness whereupon subsequent body, lifestyle, and world-view attitudes were brought into question. In studying adherents' sense of faith, then, it became possible to explore how notions such as hope, trust and healing experiences shape adherents' self-knowledge. A sense of ontological security begins to arise as adherents are then able to obtain a sense of order and meaning to their lives by sustaining a level of faith in complementary health techniques. Trust in treatments, however, can only be maintained if the therapist and client alike build a level of rapport and shared trust. Indeed, the intimacy which is created in these relationships also contributed to the open dialogue and the process of reflective dialogue which ensues. Communicating personal problems to the therapist therefore allowed clients to assess their own needs at any moment in time and provided adherents with a forum for open and honest self-evaluation.

Chapter Five moves away from discussing the internal and personal building of identity for adherents and concentrates on the discussion of *Beliefs in Healing Energy.* Healing energy plays a prominent role in the performance of health sessions insofar as it is the primary means through which practitioners 'heal' their clients, interpret and provide meaning to illness experiences and life events, contextualize the client's place and purpose in this lifetime and relate the individual to sacred, transcendental forces. The significance of healing energy is paramount to the exploration of health beliefs insofar as it demonstrates the principal way in which the body has become sacralized. The body is therefore linked to divine healing forces inasmuch as it becomes the medium through which the individual is able to directly communicate with divine forces. It is through such identification that practitioners and clients alike can believe in a contemporary expression of the sacred and how these forces can be directly linked to every individual. Energy beliefs also provoke adherents into re-assessing their sense of identity and self-perception insofar as energy experiences were believed to convey specific messages relevant to the interpretation of body ailments and to the wider social

circumstances. As such, the body, lifestyle and world-view perspectives are seen as interdependent factors which are influenced by experiences of healing energy.

The body therefore plays a prominent role in the construction of health beliefs and adherent's self-identity. Chapter Six can be seen to continue on the theme of the body in a social context by discussing *The Body, Lifestyle and World-View Perspectives.* The body is frequently viewed to contain specific dimensions and qualities, each of which can experience illness. These dimensions are believed to transmit specific messages to the individual. In interpreting these messages, and modifying lifestyle and world-views accordingly, adherents are constantly evolving and assessing their individual needs at specific moments in time. Thus, the body is continually assessed through the interpretation of these multi-dimensional body images. The building of such body knowledge again heightens the individual's sense of self-identity for it enables adherents to acquire a sense of physical awareness in context to daily lifestyle issues, for example diet and working conditions. Specific existential questions are raised while suffering from ill health. Sufferers experience feelings of normlessness and frequently feel a loss of control over their body and consequently over life events. Indeed, by interpreting body ailments and questioning one's sense of ontological security participants are able to construct a sense of placement within the wider social network and come to terms with specific life events. The ability to modify lifestyle behaviour and attitudes can, most prevalently, be seen as a reaction to newly discovered self and body awareness. Health adherents therefore recognise that alternative lifestyles and world-views can be adopted in order to bring about a sense of well-being and prospective personal development. However, these perspectives are fluid inasmuch as new self- assessments bring forth new lifestyle and world-view perspectives.

Concepts of change play a prominent role in the beliefs of health adherents. Chapter Seven continues the focus on individual development by examining *Complementary Health and Concepts of Change.* The movement of participants to health therapies suggests a process of seekership whereby the individual seeks physical alleviation from illness symptoms, a sense of self-awareness and spiritual self-awakening, and expectations of future personal development. It is these factors which contribute to the study of conventional and contemporary forms of belief in so far as

health participants are able to believe that their actions can change the social world and can possibly change their own destiny. Indeed, by examining adherents' beliefs of self-change it became possible to explore their beliefs of social and universal change. This discussion highlights the role of the sacralized body inasmuch as the body becomes the medium of change between these social factors. By studying the relationship between self, society and the cosmos health participants are able to construct a framework for their beliefs by contextualizing their place in the surrounding environment. However, although participants sense a form of connectedness to society and the cosmos they are also aware of the presence of time and place in their search for health and well-being. The consequences of health experiences, and greater self-evaluation, have led to a fundamental change in the individuals' portrayal of themselves and their subsequent self-development. The illness experience therefore initiates the individual's journey from an original sense of self to a newly evolved, developed, form. The process of self-change, however, does not stagnate as the individual can be seen to be in a continual state of reform. By analysing participants' notions of change, then, we can identify the consequences of health beliefs on one's sense of body-awareness and self-identity.

Chapter Eight will review all chapter themes (beliefs in treatments, beliefs in healing energy, body, lifestyle and world-view perspectives and concepts of change) by focusing specifically on *Cell Distinctions*. In classifying therapies into cell groups, then, I hoped to explore whether the expression and form of these beliefs were substantially different between health styles by comparing therapists' and clients' beliefs within the same cell group; and comparing across different cells. These health styles, as previously mentioned, were Integral (Cell A), Psychological/Spiritual (Cell B), and Physical (Cell C). In undertaking this analysis this chapter addressed three specific issues: whether specific cell groups illustrate more obvious features of spiritual health beliefs than other cell groups; whether the strength of adherents' beliefs rely on a particular therapy style; and, finally, whether beliefs are significantly transferred from therapist to client within each cell group. Such analysis, could eventually highlight the transference, depth and implication of health beliefs according to each therapy style. Indeed, in drawing out this debate I hope to demonstrate further the distinct characteristics of health beliefs by identifying how, and in what form, these beliefs impact on adherents' sense of self-

identity and body-awareness.

In the final chapter *Health, Beliefs and Spirituality in Complementary Health and Healing*, I will draw together the threads of this thesis by reviewing the major characteristics of complementary health in relation to Wilson's 'probabilistic inventory' (1990:279). In doing so I hope to highlight the differences and similarities of conventional and contemporary forms of belief. The chapter will therefore address the major themes present throughout this thesis and question whether complementary health and healing beliefs and practices constitute a religious belief system. Indeed, in undertaking this study I hope to contribute to the Sociology of Religion by building on existing sociological knowledge regarding the expression of modern beliefs. Moreover, I also hope to emphasise the neglected role of the body in contemporary beliefs and illustrate how notions of self-identity are consequently influenced. In undertaking this task I aim to point to new issues, within the research discipline, and conclude as to prospective changes which can be made for future studies into complementary health. As such, this thesis aimed to be the foundation to further enquiries into contemporary beliefs regarding health and the body. Further developments regarding design (greater participant observation in healing workshops, seminars), focus (the examination of one health style, the study of healing experiences in relation to conversion), and finally resources (greater financial assistance), could be made to investigate further expressions of modern belief. As such, the building of knowledge surrounding health beliefs can have a particular impact on the Sociology of Religion for it is essential that in order to understand the future of human belief we must first understand the background, content and direction of contemporary belief systems.

CHAPTER TWO

COMPLEMENTARY HEALTH AND SACRED IMAGERY

There have been many requests for further research into the study of religion and the body (Turner 1980,1984; Bailey 1983). These calls are especially noticeable within the Sociology of Religion where changes in contemporary beliefs have led to an increased interest in alternative sources of meaning. The interest being shown in contemporary meaning systems has been previously initiated by sociologists such as Towler (1974), Wilson (1982), Heelas (1996), Beckford (1984) and McGuire (1988), to name but a few. Indeed, the significance of studying such beliefs is increasingly important if we are to review the beliefs which have emerged as a consequence of modernity. Towler emphasises this need when he remarks:

> The fact that popular religion, or common religion as we prefer to call it here, lies outside the confines of official religion makes it no less significant. It has greater significance, if anything, since it survives only because of its continued ability to express the transcendent element in people's experience, and to bestow meaning on what would otherwise be perplexing (1974:149).

Hence, the current research hopes to contribute to this field of enquiry by building on existing knowledge regarding contemporary belief systems. This thesis aims substantially to review the currently available literature and to explore further areas which have hitherto been neglected. Two prominent sociologists at the centre of current enquiries are Heelas (1993;1996) and Beckford, (1984;1985a). The principal criticism of literature put forward by Heelas, to date, is the absence of empirical research.[1] Although substantial research can be undertaken using secondary sources, other ethnographic issues are often overlooked. Indeed, the use of secondary sources and the

---

[1]van Otterloo hints at such in her recent article (1999:193). Wood (1999:96-104) also criticises Heelas for his lack of ethnographic work regarding new age beliefs.

absence of empirical work can also lead to misconceptions.[2] Indeed, while Beckford could once have been criticised for neglecting adherents' underlying motivation[3] for participating in new age healing groups, his recent, collaborative work (Hedges and Beckford 2000) presents recent ethnographic data which address adherents' interests in new age practices. However, the prolific literature produced by Beckford and Heelas throughout the last decade has indeed been the foundation to the present research area concerning modern beliefs. It is with this foundation in mind that I hope to explore the contemporary beliefs and practices offered by complementary health and healing.

To begin we must reiterate our research question, that is, do complementary health and healing beliefs constitute a religion, and in what ways do these health beliefs impact on one's sense of identity? In order to establish the foundations to this study we must first review sociological literature which impacts on these research questions. The literature reviewed in this chapter will predominantly conceptualize the thesis specifically within the Sociology of Religion.

The chapter will be structured into six parts. Section One will briefly define complementary health and healing. The aim is to clarify the various definitions, and ultimately the theoretical background to the diverse field of complementary health. Section Two will review the principles of complementary health. This section will review relevant literature by outlining the various prominent concepts underlying the alternative health approach, for example, concepts relating to personal transformation and self-awareness. Ethnographic data relevant for these discussions will be considered in the following chapters. Furthermore, Section Two hopes to argue that the eclectic collection of health care approaches can be distinguished in terms of several common themes. Section Three will focus on defining religion. This section will review classical sociological literature, in the light of the present research, and evaluate the perceived

---

[2]For example, Heelas (1996) advocates that the new age is a *movement*, whereas recent, empirically-based work suggests that it constitutes a *network* (Sutcliffe (1997). In addition, Rose's (1998) empirically-based research, found that spirituality was characterised by an individual's ability to view the divine in many different forms and in a variety of environments. As such, Rose offers a theistic interpretation of the divine as opposed to a monistic perspective, as previously claimed by Heelas (1996:37).

[3]and the significance of the body in these modern beliefs

characteristics of a religion. Section Four will focus on the concepts of religion and spirituality. These terms will be re-evaluated and examined in terms of their meaning to participants. Section Five will argue that complementary health beliefs and practices encourage participants to reflect on the influences of divine forces on the body. As such the body is seen as a contemporary vehicle through which notions of the sacred are expressed. The body is, thus, contextualized in relation to the divine inasmuch as divine communicative experiences provoke adherents into reviewing their self-identity, their needs, desires and goals. The analysis of the body, in relation to these forces, can simultaneously give meaning to the illness experience. By contextualizing the body in relation to the divine adherents can construct a modern self-identity grounded on their own needs (for example, health and lifestyle changes). Hence, this discussion analyses whether the sacralization of the body has taken place in health beliefs, and argues that such a process can contribute to adherents' notions of self-identity. Complementary health promotes a process of self-reflection for adherents which often involves the search for meaning and an '"ultimate" significance' (Luckmann 1967:107). This thesis, therefore, aims to contribute towards the growing body of sociological knowledge concerning the search for a modern identity. Finally, Section Six will draw together the themes raised in this chapter and contextualize the present research within the current sociological field. This section will additionally propose certain research questions. These questions will be addressed through the following chapters.

2.1 Defining Complementary Health and Healing

There has been a gradual awareness of a secondary form of health care in modern Britain. The first of these is the scientific and allopathic care of conventional medicine, while complementary health and healing is increasingly seen as a secondary approach to health care.

Complementary, holistic, traditional, natural, alternative and fringe health care systems are all terms used while examining health from an unconventional stance. These health approaches can be seen to incorporate a multitude of concepts, differential features, and employ a variety of meanings. An explanation is needed firstly to

differentiate between the various concepts attached to complementary health. This will briefly distinguish the diversity of complementary health, and explain why the term *complementary health and healing*, and its divisions, will be employed in this study.[4] In adopting complementary health and healing as the most comprehensive term, we can then outline and distinguish the concepts identified within these practices, and define the beliefs which ensue.

One of the most comprehensive classifications of medical systems was put forward by Fulder (1988) who aimed to distinguish between health care systems mainly by their therapeutic specialities, and highlight the contrasts of each system. Fulder identifies six main fractions of health care, excluding conventional medicine. These are, firstly, *Complementary Medicine*, which he sees as including the terms alternative, fringe and natural medicine, which are 'therapeutic practices and systems which are separate from and in contrast to conventional medicine' (1988: XV). Secondly *Far Eastern Medicine* includes practices developed in the Far East, for example Chinese, Japanese, Tibetan, Korean practices. *Folk Medicine* constitutes 'practices, remedies and recipes which form a largely unwritten and unsystematic body of knowledge among the lay population' (ibid). *Holistic Medicine* is a combination of both complementary and conventional medicines. *Indian Medicine* is the practice of traditional Indian remedies.[5] Finally, *Traditional Medicine* constitutes an integral part of an aggregate culture. These six types provide an initial point in defining world complementary health and healing. Within contemporary Britain, and indeed within this present research, we are particularly concerned with what Fulder defines as 'complementary medicine'. The term complementary medicine can still be considered to be a diverse category as it embodies many styles of diagnosing and preventing illnesses. However, the term is useful as it defines the boundaries of complementary health practices by highlighting its contrast to the established medical institution.

In opposition, Saks (1992) argues against using the terms traditional, complementary or holistic. Saks excludes the term 'traditional' on the grounds that it

---

[4]The abbreviated term *complementary health* will be employed throughout the following chapters to represent the preferred usage of *complementary health and healing*.

[5]Fulder divides Indian Medicine into a further three parts: Ayurvedic, Unani and Siddha.

does not include the more recent, or for that matter re-named, re-cloned or even 're-discovered' approaches to health care. Similarly he excludes the category 'complementary medicine' as he believes it implies a co-operation with medical establishments. He argues that therapies, like Homeopathy, are based on philosophies which are, in their purest form, in direct conflict with the conventional medical establishment. Finally, Saks claims that 'holistic medicine' implies the marriage between both the mind and body of an individual in diagnosing, preventing and treating illnesses. As such, 'holistic medicine' does not take into consideration treatments such as Osteopathy which focuses primarily on a mechanistic, physical approach to health, rather than on psychological or spiritual factors. Saks argues against these terms as he believes they focus too much on the identification of similar aspects (e.g. styles of practice). He claims that categorizing health practices by their commonalities, cannot be achieved due to the wide range of techniques and methods available today. Saks therefore advocates the term 'alternative' medicine (1992:3). He recognizes the key to classifying complementary health, not so much in their likeness of content and style, but rather, 'their socio-politically defined marginal standing in the health care system' (1992:3). By defining health in such a light, 'alternative medicine' can be seen to include all health practices which do not receive support from the conventional British medical institutions. He goes on to say that this exclusion can be identified, 'whether this be through such mechanisms as orthodox medical research funding, sympathetic coverage in the mainstream medical journals, or routine inclusion in the basic medical curriculum' (1992:4). Saks does, however, acknowledge the mainly holistic approach to health in Britain in so far as there is a frequent underlying emphasis on the individual, and his/her environment, in the promotion of good health.

West (1992), too, has had a substantial impact in conceptualizing complementary health and healing. She puts forward a simple, yet systematic, categorization of therapies. Similarly to Fulder, and following the World Health Organization, West separates all forms of health care provision which lie outside the conventional health care system. By using this framework she then divides therapies in the UK into three categories. This system of categorization can be seen to be grounded on similarities of health approach. To explain, *Physical Treatments* are those which include Oriental treatments (e.g.

Acupressure), Systems of Medicine (e.g. Acupuncture), Exercise and Movement therapies (e.g. Dance, T'ai Chi), and finally Sensory therapies (e.g. Art and Music). Secondly, West categorizes *Psychological Therapies* into Psychotherapy treatments (such as Analysis and Hypnotherapy), Humanistic Psychology (e.g. Rebirthing) and finally Transpersonal Psychology. Finally, West identifies *Paranormal Therapies*, such as Healing (e.g. Exorcism, Radionics) and Paranormal Diagnosis (Palmistry, Astrology and Iridology). In addition, West offers a second, possible basis for dividing treatments. These divisions are 'those that require a high degree of professional training and skill and those that are at heart variations on first aid, do-it-yourself, and self-care techniques' (1992: 202).

Hamilton (1998a) while discussing the Mind-Body-Spirit Festivals, uses similar techniques in distinguishing between therapies. Hamilton highlights, predominately, the categorization 'mind/spirit', 'mind/spirit and health', and 'body/health' (1998a:6) to draw attention to the similarities of health styles.[6]

Complementary health techniques have increasingly multiplied and diversified in style and content since the contributions of Fulder, Saks and West. Such health techniques can be seen to be continually evolving, especially since the recent revived interest being shown in natural health and well-being. Indeed, the recognition of boundaries between types of health care continues to be problematic to this day (Murphy 2000:299). It is for this reason that this research has needed to develop a structure for categorizing treatments. The classification of health and healing treatments which I propose can by no means provide a unassailable division, but its divisions and criteria do offer a conceptual framework while studying the vast range of treatments within the Centre under study.

The conceptual framework offered by West can be seen to be influential to the development of this research's own criteria, classification and labelling of health treatments. The preferred term *complementary health and healing* was arrived at primarily through trial and error while carrying out pilot interviews in 1995. Many practitioners preferred the term 'complementary' as opposed to 'alternative', 'natural' etc. mainly because they felt that this term implied a marriage of interests with

---

[6]Further discussions of health categorization can be seen in the following chapter.

conventional medical practices. Like Fulder, the term 'complementary' does highlight its relation to orthodox medicine, while also identifying the actual nature of what 'complementary' techniques hope to achieve for its participants. Although complementary health practices are traditionally viewed as separate from the established medical system, adherents thought that these treatments were increasingly complementing other forms of health care. In contrast, Saks's argument for excluding the term 'complementary' seemed to run into difficulties. Since Saks studies treatments from a socio-political stance, this perspective can easily change with time. To explain, the term 'alternative' medicine does not continue to be a significant aspect of the unorthodox health care system's philosophy or practice. Due to a professionalization of complementary health therapies or perceived professionalization,[7] their greater regulation, ethics and institutionalization, such systems of health seem to wish to distance themselves from being seen as 'alternative' to the mainstream.[8]

Nevertheless, since the socio-political climate has changed, so has the perception of complementary health and its impression as being an 'alternative' to the established health system. Recent popularity and use (Wolsko et al. 2000:321, Boutin et al. 2000:336) of complementary health practices has emerged, to some extent, as a revival of interest being shown in one's own health and well-being. As such, if we are to follow Saks's socio-political stance then this revived system of health care aims to be permanently in contrast to the established medical system. As such then Saks implies that complementary health techniques will always be in the periphery of conventional health care. Indeed, Saks's socio-political stance also indirectly implies that complementary health and conventional health care systems are static and will not evolve and change throughout time since they will always be in contrast. Hence, Saks's view emphasises these health care systems at just one point in time.

Saks may be seen to offer the term 'alternative' as an approach to health as he indicates that some groups have always maintained, and aim to be in direct opposition

---

[7]There is a debate as to whether such professionalization of complementary health and healing therapies is a contradiction in terms.

[8]However, much more needs to be standardized and ultimately regulated in complementary health.

to orthodox health care. Saks, as a result, fails to acknowledge certain health groups who wish to combine the interests of conventional and complementary heath. Indeed, Armstrong (1986) also notes the inappropriate use of the term 'alternative'. He argues that as many of these new manifestations of health have an historic tradition, then such practices cannot be considered alternative, for 'alternative' not only, 'draws upon old techniques but also because historically it is a part of the "central tradition". Thus while it might utilize certain procedures of so-called alternative medicine, it is not itself "alternative". A marginal activity raises questions about the reasons for its marginality but the historical core of the healing arts justifies itself by the very centrality of its position' (1986:28). Complementary health is therefore an expression of modernity in so far as although these health practices are argued to be grounded on traditional (folk/Eastern) practices, such techniques in fact have evolved to re-formulate themselves to address contemporary issues.

Throughout this research I propose to refer to *complementary health and healing* and not to the term *medicine* as the phrase medicine implies substances in treating, preventing or in curing illnesses. The term medicine therefore encompasses a meaning of substances which may or may not appear in complementary health and healing practices. In addition, the term medicine is usually applied to orthodox health practices rather than being related to complementary health. In using the words health and healing, then, it becomes possible to indicate what type of health is under discussion. The term health and healing will then be employed as it conceptualizes the essence and aim of a wide variety of complementary health therapies.

In agreement with Saks, there is a diverse number of treatments available today. Within this thesis, however, we are concerned primarily with therapies available in one Healing Centre. In focusing on these treatments then, many can be traced to associated underlying techniques, or themes, which allow classifications of similarities to take place. The research divisions can be seen, initially, to correspond with those of West. Similarly then, divisions of health are founded on likeness and treatment styles. The first of these divisions are those treatments which involve both Physical and Psychological/Spiritual characteristics. Such treatments are based on the practice of both forms and cannot be easily separated. Treatments which fall into this category are

labelled *Integral* therapies. Integral therapies include Colour Healing, Rebirthing and Crystal Healing.

Treatments which do not concentrate as much attention on the physical form are those treatments which are concerned with the non-physical. These treatments are concerned with a psychological, emotive, spiritual and transcendental health care perspective. Such treatments can range from Healing, Reiki to Meditation. These treatments are labelled *Psychological/Spiritual.*

A third category can be identified as treatments which rely on physical touch (e.g. Massage), manipulation, movement (e.g. Dance) or mechanism (e.g. Osteopathy). These treatments are therefore labelled simply *Physical.*

In order to clarify the term complementary health and healing within this thesis it is necessary to provide an explicit definition of this type of health care. This outline is grounded on a combination of meanings put forward by writers such as Fulder and West. This outline additionally aims to bring about a more contemporary and useful description of the wide range of health therapies. The current research will therefore define complementary health and healing as *systems of unorthodox health care which rely on prevention, diagnosis, awareness and eventual alleviation of not only human ill health;*[9] *but also the external causes of ill health (Chapter Seven). The recognition and influences of external factors (family, work etc) are also seen as contributory elements in sustaining good health. Acknowledgement of one's state of health is grounded in an individualistic principle of balance and discovery of one's true health and potential. In order for this balance to be achieved one must also be aware of the influencing factors present within the wider, interdependent, social system. Self-awareness is thereby initiated by identifying one's present state of health and recognising future development areas relating to one's mind, body and spirit (Chapter Six). It is the identification of one's own needs (through reflective dialogue) which enables selection and choice of treatments to take place (Chapter Four). The recognition of one's self-identity, then, plays a critical role in understanding and in giving meaning to daily life events (Chapter Five). Complementary health techniques can also advocate the principle of responsibility, for own's own health, and to some degree, promote a realization of health*

---

[9]various therapies can also be applied to animals, plants etc.

education and re-education.

2.2 The Principles of Complementary Health

The current use of the term complementary health, within this thesis, can be seen to be relatively comprehensive. Its 'thick description' (Geertz 1973:6) is used due to the bricolage nature of complementary health. However, certain core themes emerge within complementary health to enable clear identification of its beliefs and practices. As we have previously indicated each of these features constitutes a relevant chapter of this thesis. Each theme is therefore discussed in detail by drawing on the research's own ethnographic material and in the light of current sociological literature. Each health theme can be seen to be grounded on the exploration of different aspects of the self. This overarching theme must be acknowledged, in the early pages, in order to contextualize the following arguments. The most prominent characteristic of complementary health is its focus on self-identity. In other words, as health and healing is preoccupied with several fundamental features of human life (health, happiness and ontological meaning), it becomes clear that the study of complementary health can possibly indicate the form and direction of modern beliefs. As we have seen previously the modern concern for self-knowledge, through alternative health techniques, has been recognised by many prominent sociologists (Giddens 1991, McGuire & Kantor 1988, Beckford 1985a). It became evident throughout the early stages of this research that the ethnographic material collected would eventually contribute to the body of literature concerning the construction of modern beliefs. In order to locate the ethnographic data within the sociological literature available one must first outline how health beliefs contribute to an individual's exploration of the self. McGuire summarizes the relationship between one's body and one's sense of self when she says:

> Bodies are important; they matter to the persons who inhabit them... Part of the reason our bodies matter to us is that we strongly identify our very selves with our bodies. We experience things done to our bodies as done to our selves... Second, bodies *are* matter. The material reality of our bodies is part of the

> grounding of human experience in reality: The 'lived' body is our vehicle for perceiving and interpreting our world (1990:284).

Here McGuire provides a useful overview as to how one's body and one's sense of self are irrevocably tied together. Indeed, as we will see throughout the following pages complementary health practices are one means through which self-identity is shaped. To lay the foundations to the following chapters one must first outline the principles of complementary health. By following the principles of complementary health, as outlined by Otto and Knight (1979), we are able to highlight the critical functions and aims of contemporary health beliefs. Otto and Knight construct eight principles through which 'wholistic healing' (1979:8) is based.[10] The first of these deals with concepts of personal change. They write: 'Recognition that every human being has vast untapped potentials, resources, and powers is inherent in wholistic healing ... Since every person has vast unused resources and capacities, *the paradigm of the human being as an energy system* with tremendous latent powers is especially appropriate' (1979:9). Likewise, Beckford goes on to say that despite the great variety of spiritual and therapeutic practices available today, in New Religious and Healing Movements, there is a remarkably consistent set of underlying themes (1984:263). Again, notions of change arise when he comments:

> It is believed that the powers or potentials for self-realization and self-expression can be released or unblocked by appropriate thought and action ... 'Transformation' is the term which most frequently refers to this active and optimistic image of the self as an entity which can freely choose to change and to grow. But self-transformation is usually located in the context of cosmic, cultural and social forces which are believed to be ushering in a New Age. Thus ideas of growth for the self are rarely separated from ideas of universal or cosmic

---

[10]It must be noted that the term wholistic in the 1970s, and early 80s, was the most common term used to describe all health care which did not fall under the control of the established medical institutions.

progress, although the association between them can take many different forms (1984:262).

Personal growth, therefore, is argued to manifest itself through a greater awareness of one's physical, psychological and spiritual self. These beliefs in transformation not only materialize in self change, but ultimately in the development and recognition of potential for society and the exterior cosmos. Indeed, while discussing healing, McGuire (1988) identifies the 'transformation of the self' and one's ties to the surrounding environment when she comments:

> 'growth' means producing greater understanding of self and others, greater awareness of one's body and emotions, greater balance and harmony in one's relationship to inner self, to others, and with the cosmos... 'health' is linked with strong awareness of a core self that is able to choose relations and reactions. The ideal is also a self that experiences a powerful sense of connectedness with others, as well as the natural environment (or, indeed, the entire cosmos) (1988:254).

While York (1995) can be criticised for failing to provide an adequate overview of sociological work relating to new age healing beliefs he does offer a very brief remark as to one of the core themes present in contemporary meaning systems. He says: 'What unites all New Agers...is the vision of radical mystical transformation on both the personal and collective levels' (1995:30). As such, York also notes the presence of 'transformation' within the new age milieu.

By initiating self change then, complementary health wishes to emphasis the additional link between the individual, society and ultimately the world. Images of change at these levels become contributory factors in the belief system of certain health and healing techniques.[11] Indeed, the importance of studying contemporary notions of transformation is additionally highlighted by Albanese when she comments:

---

[11]See Chapter Seven, Section Three.

...whether for single person or for society, New Age transformation requires specification: it is transformation of a special sort, radical change of a particular kind. And it is the kind of change that is desired, the substantive nature of the sought-after transformation, that tells most about the central thrust of the New Age and about its way of linking personal to larger social concerns (1992:74).

Otto and Knight themselves identify 'self-awareness' (1979:9), and ultimately 'self-healing' (1979:11) as contributory factors within complementary health. The acknowledgement of oneself, one's physical, psychological and spiritual self, also underpins substantially the beliefs in an underlying interconnectedness between all individuals and their environment. One such argument of this link is put forward by Hayes-Bautista and Harveston when they comment, *'individual illness is a reflection of societal illness'* (1977:8). As such Hayes-Bautista and Harveston identify societal and external problems as causing individual ill health. That is, 'an ill society will yield naught but ill individuals' (1977:8). They particularly highlight economic, cultural, racial and even housing problems as examples which would need to be addressed, in what they define as holistic treatments, before any illnesses of an individual can be alleviated. Hence, the repercussions of a multitude of healthy bodies is thought to accumulate to form a healthy society. To maintain a balance between self (internal) and society (external) depends on promoting and implementing a number of good health habits beginning with oneself. If one wants to realize one's true potential one needs to address the 'primal cause' (Otto and Knight 1979:12) of the problem. He should, therefore, 'take care of his daily food intake, his physical movement pattern, a right balance between tension and relaxation, the right way of breathing, his mental attitude and so on (and influencing the environmental conditions)' (Aakster 1986: 267). Such actions can then be seen to imply that '*as much as possible the person striving for health needs to be actively involved in the processes designed to foster healing*...The responsibility for attaining health is thereby placed where it belongs: it is *primarily* the responsibility of the person seeking wellness'(Otto and Knight 1979:10). By reviewing one's body perspective, therefore, one has placed the key to seeking and attaining health primarily onto the individual.

Wilkler (1985) also raises the notion of personal responsibility for health while examining holistic medicine. He argues that despite its fundamental importance in holistic health there is a distinct lack of clarity in its appearance. Wilkler begins reviewing the types of responsibility by claiming that holists' end aim, in incorporating responsibility in health, is primarily to change 'some basic attitudes about health and about the relation of individuals, the professions, and the state' (1985:137). He does not pretend to offer an expansive review of responsibility but wishes to distinguish a few major themes. Firstly, Wilkler talks of '*causal responsibility*' (1985:139) in which it is acknowledged that one's actions do have health related consequences. It is, therefore, by actively seeking and becoming responsible, that participants can most effectively stay healthy. He says: 'If the mind causes all physical disease, then perhaps a change of mind will prevent or cure disease' (1985:140). Wilkler goes on to distinguish beliefs of *positive* autonomy and *negative* autonomy in responsibility. Positive autonomy emerges when individuals actively take an interest in themselves, paying particular attention to their health needs (e.g. diet and nutrition) and their wider wishes and aims. Negative autonomy is the absence of such self-governance which is seen through a lack of knowledge and awareness surrounding their potential health and needs.

Kopelman and Moskop, in their survey and critique of complementary health, identify responsibility as one tenet for promoting well-being. Similarly to Otto and Knight (1979), Kopelman and Moskop (1981:215) focus initially on the interpersonal relationship between client and practitioner. Hence, the carer's role as a facilitator to an individual's development is expressed by a transference of authority and responsibility from the practitioner back to the client. Practitioners then may provide the *'..warmth, empathy and understanding and are furnishing the type of emotional nurturance particularly needed at a time of illness'* (1979:10), but ultimately decisions and the balance of power are believed to reside exclusively with the individual client. Such individualism further highlights the premise of complementary health as being uniquely inherent to the personal needs and desires of the health participant. However, although the client-practitioner relationship is, on the surface, seen as equal each party brings a unique factor to the interaction. A 'mutual influence' therefore occurs where

the practitioner's '...knowledge shapes the individual's experience of illness and the individual's experience and social needs... shape the physician's knowledge' (Telles and Pollack 1981). Kopelman and Moskop take us back, once again, to our links with others when they comment: 'We share our environment and social setting, so the responsibility of evaluating and changing it falls to each of us' (1981:215).

Otto and Knight provide us with two final features of complementary health. These are group interaction and one's spiritual resources. The emergence of 'therapeutic forces inherent in group interaction and group work' (1979:11) enables individuals the opportunity to share ideas. Group interaction is then seen as an essential element in sustaining and promoting health therapies. The interactions, between practitioner and client, and between therapists and organizations, all aim principally to encourage individual seekers of health. Finally, Otto and Knight express the 'utilization of a person's spiritual resources or belief structure' (1979:12) in the healing process. Crawford, while explaining 'new health consciousness' (1980:367), portrays complementary health as:

> 'a way of being', an interrelation or balance of body, mind, and spirit, a concern with 'high-level wellness', 'superhealth' or the 'joy of life'. Often holistic health incorporates a religious view, and both Western and Eastern religious practitioners and organisations have promoted holistic health services. In all its manifestations, holistic health encourages clients to become active participants in the healing process and to exert self-responsibility (1980:366).

Crawford's identification of 'superhealth' and the 'joy of life' highlights the particular world-view which emanates from complementary health and healing, that is, an approach to health which is based on a number of implicit beliefs (body perspective, self-transformation, self, society and cosmos interconnectedness). Through this perspective it can become possible to appreciate Hamilton et al's remarks when he says: 'To be healthy is almost to be saved' (1995:500).

We can therefore emphasise that complementary health beliefs also 'serve the illusion that we can *as individuals* control our own existence, and that taking personal

action to improve health will somehow satisfy the longing for a much more varied complex of needs' (Crawford 1980:368-369). These needs have found expression through complementary health, and have drawn attention to the gradual desire to find significant answers, meaning and explanations for daily life events. Hence, even Hamilton et al's writings on the spiritual significance of alternative diets bring into question the spiritual and implicit religious beliefs which arise throughout modern health practices. Hamilton et al goes further by arguing that such spiritual and implicit religious beliefs have been overemphasised in the quest to find a modern meaning system. Hamilton et al put forward the idea that perhaps complementary health and healing groups can be seen as 'non-religious quests for a meaningful pattern of life in a world where traditional religious answers to the problem of meaning are no longer satisfying or credible for a increasing number of people, at least to the extent that they continue to carry a lot of what many would see as outmoded supernaturalist baggage' (1995:509).

However in opposition to this perspective, Mattson envisages this new health approach as perhaps a contemporary expression of religious belief. She declares: 'If the goal of holistic health is the transformation of world-views then we must view it as a religious movement, not merely an alternative to the present cosmopolitan medical system' (1982:130). In exploring complementary health practices one can increasingly identify the similarities of faith and beliefs held by both health participants and conventional religious adherents. Hamilton et al, in particular, put forward their concerns relating to the close proximity of these concepts by criticising the employment of terms which were once applied purely to studies of conventional religious beliefs. Hence terms such as 'secular cults', 'invisible' religion, 'quasi-religion' and 'implicit' religion, are thought to be 'cumbersome, ambiguous and contradictory conceptual and terminological apparatus' (1995:509) when applied to alternative belief systems. Indeed, in such times where the Sociology of Religion can fully encourage, develop and fund its research interest in the more peripheral aspects of specific group beliefs, 'conceptual and terminological' tools, as discussed above, will continue to be used, and be related to this growing subject area. In the absence of alternative concepts sociologists must start research using the basic concepts offered by the Sociology of

Religion. Such as it is, terms like 'quasi-religious' will be relevant until there is a greater development within this field. Developments naturally begin by using these basic conceptual descriptions and by encouraging further ethnographic studies. If the description which Hamilton wishes to avoid were to be disregarded from the outset, once examining health beliefs, we would inevitably find ourselves without a foundation on which to begin theorizing. However, once greater developments have begun within the Sociology of Religion we will then be able to formulate new, and more appropriate terms. It is only by researching modern beliefs, which are on the fringes of contemporary society, that we can adequately develop new concepts to distinguish them from conventional religious belief systems. Van Otterloo again discusses the broad, and often confused, usage of terms while discussing new age health centres. She comments:

> ...a continual change in expression is taking place, in which both suppliers and consumers in the market play their own part. It appeared from the brochures that 'spirituality' does not have a clearly defined meaning. The term is subject to a broad process of bricolage, resulting in a plethora of varieties and shades of meaning. The terminology points to concepts derived from esoteric, psychological and physical ideas and practices, as well as to elements of beliefs and rituals, borrowed from the great eastern and western world religions. (1999:199-200)

If complementary health resembles certain characteristics of religious belief systems we are left to ask ourselves: What is a religion? And how, if at all, are complementary health beliefs and practices differentiated from conventional religious beliefs?

2.3 Defining Religion

The following discussion attempts to answer the question 'What is a Religion?' by exploring the primary features present in conventional religious beliefs. However,

difficulties emerge while attempting to offer a single, comprehensive and generally universal understanding of the function and essence of religious beliefs. The problems involved with defining religion range from its confused boundaries, wide diversity (from Buddhism to Quakerism), and increasing pluralism [12] of beliefs (e.g. Scientology). Nonetheless, the following examination will attempt to outline sociological literature concerned with defining religion and attempt to review the surrounding issues of 'belief' and 'spirituality'. Section 2.4 will continue this discussion by questioning how religion is differentiated from spirituality. The following section will additionally assess how complementary health beliefs and practices can resemble aspects of both religion and spirituality.

There are two commonly accepted stances held within the Sociology of Religion through which religion can be discussed. These are the functionalist and the substantive perspectives. Both, however, encounter difficulties. Emile Durkheim (1976) can be seen to be one of the main contributors to the study of religion primarily from a functionalist perspective. Durkheim begins defining religion by noting two themes which *cannot* be taken into consideration while constructing a definition of religion. These two themes can be identified as being substantive in nature. He explains his first concern when he begins, 'One idea which generally passes as characteristic of all that is religious, is that of the supernatural' (1976:24). By applying the notion of the supernatural to definitions of religion we are then instantly going beyond our world of knowledge and perception. Durkheim believed that by founding a definition on the supernatural, 'religion would be a sort of speculation upon all that which evades science or distinct thought in general' (1976:24). Thus any phenomenon which does not conform to theories of science would be deemed a 'religion'. In addition, Durkheim believed that such a supernatural feature of religion has only a place in a certain number of advanced religions as: 'It was not given to man; it is man who has forged it, with his own hands' (1976:29).

Durkheim's secondary concern deals with attempts to define religion in relation to notions of 'divinity'. Durkheim therefore focuses on the role of spiritual beings or a supreme deity. However, this criterion too, according to Durkheim, has limitations as,

---

[12]See Davie's (2000) discussion of religious pluralism in modern Britain.

'there are great religions from which the idea of gods and spirits are absent, or at least, where it plays only a secondary and minor role' (1976:30). For example, Buddhism is recognized as a religious system which does not in itself acknowledge a god or supreme being. The focus of Buddhism is grounded specifically on one's own journey through life and a belief in self-reliance, through meditation and development of an inner wisdom. Then and only then can deliverance and ultimately Nirvana be accomplished.

Placing Durkheim's theories of what does *not* constitute a religion aside, we move to his formula of how to look at defining religion. He begins by claiming that all known religions present one common characteristic. That is, religions create 'a classification of all the things, real and ideal, of which men think, into two classes or opposed groups, generally designated by two distinct terms which are translated well enough by the words *profane* and *sacred*' (1976:37). Hence the world is divided into two parts, one incorporating all things sacred, and secondly all that is profane.[13] Such a distinction contributes greatly to Durkheim's final definition of what constitutes a religion, as he highlights the distinction between the sacred and profane, rituals and beliefs, when he writes: 'A religion is a unified system of beliefs and practices relative to sacred things, that is to say, things set apart and forbidden - beliefs and practices which unite into one single moral community called a Church, all those who adhere to them' (1976:47). According to Durkheim, then, religion expresses beliefs and practices which are grounded in 'sacred things' (1976:47).

Complementary health and conventional belief systems can be seen to be separated by modern interpretation of the sacred. Within complementary health, then, the sacred is personally constructed as divine powers are specifically linked to the body. The healing process is therefore facilitated by the presence of supernatural powers and, as such, the body becomes the receptacle for transcendental powers. This personal identification with the supernatural becomes one of the main features in separating

---

[13]By focussing especially on notions of the sacred, beliefs and rituals were also considered important once analysing religions. These were argued by Durkheim to arrange religion into firstly, beliefs where opinions and representations can be made relating to the sacred, and secondly rituals, as these are direct actions resulting from beliefs. Durkheim hoped to distinguish these categories as these concepts separated thought from action.

religion from spirituality.

While Durkheim rejects the importance of the supernatural while defining religion he additionally emphasizes the sense of social unity a religious group may develop in sustaining their beliefs and practices. Although complementary health adherents may, on occasion, demonstrate their beliefs by means of unified groups (festivals, workshops), such collectivity plays only a marginal role in maintaining health beliefs and practices. However, due to the fluidity of network groups, adherents do not primarily illustrate their beliefs by collective actions.

However there are several limitations which must be addressed in examining functionalist approaches to religion. The primary critique of functionalism is that its boundaries are very unclear as to what constitutes a religion. For example in viewing notions of divinity the functionalist perspective does not offer a distinction between religious beliefs in transcendental forces and beliefs which offer alternative views of supernatural phenomena, such as those found in divinatory practices (mediumship). Indeed, the boundaries are also unclear when addressing notions of community and solidarity. If we are to view religion in a functionalist perspective we must then identify how it is a mechanism through which adherents are brought together by shared interests. The dangers of defining religion on such a premise enables any movement, or group of individuals, which promote unifying ideas, to be classified as a religion (for example political groups). Berger highlights the broad boundaries to the functionalist perspective when he comments that:

> functional definitions are likely to include such meanings-complexes as nationalism, or revolutionary faiths, or the mobility ethos, or any number of new 'life-styles' with their appropriate cognitive and normative legitimations. One result of this casting of a very broad definitional net is quite simple. The *commonalities* between, say, the Hindu metaphysic and the new 'sensitivity' of the contemporary counterculture are brought into focus - and, by the same token, the *differences* between them are relegated to inattention (1974:128).

Luckmann illustrates the movement from a collective and dominant social

institution which promote unified sacred beliefs, as previously seen in religious establishments, to the expression of the sacred in the "private sphere" (1967:109) of the individual. He therefore argues that the emergence of individualism has re-shaped the individual's relationship to a dominant social order. Such changes enable individuals to find their own '"ultimate" significance' (1967:107).

While the functionalist view of religion focuses predominantly on the functions which religions perform, the substantive perspective highlights what a religion is to the participating adherent. To explain, the substantive perspective identifies religion in relation to how adherents understand their beliefs in terms of their actions. This perspective therefore enables individuals to define their own existence by means of reflecting on certain existential questions. These questions encourage adherents to come to terms with their sense of self and enable a level of ontological understanding to arise. An individual's actions are therefore defined by their ability to reflect on specific existential issues.

The substantive approach to religion also highlights the particular role of the sacred for the individual.[14] Hence 'Religion, then, consists of beliefs, actions, and institutions which assume the existence of supernatural entities with the powers of action, or impersonal powers or processes possessed of moral purpose' (Bruce 1996:7). The substantive definition of religion posed by Bruce includes notions of individual action and supernatural beliefs. Bellah also puts forward a substantive definition of religion when he comments that it represents 'a set of symbolic forms and acts that relate man to the ultimate conditions of his existence' (1970:21).

The limitation to the substantive perspective is located in its inability to encompass non-Western notions of the supernatural. Bruce draws attention to this difficulty when he comments:

> ...when we seek to unpack the notion of 'superhuman' or 'supernatural', we find

---

[14]For one's concept of the supernatural can be influential to one's actions. For example, within complementary health, divine interaction is believed to result in changes of lifestyle habits. See Chapter Six. In addition, in Berger's 1974 article on substantive definitions of religion he particularly notes the impact of religious experiences on the construction of one's own social reality and consequently one's social actions.

> difficulties with some non-Western or traditional cultures. Where people daily commune with the spirits of their ancestors or take steps to avoid ubiquitous witchcraft, it may not be easy to discriminate the natural from the supernatural in the minds of those concerned. (1996:7)

Hence, substantive definitions:

> are appropriate for studying religion in relatively stable societies, which present few problems with issues of social change and cross-cultural applicability. Substantive definitions are problematic precisely because they are historically and culturally bound, based upon what is considered religion in one place and time. Because of their basis in Western historical experience, substantive definitions are often too narrow to account for non-Western religious phenomena. (McGuire 1981:5)

By the same token the strength of the substantive definition is in its more explicit nature regarding the context of religious experience within a certain culture and historical period.

One of the main exponents of the substantive perspective is Bryan Wilson (1990). Throughout Wilson's study of the rights of Scientology, in their wish to be recognized as a religion, Wilson focuses on the fundamental question of defining religion. He says: 'Whether a particular ideological or therapeutic system can properly be designated a religion is an issue that is not solely academic'(1990:267). In the sight of the law in Britain such definitional considerations are seen as critical if a movement is to acquire charitable status, premises to be registered as places of worship, and if other concessions are to be granted (e.g. tax-exemption). Identifying a religion can, therefore, become problematic. Nonetheless, like many social processes of change, what is seen as a religion at one point in time may now have changed and evolved into something completely different. Wilson argues that within modernity concepts of religion have changed, and will continue to do so. Hence, Wilson predicts the emergence of 'more secularized forms of religion' (1990:268). Wilson questions

whether secularized forms of religion have emerged in contemporary society by attempting to enumerate features and functions that, 'are frequently observable of known religions and thus might be expected to be found in any hitherto unexamined phenomenon'(1990:279). In order to address the contemporary problem of identifying a religion Wilson puts forward a 'Probabilistic Inventory' (1990:279) in an attempt to identify religious groups. Wilson's inventory aimed to organize the beliefs and practices offered by movements claiming to be a religion.[15] The inventory's structure and comprehensive outline can be argued to be one of the most detailed put forward by a contemporary sociologist. Wilson argues that although: 'No religion will conform to all the ideas in the inventory ... a high degree of convergence must amount to prima-facie grounds for regarding that candidate as a "religion"' (1990:286).[16]

In accordance with Wilson's 'Probabilistic Inventory' (1990:268), I aim to analyse the beliefs held by health adherents. Indeed, the similarity between Wilson's analysis and my own research findings are compared to review the particular features of conventional religious and contemporary health beliefs. However, as this analysis summarizes aspects of the research findings it will be located in the concluding chapter. This analysis aims to highlight how various health beliefs can resemble features which are present on Wilson's 'Probabilistic Inventory' and to, perhaps, contribute to his inventory list. In order to explore these belief systems it becomes necessary to address certain questions relating to the nature of complementary health beliefs. Such questions include: What are the various features of complementary health and how do complementary health beliefs emerge? How do these beliefs relate to conventional forms of belief? Whether health adherents believe in divine forces, and if so, whether these forces influence the body? In what ways do health experiences impact on adherents' sense of faith? How do health beliefs manifest in adherents' everyday lives? And whether health beliefs impact on adherents' sense of identity? Indeed, by outlining

---

[15]Wilson especially focuses on the therapeutic practices of Scientology.

[16]Indeed Wilson specifies that groups who represent over fourteen aspects of his 'Probabilistic Inventory' (1990:279) can be classified a religion. Wilson concludes by claiming that the beliefs and practices illustrated by Scientology qualified its status as a religion.

the similarities and differences between conventional and complementary health beliefs it first becomes necessary to distinguish between the terms religion and spirituality.[17]

2.4 Religion and Spirituality

In reviewing adherents' beliefs we must first explore participants' perspectives of their own beliefs and practices. As Sutcliffe and Bowman (2000) hint in their recent study of alternative spiritualities adherents who participate in new age beliefs and practices often refute the 'new age' label for they do not consider themselves to be participating in a collective religious belief. The variety of centres, groups, networks and workshops which are present in complementary health alone offers a perspective which illustrates that new age beliefs extent over many areas of interest.[18] Here Sutcliffe and Bowman identify the reoccurring theme of 'self-presentation' (2000:8) in the study of contemporary beliefs. As will be noted in Chapter Three then, Wallis and Bruce (1983) question research participants' rights to define their own actions. Wallis and Bruce begin their discussion by advocating that the actor's intentions must be explored in order to view whether actors' self-interpretations of their actions are correctly expressed. The principal question which arises concerning complementary health participants is: In what ways do actors view their beliefs and are these beliefs spiritual or religious in form?

Again, as subsequently discussed, health advocates define their own actions and intentions in relation to the prospect of personal change and transformation. Such change does not originate from beliefs, but is, in fact, initiated through participants' decisions to change and improve lifestyle conditions. Subsequent beliefs and faith in treatments therefore only occur after some form of experience has taken place.[19] The

---

[17]The empirical research presented in the following chapters will demonstrate the particular characteristics of health beliefs.

[18]Hedges and Beckford, however, illustrate four common features which occur thoughtout a variety of new age beliefs and practices. These are hope, criticism, openess and appreciation (2000:170-171).

[19]See Chapter Four.

intention of health advocates, then, is self-development through a greater understanding of oneself. Hence, as Wallis and Bruce comment:

> Explaining social action therefore entails understanding individual motivation and belief, and thus taking actors' meanings, and what they say about them, seriously. Doing that, however, requires constant reference to a social and historical context. No-one will adequately explain social action who does not understand how individuals interpret their world. But no-one will understand how individuals interpret their world who is not aware of the social and historical context within which they do it (1983:109).

The preliminary steps to such self-understanding are grounded in one's ability to explore one's identity and prospective development. Hence, it can be argued that if the actors themselves do not interpret their actions to be religious, then we must obviously consider what factors are relevant in defining health spirituality as religious.

The central feature which usually distinguishes the notions of spirituality and religion is concepts of the sacred. Traditionally, the sacred had been found in an institutionalized, and collective, body of beliefs as opposed to the modern, autonomous system of beliefs. Indeed the distinction between spirituality and religion is noted by Bloch when discussing spiritual networks. He says: '...the alternative spiritual network indeed is "spiritual" as opposed to being a "religion", as the latter term connotes a more organized body (and persons who explore these beliefs characteristically call themselves spiritual but not religious)' (1998a:287). Previously, Towler referred to concepts of religiosity, and hence the sacred, as being located primarily in the domain of institutions. While exploring common religion he notes: 'If by official religion we mean beliefs and practices which are prescribed, regulated and socialized by specialized religious institutions, then common religion may be described as those beliefs and practices of an overtly religious nature which are not under the domination of a prevailing religious institution' (1974:148). Luckmann additionally notes the organizational structure of contemporary belief systems when he comments 'The "New Age" programmatically refuses organization in terms of big institutions. Instead, it

cultivates the notions of "networks"' (1990:136). As such, these networks have 'no stable organization, canonized dogmas, recruitment system, disciplining apparatus' (1990:137). Indeed, although Luckmann argues that 'Modern religious themes such as "self-realization", personal autonomy, and self-expression have become dominant' (ibid:138) he advocates that this does not necessarily mean 'a loss of the "sacred"' (ibid). Thus, Luckmann argues that the individual has become sacralized inasmuch as the sacred can be located in the private sphere of the individual. Indeed, emphasis is once again placed on the organization of religions in contrast to an individual's quest for spirituality. Once more this is noted when Shimazono remarks: '"Spirituality" in a broad sense implies religiousness, but it does not mean organized religion or doctrine. Rather, it is used to mean the religious nature expressed by an individual's thoughts and actions' (1999:125). Equally, notions of the sacred, put forward by contemporary writers such as Rose (1998), Zinnbauer et al (1997) and McKee and Chappnell(1992), can be argued to have gradually hinted at a movement from a collective experience of the sacred, to an individual expression, and exploration of one's own perspective of the sacred. Hence, as both religion and spirituality include notions of the sacred in their definitions, the fundamental difference is the *expression* of modern sacredness. Zinnbauer et al (1997) comment on the common and differential themes of these notions when they relate:

> ...definitions of spirituality most often included references to connection or relationship with a Higher Power of some kind, belief or faith in a Higher Power of some kind, or integrating one's values and beliefs with one's behaviour in daily life. As with definitions of spirituality, definitions of religiousness included belief or faith in a Higher Power of some kind and integrating one's values and beliefs with one's behaviour in daily life, but they also commonly included references to organized activities such as church attendance and performance of rituals, as well as commitment to organizational or institutional beliefs or dogma. Therefore, both definitions share some features in common, but they diverge in the focus of religiousness definitions on organizational or institutional beliefs and practices, and the focus of spirituality definitions on the

personal qualities of connection or relationship with a Higher Power (1997:557).

Two factors therefore distinguish religion from spirituality. The first factor is the nature of one's relationship, and personal exploration, with a higher power, and secondly, the institutional or organizational expression of religion and spirituality. Rose emphasises the first of these factors particularly when he defines modern interpretations of the sacred. He differentiates between the traditional sense of divine forces, examples being 'God' or 'any form of central Being', and the modern concepts of, 'a "sacred Energy" or the like, which participants believe permeates everything everywhere' (1998:12). One's connection to these higher forces stems from one's own ability to relate or connect to 'an all-pervading "Force" or "Energy" which is seen to be sacred and which is not believed to be separate from the individual' (1998:13). Health participants' concepts of the sacred can therefore be seen to permeate many areas (see Chapter Nine regarding Entheism), including notions of one's own body sacredness,[20] one's body as a medium for these forces, and one's interpretations of divine contact. Spirituality therefore, is more closely associated with the individual due to the emphasis on body sacredness.

The second factor that needs to be explored is the institutional and organizational form of conventional religion and spirituality. As we have previously argued conventional religion is seen to have an established, organizational base where participants' roles are defined and hierarchical structures emerge. Wilson claims that a 'class of specialist religious functionaries' (1990:281) who provide a 'systematized and legitimized' (ibid), body of knowledge is found in conventional religious beliefs. Although complementary health and healing practitioners resemble the 'custodians of sacred objects' (ibid) we can see a distinct attempt at a relationship which aims to promote egalitarianism.[21] In addition, the organizational structures of conventional

---

[20]See Section 2.5 on the sacralization of the body, and Chapter Five for a discussion of the body as a medium for these sacred forces.

[21]See Chapter Four regarding reflective dialogue.

religions have been established throughout history. This directly opposes the formation of some complementary health associations. Although some health associations have been established for a number of years (for example, the National Federation of Spiritual Healers (NFSH) was established in 1955, British Homeopathic Association was established in 1902) the organization of healing groups, centres and festival organizers are constantly evolving and changing.[22] As such, the organizational lifespan and structure of health groups are different to those associated with religious establishments.

Previous definitions of spirituality, put forward by writers such as Rose (1998), van Otterloo ('individual bricolage' 1999:192), and Heelas ('self-spirituality' 1996:18) also seem to indicate the individual's need for salvation. Salvation, in this contemporary form, could be expressed through a desire for greater self-knowledge.

The distinguishing characteristics between religion and spirituality therefore are both one's interpretations of, and one's relationship with the sacred as well as the organizational form that religion and spirituality take.[23] The following descriptions aim to distinguish the phenomena, spirituality and religion. For the purpose of this thesis spirituality will be defined as follows:

Spirituality in the case of complementary health and healing participants is concerned with the essence of the individual, one's inner thoughts, beliefs and practices. Spirituality is constructed by identifying with all aspects of oneself, one's surroundings and ultimately the cosmos. Such identification encourages the development of a world-view through which social reality is interpreted. Spirituality practices can be performed in isolation or collectively in network groups. Participants often base their beliefs on divine beings or forms of contact with transcendental powers. The images of the divine do not necessarily have to be personified but these

---

[22]The exception to the constantly evolving 'spiritual marketplace' (Bowman 1999:181) is particular areas or locations. See Bowman (2000) for a discussion of alternative spiritualities in the Glastonbury area. In addition, the strengths of these constantly changing groups lay in their ability to cater to the changing needs of their adherents.

[23]However these concepts, in some circumstances can be bridged. Bailey, while exploring implicit religion suggests that some implicit beliefs can in fact, 'be found to be identical with official religion' (1990b:501) due to the presence of spirituality.

divine forces can, on occasion, be seen as either one's higher, pure self, or a belief in healing angels, guides, or more conventionally, God. Additionally, adherents believe that they have direct access to these divine forces. As such, these higher forces can be individually invoked. Spirituality for health participants, then, is individually constructed. Spirituality provides structure and clarity for an individual's sense of purpose, while often contributing to an individual's beliefs of potential development.

Religion will be observed as:

An institutionalized system of sacred beliefs and practices which enable participants to identify with an ultimate shared meaning system. Such a meaning system allows a formulation of a world-view through.which adherents can conceptualize a social order and social reality by which to interpret and make sense of themselves, and their social surroundings. This world-view is strengthened by means of collective shared experiences (congregations) and performances (rituals). Beliefs may embody notions of divinity (through beliefs in named higher beings). Finally the emergence of individual, societal, or global potentialization or change may arise, which are seen to be a direct consequence of such religious beliefs.

The main differentiations between religion and spirituality can therefore be seen in the different notions of the sacred, and one's relationship to the sacred, as well as the organizational structure through which these beliefs are expressed. Notions of the sacred can also be differentiated between shared experiences, as emphasised in established religions, and individual expressions and experiences, as illustrated in health beliefs. The divine within complementary health is expressed and experienced by means of the individual's body. The individual is therefore at the centre of health beliefs thereby enabling them to interpret and apply specific meanings to events, actions and illnesses. Health adherents are also able to invoke, directly, specific divine forces. Conventional religions, on the other hand, highlight a shared meaning of the sacred and view supernatural forces as largely external to the individual. Communication with these supernatural forces is also seen to be through a custodian of sacred rituals, for example priests. These custodians are therefore authorized to perform certain rites and administer specific sacraments. The structure and organization of spiritual and religious groups can also be seen to be a consequence of the ethos and aims of each group.

Groups which represent a high level of spiritual practices and emphasise aspects of personal development thereby mutate and change according to the individual participant. As such, these groups are consequently changing and evolving with the requirements of the adherents. Nevertheless although conventional religious groups also evolve and change, the emphasis on shared experiences and shared knowledge limits the extent of such fluid changes. Hence, these groups have well-established hierarchical and organizational foundations.

The presence of supernatural forces, and particularly the expression of these forces in the definitions proposed can be seen to distinguish spirituality from religion. The supernatural in the definitions proposed is seen to have departed from the classical definition of religion as portrayed by writers such as Durkheim. The definition of religion offered above can, therefore, resemble the previous substantive definitions of religion. As we can observe, then, these definitions emphasise the presence of transcendental forces and note these forces in relation to the individual. The significance of the individual, and the construction of one's own sense of identity, is therefore observed in contemporary expressions of belief.

Bellah acknowledges that the future of religious evolution, for contemporary society, must be interpreted as a continuous cycle of growth and decline which increasingly focuses on one's own ability to seek ontological answers. Bellah declares:

> I see in them the increasing acceptance of the notion that each individual must work out his own ultimate solutions and that the most the church can do is provide him a favourable environment for doing so without imposing on him a prefabricated set of answers. And it will be increasingly realized that answers to religious questions can validly be sought in various spheres of 'secular' art and thought (1970:43-44).

The notion of identity can therefore be argued to be a further characteristic which differentiates between spirituality and religion. Self-identity, for complementary health adherents, encompasses a complex system of interpretations and perspectives. One's body, mind and spirit, although departmentalized on occasions, all combine to

form a sacralized image of oneself (see Section 2.5). To explain, through health practices one can achieve new found awareness of the self which leads the individual to consider ontological issues surrounding one's desires, aims and purpose. While calling for the adoption of new sociological terms to describe new age phenomena, Shimazono draws particular attention to identity as one of the main differences between religion and spirituality. He comments:

> ...there are grounds for the people involved to claim that their movement is different from a religion. Considering that many of them believe their acts to be deeply bound up with their own identity from a 'spiritual' and not 'religious' view, and taking into account emic elements of their self-understanding, it is appropriate to classify them within the New Spiritual Movement and Culture (1999:131).

By studying the beliefs and practices of adherents we are able to view, most prominently, the impact of these notions on their sense of self-identity.[24] Health advocates' relationships with each other (Chapter Four), their beliefs in sacred entities (Chapter Five), body and lifestyle perspectives (Chapter Six), and finally concepts of self-transformation (Chapter Seven), all underline the contemporary need to discover one's identity.

2.5 The Sacralization of the Body

So far throughout this chapter, I have argued that complementary health beliefs illustrate various characteristics which impact on one's sense of self-identity.[25] Complementary health can be seen to offer a guide for life, providing meaning and

---

[24]Although religious groups can also claim that their religion is equally concerned with identity (for example in Northern Ireland), within complementary health there is an emphasis on personal development through individual seekership and action as opposed to collective group action.

[25]For example concepts of the divine.

purpose to daily events. Throughout the main themes of this thesis, we can recognise that attitudes towards the body, lifestyle changes, world-view perspectives, self-spirituality notions, beliefs in healing energy and healing experiences all play a significant role in the construction of an increasingly sacralized body. Indeed, as we have seen throughout this chapter, and what will be illustrated throughout the following chapters, the body, within complementary health and healing, is the vehicle through which we are able to interpret not only our own health status but also lifestyle, spiritual and ontological issues. Hence, emphasis is placed on body interpretations as a means to discover one's own health status and to acquire knowledge on how to reach a level of general well-being. The sacralization of the body can be defined as the extent to which one interprets health, lifestyle and, most importantly, spiritual needs by means of one's body ailments. In addition, the body is believed to be the receptacle of the healing forces. The body therefore becomes the central focus for the construction of one's self-identity and social reality. The following section will develop this theme by arguing that due to modernity one's concept of the divine has influenced notions of self-identity and body image. As a consequence, one's body has been sacralized. Several prominent writers have predicted the future changes of belief systems (Wilson 1990, Luckmann 1967). Such changes are predominately seen as a move from established religiosity to a greater focus on individualized modern beliefs. Luckmann, although criticized by writers such as Bibby (1983), mentions such a 'modern religious theme' when he writes:

> ...the social basis of the newly emerging religion is to be found in the 'private sphere'. The themes that have come to occupy a dominant position in the sacred cosmos today originate in and refer to an area of individual existence in modern society that is removed from the primary social institutions... The dominant themes in the modern sacred cosmos bestow something like a sacred status upon the individual by articulating his 'autonomy'. This, of course, is consistent with our finding that 'ultimate' significance is found by the typical individual in modern industrial societies primarily in the 'private sphere' - and thus in his '*private*' biography. (1967:107,109).

In looking at what Luckmann describes as an individual's 'autonomy' and finding man's 'ultimate significance' (1967:109) we are able to recognize the formation of modern meaning systems. He goes on to say: 'In the modern sacred cosmos self-expression and self-realization represent the most important expressions of the ruling topic of individual "autonomy"'(1967:110). The connotation which arises from the notion of autonomy is seen through a wish to potentialize oneself by means of an exploration of one's identity and purpose.

Complementary health and healing can be seen as just one of the most prominent modern features in the exploration of self-identity. The search for self-identity in complementary health is initiated by ill-health's nature of disabling the individual. Such events consequently lead an individual to contemplate various issues within their lives. Hence, the articulation of individualistic meaning systems emerges quite naturally through complementary health beliefs.

McGuire particularly notes the significant relationship which occurs between one's body and one's sense of self when she says:

> All features of our embodiment affect our interaction with our social and physical environments. For example, if my body is extremely thin, or if I am exceptionally beautiful, if I am missing a leg, or I if I have brown skin, if I cannot see, or if I am tall - all such features of my embodiment affect how I interact with my world and, indirectly, my self-experience...Illness is especially damaging to the self when it is experienced as *overwhelming*, *unpredictable* and *uncontrollable*. Such illness paralyzes the person's ability to manage life, to plan, to act - in short, to exercise agency (1990:288 & 287).

Illness is therefore seen as an 'biological disruption' (Bury 1982:167) which affects all areas of one's life. Bury specifically highlights three areas where 'illness, and especially chronic illness, is precisely that kind of experience where the structures of everyday life and the forms of knowledge which underpin them are disrupted' (ibid:169). The first of these 'involves attention to bodily states not usually brought into

consciousness and decisions about seeking help' (ibid). Secondly, 'a fundamental re-thinking of a person's biography' (ibid). And finally 'the response to disruption involving the mobilisation of resources, in facing an altered situation' (1982:170). Here Bury identifies the specific factors which ground the relationship between one's body and one's sense of identity. Complementary health beliefs and practices can be seen, throughout the following pages, to address these issues. However, by focusing on these aspects it becomes possible to identify how the body has become increasingly important, not only to the construction to one's sense of identity but also how one's body is the means through which divine intervention effects one's physical and social circumstances. In other words, within complementary health and healing, it becomes possible to identify how the body has become the vehicle for interpreting spiritual illness and even social experiences.

More recently van Hooft stresses the ties between health and identity when he remarks:

> Health contributes to our well-being not just through being the material wherewithal for our physical functioning and social effectiveness and not just through being the inchoate basis of our enjoyment of living. It also does so through being one of the forms given to our search for meaning and integrity in our lives. It extends to the spiritual well-being that comes from feeling good about ourselves in moral and existential terms... It follows that the loss of health through injury or disease is a personal trauma much more profound than just the experience of pain or disability. It threatens one's very existential being (1997:35-36).

Again, we can see how ill health focuses new attention to concepts of oneself.[26]

---

[26]Cassell emphasises the ability of illness to focus on the individual self when he comments: '...people in pain frequently report suffering from the pain when they feel out of control, when the pain is overwhelming, when the source of the pain is unknown, when the meaning of the pain is dire, or when the pain is chronic...suffering can be relieved, in the presence of continued pain, by making the source of the pain known, changing its meaning, and demonstrating that it can be controlled and that an end is in sight' (1982:641).

Indeed Ellison specifically outlines four possible avenues through which beliefs can enhance aspects of well-being. These are 'social interaction' (1991:80), 'personal relationships with a divine other' (ibid), existential meaning and finally, quality of lifestyle. The consequence of health and spiritual beliefs can then be seen to have a direct impact on one's sense of well-being and hence, identity.

Similarly, Giddens, while discussing ontological security, draws attention to specific existential questions we each ask ourselves while trying to establish our sense of security. Without anticipating the discussion which constitutes Chapter Seven, we can see that Giddens's notion of modern self-identity is bound to one's ability to ask ourselves fundamental existential questions. As these questions frequently arise when one encounters ill health then notions of identity become a fruitful avenue for further discussion and exploration. When discussing anxiety, Giddens notes the necessity of 'an ontological understanding of external reality and personal identity' (1991:47). The presence of ill health can be argued to initiate the process of anxiety and consequently the questioning of one's identity. Whilst Giddens emphasizes four aspects needed to establish ontological security, these being an understanding of one's sense of being, of being in the world, of others, and of self-identity, Giddens's work can be seen inadvertently to parallel Wilson's 'Probabilistic Inventory' (1990:279). That is, Giddens's four notions of ontological security, and indeed, Ellison's four notions of religion and well-being, can both be seen to be represented in Wilson's criteria for religious beliefs. In accordance with these criteria then, the emergence of complementary health beliefs can also be illustrative of these notions. Thus, the specific issue of ontological security, as laid down by Giddens, is seen to be represented within complementary health beliefs and practices. Indeed, even Beckford and Suzara's notion of holism, in relation to healing, can be argued to hint at the present notion of ontological security. They remark: 'In summary, holism is a notion that has come to signify a distinctive understanding of the individual-in-relation-to-others; an integrated view of the spirit and matter; and a world-view that considers all of nature as interconnected and integrated' (1994:129). Hence, health beliefs can be argued to contribute towards one's sense of self-identity. Thus, if we are to believe the essential features of modernity, as emphasised by Giddens, we are then moving towards a state

of increasing self-reflection and personal introspection. Such developments do not, however, cease at personal contemplation. One's physical body is seen to play a significant role in this process. The sacralization of the body can be argued to be a direct consequence of such self-reflection.

However, Giddens is not beyond criticism. While arguing that 'complementary therapy' (2000:169) has mistakenly been portrayed as an 'excessively individualistic activity' (ibid), Hedges and Beckford criticise Giddens for 'virtually' limiting his discussion to specific therapies[27] and hence for regarding 'all forms of therapy with a degree of ambivalence' (2000:174). As such, Giddens is accused of underestimating the wider influences of various therapies in contemporary society.[28]

The themes present throughout this thesis will, therefore, demonstrate how the body has become the medium, not only for communicative experiences with divine forces,[29] but also for interpreting one's social environment. Complementary health therapies are, on the surface, individualistic processes where physical, emotional, spiritual and psychological needs are addressed. However, it is through these processes that individuals, their families, and their wider social networks can be assessed, social networks strengthened, and lifestyle modifications made. Indeed, the sacralization of the body is the foundation to this process for one's body is the means through which all future assessments and interpretations are made.

While studying new age centres in the Netherlands van Otterloo addresses the significance of the body in modern belief systems. She comments '...the body often appears to be presented by the Centres as a means to enter upon and follow the spiritual path...To my mind the widespread presence of this type of therapy is a direct reflection of the increased societal importance of the physical side of the human existence here and now' (1999:193,200). In seeking healing: 'The individual is the vehicle for

---

[27]For example psychoanalysis and psychotherapy.

[28]Indeed Jamieson, also notes the 'individualising tendencies of therapy' (1999:480) while reviewing Giddens's notion of 'the transformation of intimacy' (1992). Here Jamieson criticises Giddens for his relatively uncritical review of 'therapeutic literature' (ibid) as related to concepts of 'personal and social change' (ibid).

[29]and consequently the means to finding good health

religious experience' (Campbell 1978:153). In direct contrast to the present argument, Turner views the body as being increasingly secularized. Turner argues that due to medicalization the body has moved from its 'sacral moorings' (1984:216) in religious institutions and has been transformed to an area of 'secular professionalism' namely the medical establishment (ibid). He writes:

> This study of the body has presupposed a process of secularization which has transferred the body from an arena of sacred forces to the mundane reality of diet, cosmetics, exercise and preventive medicine. For example, diet was once an aspect of religious regimen of passions and the aim of asceticism was to liberate the soul from the cloying distractions of desire. In a society where consumption has become a virtue, diet is a method of promoting the capacity for secular enjoyments. (1984:216)

Although Turner puts forward a convincing argument as to the medicalization of the body contemporary health beliefs perhaps indicate the co-existence of a paradoxical relationship between sacred beliefs and the body. In other words, complementary health practices present an emergence of a sacralized body for its practices address issues of faith and offer a contemporary environment where the body can regain its identification with sacred forces. The newly evolved and revived interest being shown to the body, health and healing can be seen to be directly opposed to Turner's account of a reallocation of sacred forces to the mundane. However, this paradoxical relationship, between complementary health beliefs and Turner's perspective of the increased preoccupation with one's physical state (medicalization), can perhaps be illustrative of Turner's comments of the 'mutation', 'reallocation' (1984:218) and reappearance of religious beliefs in modern society. Indeed, Nesti remarks on the variations, expressions and every diverging contemporary belief when he comments:

> Despite the wave of secularity hitting us, it is possible to trace many paths within contemporary culture and daily life. Some are like labyrinths with

specific dimensions of radical meaning. When we are faced with love, pain, death and the dilemmas of life, these paths reveal existential and normative outcomes; yet they do not themselves postulate a relationship of adherence to any confessional institution. ...Implicit religion is a phenomenon within the complexity of religious phenomena; furthermore, because of its particularity, it is a good expression, on the general plane, of the torment of existential autonomy and the symbolic and normative trans-significance operating in contemporary society (1990:436).

The body can be argued to have gone through a process of sacralization due to the significance of modern beliefs which are applied to the body. Meaning is then given to individuals, through the utilization of complementary health beliefs and practices, regarding the body. Hence, the following pages of this thesis will additionally highlight the attitudes and beliefs concerned with the physical form.

2.6 Conclusion

This chapter has aimed to address the neglected issue of contemporary beliefs regarding the body and beliefs. I explored definitional issues of complementary health and healing, religion and spirituality. In doing so I have highlighted the functional and substantive definitions of religion, and have assessed the common and differing features of religion and spirituality. Two specific features contrast religion and spirituality. The first of these is the individual's expression of and their personal relationship with concepts of the sacred and secondly, the organizational structure of conventional religious beliefs.

Indeed, overall the chapter indicated the movement into late modernity by illustrating the central themes of complementary beliefs and practices. Such discussions also aimed to extend the notion of identity, and to contribute to the understanding of contemporary health beliefs, particularly regarding concepts of the self in modern society. In addressing these issues I have argued that complementary health beliefs have led to the sacralization of the body. As a consequence of modernity, health advocates

are more conscious of their body, lifestyle, and even beliefs, as these issues are all thought increasingly to infringe upon their physical health and ultimate well-being. A process of sacralization ensues whereupon individuals review their approach and attitudes towards their bodies and lifestyles by the employment of introspection and existential questions.

This chapter has therefore reviewed the various expressions of religious and complementary health beliefs available today and has commented on the contrasts and similarities of these types of beliefs. The review has additionally hinted at the relationship between beliefs, the body and one's sense of identity. In reviewing the existing sociological literature I hope to have grounded the current research and lay the foundations for the following discussions.

The review of sociological literature has additionally highlighted the limited body of knowledge concerned with empirically-based research concerned with contemporary beliefs and the body. The following research therefore aims to address this gap by analysing original ethnographic material.

Indeed, although this chapter has reviewed current sociological literature many questions subsequently arise. Wilson's 'Probabilistic Inventory' (1990:279) provides a useful framework for us to explore further the beliefs and practices of complementary health and question the extent to which these beliefs can be seen as a religious belief system. The following pages will therefore explore complementary health beliefs and practices and question the appropriateness of labelling complementary health a religion. These pages will begin by exploring the central themes which underpin complementary health and ask whether, or in what ways do these health beliefs impact on adherents' daily lives? I therefore hope to address the somewhat neglected issue of beliefs and the body. In order to adequately address these issues, however, other related questions arise. These include: How adherents came to believe in health treatments? Whether health adherents believe in transcendental forces? And if so, how do these beliefs manifest themselves in adherents' daily lives? And finally how do health beliefs impact on adherents' sense of self-identity?

In undertaking this research I hope to have to contributed to the small collection of empirically-based work regarding contemporary expression of belief and to build on

existing sociological knowledge concerned with beliefs, the body and identity. The following chapters address these issues by drawing on ethnographic data collected from a particular health milieu. These chapters therefore aim to draw together the themes discussed in this chapter and to address these specific research questions. However, before we proceed with this analysis it is necessary to draw attention to the methodological design and research structure. Chapter Three will therefore outline the ethnographic steps undertaken in carrying out this qualitative research.

CHAPTER THREE

METHODOLOGY & THE RESEARCH PROCESS

Research design plays a critical role in any social research. Research design provides a structure through which research is grounded as well as setting the agenda while the research is in progress. As such, techniques and strategies applied in social research aim to acquire knowledge and interpret data within a specific discipline. Ultimately methodology becomes directly influential to the research results as the research design becomes a prerequisite as to whether the research will eventually yield relevant, new or interesting data. The aims of the research must not only be reflected in the chosen methods, to get the best possible results, but it must also set a logical progression and development of the research question. The research approach, therefore, should enable the social researcher to collate material through an established pattern, while allowing limited modifications to take place if no practical results arise from the original design (Fielding 1993b:157).

This chapter will be divided into seven parts. Each part concentrates on a specific theme which was addressed throughout the research process. The first section entitled research design will explain, briefly, the research progression. This will conclude by reiterating the research problem and the principle methods employed in the research process. Section Two will be dedicated to outlining the sample and criteria for the selection of therapies under study, and pilot interviews held throughout the early stages of the research. Question design and interview guides will be the focal points to Section Three. This includes the development of the research questions and interview guides. Particular attention will be paid to the interview questions and approach in the light of the various pilot findings. Section Four will look at the processes of gaining access to the research field through attendance in the Healing Centre's annual open day. This event played an essential role in gaining access to the wider setting of the research, enabling access to a healing centre, their therapists and clients. Section Five will discuss the interview process. The discussion will include a brief description of methods used in gaining interviews, negotiation of client access, and interview style. Section Six focuses on participant observation in workshops, health sessions and festivals. Although this

method was not originally predicted to play a significant role in the research process, participant observation in a variety of health events was seen to be a highly significant method through which data collection and analysis was achieved. Finally, Section Seven will bring together the collated data of the research by exploring the use of computer assisted software and the research's analytic process.

3.1 Research Design

On Sunday 4th December 1994 on BBC 4 radio a programme entitled "Sunday" was broadcast. The programme was ten minutes long and was devoted to an interview held at an alternative health centre entitled Holistic Health.[1] The BBC interview looked at the significant rise of interest in complementary health and asked whether complementary health has developed itself into a form of religious belief system.[2] Throughout the discussion the proprietor of Holistic Health mentioned physical beauty and complementary health treatments as contributory factors in a sense of one's personal and physical transformation. Although the interviewee was not describing complementary health as a religion, she believed an element of faith was needed within complementary health practices. In order to comprehend fully the issue of belief and faith raised by this BBC interview I decided to follow it up by visiting the centre and, if possible, interview the proprietor. The primary aim of the interview was to explore more fully the comments made in the original BBC interview. The aim of my interview, therefore, was to see whether complementary health's beliefs and practices could be interpreted as implicitly religious. Fortunately I was able to secure an interview with the proprietor of Holistic Health. A number of themes arose from this interview which played a considerable part in the development of the research themes and approach. Among the themes raised by this initial interview were beliefs in healing energy,

---

[1]For reasons of confidentiality pseudonyms have been given for each health centre. In addition all interviewees, throughout this thesis, are referred to by pseudonyms. Quotes are displayed verbatim with dialogue pauses replaced with three consecutive dots. Finally on all interview quotes, transcript line numbers are displayed. (Silverman 1993:19).

[2]A transcript of the BBC "Sunday" broadcast can be seen in Appendix 3.1.

lifestyle and body perception, and personal, societal and global change. These beliefs would eventually be identified throughout a wide range of health treatments. Following this interview it was clear that a potentially fruitful research area had emerged, that is, to explore whether complementary health beliefs and practices could be interpreted as illustrating characteristics of a religion.

What became initially clear from this exploratory interview into complementary health was the diverse range of health treatments available within a single health centre. A secondary focus was, therefore, to explore whether the beliefs differentiated between the wide range of treatment styles, for example, Reiki and Reflexology. A cursory examination of the brochures of a number of health centres showed that they incorporated into their services a wide range of therapy styles. Studying one commercial, public health centre then allowed the research to be open to a diverse range of clients and their motives for attending within one centre; while simultaneously enabling the research to cover several health styles. Although the research was initially designed as a case study, subsequent serendipitous events, especially participant observation, led the research to a more open design of investigation. The research therefore evolved to encompass a number of social environments. Stoecker defines a case study as: '*...research projects which attempt to explain wholistically the dynamics of a certain historical period of a particular social unit*' (1991:97-98).The present research can therefore be seen to evade the two principle criticisms of which many case studies are accused. These criticisms are, firstly, the 'threat of bias' and its assumed impact on internal validity (1991:91), and secondly, the restrictions that are placed as case studies do '..not allow us to generalize our findings to other settings' (1991:91). [3]

It became clear while reviewing therapies available within a healing centre that it would be necessary to distinguish between the various styles of health treatments. Given the relatively broad focus, style and implementation of the health therapies, there emerged a possibility of comparative analysis of health beliefs according to their

---

[3]Although it is important not to argue beyond the realms of the data collected, the study of a single health centre, hypothetical inferences were made regarding the beliefs held by a wide range of health participants. Inferences were additionally shaped by participating in a variety of health and healing events. The issues raised in this thesis, could therefore, hint at beliefs held by individuals participating in the wider health and healing network.

different health approaches. It became apparent that complementary health therapies vary along two main dimensions according to the stress they give to either the physical and/or the psychological/ spiritual. Three basic types of therapy were, therefore, distinguished: (A) the Integral (stressing both physical and psychological/spiritual); (B) the Psychological/Spiritual; and (C) the Physical (See Table 1). The matrix of therapy types was purposefully simple to enable a clear understanding of the different classifications of health therapies available. The additional benefit in constructing the matrix was its ability to organise a diverse range of health therapies into manageable research areas. Furthermore, dividing therapies into these cell groups also facilitated cross cell analysis and comparisons. The decision to construct a matrix was aided by the writings of Miles and Huberman concerning the uses of matrices in social research (1994: 240).

My selection of the two dimensions in the matrix followed the suggestion of Marion Bowman, a researcher of New Age phenomena who suggested: '... that there might be some way of distinguishing between "manipulative" therapy - Massage, Shiatsu, etc., and that which involved no actual physical contact between therapist and client' (Bowman, 1995, private communication). Secondly, in order to classify all treatments in a healing centre it was necessary to ask the therapists themselves how they perceived their practice styles, for example predominately physical or psychological/ spiritual or integral. Where therapists were not available to answer this question therapy literature and brochures were used to classify treatments.

Distinctions between therapy styles were noted, much later, by Hamilton (1998a) in a paper presented at the Annual Conference of the British Sociological Association. Hamilton distinguished mind/spirit, mind/spirit/health, body and health, ambivalent and other types to differentiate between treatments, lectures and workshops within a particular New Age environment. Hamilton emphasises the dangers associated with assigning some health practices into one classification, as some practices cannot clearly be categorised, but accepts that it is necessary to make such distinctions in the course of social research.

	Physical Positive	 Negative
Positive	<u>Cell A</u> 4. Art and Drama Therapy 5. Colour Healing 8. Crystal Healing 18. Qi Gong 27. ReBirthing Total: 6 Therapists/ 5 Clients	<u>Cell B</u> 10. National Federation of Spiritual Healers 12. Hypnotherapy 16. Neuro-Linguistic Programming 19. Psychology 20. Reiki 23. Meditation 24. Creating Prosperity Total: 8 Therapists/ 9 Clients
Spiritual / Psych Negative	<u>Cell C</u> 1. Acupuncture 2. Aromatherapy 3. Alexander Technique 6. Colonic Hydrotherapy 7. Cranio-Sacral Therapy 9. Feldenkrais Method 11. Holistic Massage 13. Homeopathy 14. Jin Shin Jyutsu 15. Kinesiology 17. Nutrition 21. Reflexology 22. Shiatsu 25. Bowen Technique 26. Radionics 28. Yoga 29. Natural Healing Total: 7 Therapists/ 6 Clients	<u>Cell D</u> N/A

<u>Table 1 Complementary Health and Healing Matrix</u>

The research unfolded, therefore, through an initial investigation into beliefs held by complementary health practitioners and a number of new and emerging themes in the Sociology of Religion. The research also aimed to examine the significance of these beliefs for both clients and therapists. Ultimately I aimed to identify the significance of these health and healing beliefs and to ask whether these notions could be interpreted as religious. Thus I wished to study the extent to which complementary health beliefs and practices could be interpreted as 'religious'. Although the research cannot really be considered a case study, as other environments such as

health shows were visited, the focal centre did, in fact, provide the nucleus for the majority of therapists/client interviewees and participant observation work undertaken.

Treatments for study were selected according to their location on the Complementary Health and Healing Matrix. Hence, it was proposed to study at least one health treatment from each cell group. Although questionnaire surveys and participant observation could potentially have yielded fruitful data I decided to conduct qualitative interviews. This decision was based on the realization that the subjects of discussion could be seen as relatively sensitive in nature (Lee & Renzetti 1990). Informal but focused interviewing generated a mass of rich data.[4] The number of therapists and clients interviewed in each cell of the matrix has been given in Table 1.

3.2 Sampling and Pilot Fieldwork

Pilot work, including exploratory interviews and some participant observation, in three health centres, led to greater clarity and focus in the final research design. It helped conceptualize, re-focus and ultimately reduce the number of research themes to manageable proportions (Miles & Huberman 1994:10-11). It aimed firstly, to establish, and amend if necessary, the specific design and style of questions and interview technique; secondly, to establish preliminary links with health and healing centres; and finally, to enable a greater understanding of the key complementary health and healing beliefs.

Although this pilot and sampling work was time consuming, initial results from this early work contributed considerably to the long term aims and themes of the research. Oppenheim discusses the fundamental importance and benefits of pilot work when he writes:

> Piloting can help us not only with the wording of questions but also with procedural matters such as the design of a letter of introduction, the ordering of question sequences and the reduction of non-response rates. We should realize from the beginning that pilot work is expensive and time-consuming,

---

[4]See Section 3.5 for an explanation of this decision.

but avoiding or skimping on pilot work is likely to prove more costly still (1992: 47).

The pilot work began by initially interviewing the proprietors/managers of three complementary health centres. These centres were selected from a health magazine entitled *The A-Z of Alternative Medicine* which was published as this research commenced. The magazine included a comprehensive guide to 'Alternative Medical Centres throughout the UK' (1994, Edited by Michael Morgan). This magazine was selected due to its comprehensive, detailed and up-to-date coverage of centres and therapies compared to similar publications. One obvious difficulty which occurred, once looking at this health magazine, was the criteria appropriate for selecting a number of health centres on which to pilot the research methods. For example, the initial criteria of the research were grounded on the publication's criteria of affluence (advertising fee), location and type of treatments/ services available (health orientated).

Clinics and centres were reviewed and listed according to a number of criteria (Miles and Huberman 1994:27). These were: firstly, geographical area, the London region; secondly, estimated size of clinic according to advertisements, e.g. range of therapies that were available, number of therapists, estimated number of clients and finally number of consulting rooms. The range of treatments had to include Physical, Psychological/Spiritual and Integral forms of health care. These simple criteria were used as a yardstick through which the first range of health centres would be selected.

Within the London region 13 centres were possible subjects of study. Letters were sent to the proprietors/managers of these health centres requesting a possible interview. The letter contained a brief outline of the study which excluded any mention of implicit or quasi-religious beliefs. Such phraseology was thought likely to generate somewhat negative reactions, especially as many complementary health centres actively wish to be seen as distinct from any mystic, magical or religious associations. Letters were therefore built around terms which arose from the BBC Holistic Health transcript. For example instead of using the term 'beliefs' the words 'holism', 'energies' and 'change' were used to represent the central themes of the research. Taylor and Bogdan (1984) recognize the benefits of disguising aspects of the study when they say:

It's usually wise not to let informants know what you want to learn about or see (if you know yourself)... it is sometimes useful to camouflage the real research questions to reduce self-consciousness and the perceived threat... when informants know too much about the research, they are likely to either hide those things from the observer or stage events for his or her benefit (1984: 46-47).

The tailoring of language, again, is noted by Fielding (1993:157) when discussing ethnographers' approaches to social research.

Three centres immediately wished to be excluded from the study, including the centre that was the focus of the BBC broadcast, Holistic Health. I received positive responses from two centres. These were called The Healing Centre and Natural Health. Interviews were arranged and conducted at both centres. These pilot interviews yielded both interesting and constructive data which contributed towards the research development. The interviews additionally highlighted the various difficulties which accompany ethnographic data collection. The difficulties encountered while carrying out social research did not only include one's performance in the interview situation. It became clear, very early in the pilot interviews, that a variety of skills must be employed while performing a whole range of ethnographic tasks. Personal appearance, conduct, tone, expressions and language of the researcher all impact on the interview situation, and indeed the interviewee. Such matters directly influence the relationship one has with the respondents and consequently the degree to which respondents are willing to disclose personal or sensitive information.[5] Oppenheim (1992:70, 95) highlights the qualities necessary in conducting fieldwork.

By conducting pilot work, therefore, I was able to develop and build upon both my interpersonal skills and my questioning, and probing abilities. Hence, these interviews turned out to be very constructive to the research. The offer of further assistance from these centres, following the interviews, was seen to indicate a possible

---

[5]I was particularly aware of my appearance while interviewing Colour Healers. As specific colours symbolised particular meanings I took additional care as to the combination of colours I chose to wear while interviewing.

avenue of further enquiry.

Although only three pilot interviews took place the early data from interview transcripts, centre literature and pilot field notes, were very rich and made a substantial contribution to the research development. In addition, observation notes taken while conducting pilot interviews assisted in selecting a health centre on which to focus the study. This early observational analysis can be seen in Appendix 3.2. Such observational analysis became useful to the extent that it raised inquisitive questions as to the nature of complementary health centres and their wide range of approaches to health issues. The pilot work encouraged the practising of my observational skills. The observational field notes, regarding research settings, and research subjects, became valuable data in contextualizing and understanding further the research environment. Field notes and observational analysis also contributed to the selection and ultimate reduction of the health centre sample. Fielding (1993:161) and Denzin (1970:73), particularly, comment on the usefulness of field notes and fieldwork observations.

Shortly after the pilot interviews had taken place I was invited to attend the Healing Centre's open day. The open day would be the first event in which all participants within the centre, whatever their role, would attend and meet. The opportunity of attending the Healing Centre's open day turned out to be an essential step in gaining access to the centre's therapists and clients. Following my participation at the Healing Centre's open day it was increasingly apparent that I could achieve my research aims by studying the range of therapies practised in this one centre. I therefore selected to study the Healing Centre and did not continue further with the explorations of other centres.

Once the Healing Centre had seen selected it was necessary to focus on the interviewee sample. I intended to interview a sample of both clients and practitioners from each cell group. However, I was aware from my experience of pilot interviews that negotiating and securing client interviews would be difficult.[6] In order to secure a

---

[6]Several explanations were given by therapists as to the difficulties in securing client interviews.These were: issues of professional politics and confidentiality, whereby therapists believed that they should uphold the same standards of ethics and confidentiality as conventional health practitioners; economic reasons (my enquiry could jeopardise the practitioner's income); clients were rich and famous (and hence, their privacy would be compromised); and finally a

sample of client interviews it was necessary to interview the practitioners of several treatments from each cell group. A realistic number of client interviews would therefore be achieved since the client sample would be spread over a greater number of practitioners. As such, the client sample was predominantly based on the willingness of practitioners to recommend my name to prospective interviewees. A simple strategy was therefore adopted. Practitioners of a specific treatment would be targeted. If an insufficient number of interviews were conducted a secondary therapy, within the same cell group, would be targeted. Practitioners of this second treatment would then be targeted for study. This strategy would be implemented until a sufficient number of therapist and client interviewees had been conducted from each cell group.[7]

3.3 Question Design and Interview Guides

Once several pilot interviews had taken place it was necessary to analyse the interview data. This analysis began by concentrating on question design, wording and style and even delivery which not only directly influence question responses but, ultimately the wider research findings.

The pilot interviews, although few in number, helped substantially in the amendment of question wording and design. One most prominent outcome to these interviews was sensitivity in asking questions and listening to question responses. Fielding explores the field worker's ability to study sensitive social phenomena when he observes: 'In designing research, field workers need to give serious attention not only to what they see as controversial, but to what subjects find sensitive. It is not just another obstacle in the field but a compelling part of a well-founded analysis' (1990:620). Here Fielding not only hints at the potential consequences of handling sensitive issues, groups and individuals in social research, but also any potential consequences for the field

---

knowledge that their clients would not be interested in participating (and hence, there would be little gained in interviewing them). (Based on field notes taken, August 1995).

[7]The maximum number of therapies studied in each cell group was three. This indicated that the strategy of gradual sampling across different treatment styles enabled the research to accumulate a satisfactory interview base.

worker. Although the interview questions, for both therapist and client, were not directly intrusive into the respondent's personal health and belief system, I had to be fully aware when asking questions which could be seen as sensitive in nature. For example, questions relating to belief in the concept of energy must be delivered sensitively as occasionally these beliefs are often thought of as delicate and very personal to the individual.

Hay and Morisy (1985), while conducting their own research into individuals' concepts and experiences of the sacred, specifically highlight one of their 'methodological strength'[s]. They observe that research methods should have '...the freedom to probe with some sensitivity the meaning the individual places upon his experiences, as well as to note their social consequences. It was in fact observed during fieldwork that access to people's beliefs was gained through talking about an experience. The description and explanation of an experience incorporated and gave a scaffold for beliefs' (1985:215). The handling and delivery of sensitive interview questions can be seen as one ethical consideration while collecting ethnographic material. As Oppenheim remarks: 'High ethical standards should prevail; no respondents should be afraid to produce self-incriminating or embarrassing feelings or information, and if a respondent gets angry or tearful the interview should be gently discontinued and the respondent helped to regain composure' (1992:70).

As the research focus was not specifically concerned with the respondent's health status, interview questions were constructed to omit direct questions relating to respondent's health problems. However, question wording was formed to enable respondents to disclose freely any personal information which they thought might be relevant to the discussion. Hence, interviews were performed around the respondent's willingness to disclose information. Miles and Huberman also highlight several ethical issues which must be addressed while interviewing respondents. Issues relating to 'informed consent', 'honesty and trust', and 'privacy, confidentiality, and anonymity' (1994:291-3) all contribute to the ethical standards which are recognised by the social researcher. Furthermore, the researcher must also note the issues surrounding sensitive topics (Lee and Renzetti 1990). Indeed, it is these issues which contribute to the complex and problematic nature of ethnographic research.

However, question design and delivery must still retain clarity. The following field note was taken after an initial pilot interview: 'Subtlety is not always beneficial in questioning style. You can tread too carefully and not get to the guided issues. There could also be a degree of mis-interpretation/ mis-understanding. Hence, plain and straight forward questions are always better and are more likely to get better responses'(Field notes 25/5/1995).

Fielding (1993), while discussing 'front management' of ethnography, raises the issues of the researcher's role when he comments: 'A useful observational tactic is the cultivation of an impression of naiveté and humility, so the members feel obliged to explain things that seem obvious to them' (1993:158). Again, sensitivity is highlighted by Newell (1993) while discussing question design. Newell draws attention to 'seemingly straightforward questions' (1993:106) which may be particularly sensitive to the interviewee. Thus, a sensitive interviewing approach must be adopted while questioning individuals on issues relating to their concepts of health and personal belief systems. The interview guide must then be worded such as to enable discussion of sensitive issues (e.g. belief in energy), to be raised while still retaining its clarity and purpose. Interview questions must also be delivered sensitively to enable interviewees to be open about their responses.

Question design was appropriately amended once pilot fieldwork had been assessed. Pilot interviews helped substantially towards identifying the research themes. Often themes were confirmed, and new themes emerged after pilot interviews had taken place. Thus occasionally, unexpected and new themes would arise or be highlighted during piloting. Pilot work can also uncover specific ideas about question design and style, and interview techniques which otherwise might have been neglected. Question wording and design are, therefore, important in the research process. In the light of pilot field notes, a decision was made to make questions simple and clear, while retaining the possibility of further probing questions. The design of interview questions was based on a number of premises. The framework for question design was initially based on the writings of Oppenheim (1992) where he emphases a number of recommended criteria. He writes:

Length - questions should not be too long...*Avoid double-barrelled questions* - 'Do you own a bicycle or a motorbike?'...*Use simple words, avoid acronyms, abbreviations, jargon and technical terms* or else explain them...*Beware 'leading' questions...Beware loaded words...* (1992: 128-130).

It is important to note that although these criteria were followed while designing question wording the interview guides were simply intended to direct the interview conversation. In order to maintain an informal and continuous dialogue it was frequently important to adapt questions to suit the individual interview situation. Moreover, in order to discover respondents' own beliefs and attitudes I was particularly conscious of the importance of omitting leading questions from any interview guide. Due to the exploratory nature of the research it would have been futile to have worded questions in a format which would have communicated preferable answers. The presence of leading questions within the interview guide would have limited the field of enquiry as the emergence and discussion of themes were intended to be an exploratory and organic process. To maintain the 'free-flowing and probing character' (Lofland and Lofland 1995:86) of interviews I aimed to 'get respondents to express their own ideas spontaneously in their own words' (Oppenheim 1992:74). In order to enable respondents to express their beliefs independently and without their comments being shaped by my own remarks I aimed to conduct interviews with minimal verbal intervention.

Other useful comments on the design of interview questions emerged from Newell (1993) while discussing question development. She says: 'The wording should not appear too simplistic for some, seeming to insult their intelligence; on the other hand, it must not be too sophisticated for others...questions need to be developed carefully to match the sample to be used' (1993:104-105).

Here Newell (1993) rightly emphasises possible differences between interview respondents in understanding questions. Therefore two interview guides were created. One was designed for therapists, the other for their clients. This was necessary as it was felt likely that there would be different degrees of understanding of beliefs between the clients and their therapists. The primary reason why this division had to be taken into

consideration was that earlier pilot work indicated that therapists knew a lot about the research subjects, energy and concepts of change, and were then more likely to discuss these issues openly, if similar terms were used in the interview conversation. Clients, however, were found to be less knowledgeable of specific terms and were more likely to describe their beliefs and experiences in different, general terms. Pilot work therefore identified a division of knowledge between therapists and their clients. The interview guide was created to portray corresponding question themes while still recognising the different vocabulary between respondents. Each guide, then, represented the same research themes but with the wording tailored according to therapist or client status. Indeed, although interview guides were simply used to direct conversations, different question wording was considered appropriate for therapists and clients. Copies of interview guides for clients and therapists can be seen as Appendix 3.3 and 3.4.

The various suggestions of Newell (1993), Oppenheim (1992) and Fielding (1990, 1993b), contributed to the creative process of designing or amending question wording.

In addition to their recommendations question design was enhanced by referring to pilot field notes. These included preliminary observations on particular linguistic and terminological phrases used by interviewees. Thus, the health centre was found to employ a particular discourse and this was then taken into consideration while amending question wording. An example of this occurred when carrying out an early pilot interview. I introduced the research by using the term 'alternative' when talking about complementary health and healing. The interviewee mentioned that the centre, of which she was proprietor, was not based on an *alternative* approach to health but based more on the marriage of complementary health and healing techniques with that of conventional Western medicine. While discussing complementary health with therapists and clients it seemed the term *complementary health and healing* was an appropriate title to use.

Specific features and properties had emerged from the pilot fieldwork to suggest that complementary health beliefs could be illustrative of conventional religious beliefs, for example beliefs in transcendental forces. In order to explore fully these features it was necessary to review health beliefs in relation to a comprehensive description of

religion. Hence, Bryan Wilson's 'Probabilistic Inventory' (1990:279) was employed to identify specific elements of religious beliefs. Wilson's inventory highlights the 'features and functions that are frequently found in phenomena that in normal usage we recognize as a "religion"' (1990:279). Many questions on the interview guide were coded according to the themes raised in Wilson's 'Probabilistic Inventory'. Indeed, although the interview guides were structured according to pilot fieldwork the underlying themes of questions could also be seen to mirror the major themes raised in Wilson's inventory.

Hence, the final step in question design was the coding of interview questions in relation to Wilson's inventory. The aim of this coding was to identify clearly and organize the principal themes raised in complementary health practices.[8] The coding of interview questions, by theme, could additionally assist the analytical process by interpreting and relating interviewees' responses to sociological literature concerned with defining religion. Such coding does not, by any means, create a comprehensive framework of reference, but such a process does enable, at a later date, the further coding, classification, structuring and interpretation of data in the interview transcripts. Such forward thinking was most beneficial throughout the data analysis process. Coding and managing data could be seen to play a critical role in the comprehension of research material. Jane Fielding (1993) notes the inevitable stage of managing data in social research. Managing data, transcripts and field notes therefore automatically includes the need to create categories to code, sort and define in order to make sense of the collected data. Fielding comments that the initial steps to qualitative interview coding is to '...develop the set of categories into which the data will be coded. The categories may come from theory, intuition or from the data themselves' (1993:227).

3.4 Access

Gaining access to the research setting can be seen as the first major issue while carrying out social research. Hammersley and Atkinson (1995) recognize the researcher's task in gaining access to the research setting when they write: 'achieving

---

[8]See Section 3.7 for a description of the coding process and the eventual emergence of themes and grounded theory.

access is not merely a practical matter. Not only does its achievement depend upon theoretical understanding, often disguised as "native wit", but the discovery of obstacles to access, and perhaps of effective means of overcoming them, itself provides insight into the social organization of the setting' (1995:56).

Access to the Centre's open day was only gained as a consequence of an early pilot interview with the proprietor of the Healing Centre. The advantage of securing access from the proprietor was to legitimate my presence at the Centre, while simultaneously offering personal recommendations to the therapists as to my purpose. In some research settings it is sometimes thought to be a disadvantage to gain access with the knowledge and backing from an authority figure (for example, research into factory floor workers). However, within the complementary health milieu, as each therapist is considered independent, and not directly controlled by the proprietor, it was found that therapists acknowledged the proprietor's recognition of me, but did not feel directly obliged to grant me an interview. Physical access to the research setting was achieved by the proprietor's willingness for me to explore the Centre. However, it then became necessary to acknowledge and focus on the social access required if I were to interview therapists and clients.

The invitation to attend the Healing Centre's open day presented an essential opportunity in gaining access to the Centre's therapists and clients. The serendipitous event of my being invited to the Centre's open day was a major factor in gaining access to a number of therapists. Arber (1993) draws attention to the unexpected development of social research when she comments:

> ...because sociological research is primarily about discovering new knowledge, we should not be surprised when a project develops in unexpected directions. Indeed, since research involves the continual interaction of ideas and data, you should always be on the look out for serendipitous or unexpected findings. These may suggest fruitful avenues and sometimes dramatically alter the course of the work (1993:33).

The Open Day began with the chance to walk around the Centre and view the

consulting rooms and talk to the practising therapists. At intervals throughout the afternoon talks, workshops and performances were held. These ranged from a treatment entitled Creating Prosperity to Qi Gong. These demonstrations and workshops not only contributed in constructing general knowledge surrounding complementary health but, in addition, allowed me the opportunity to participate, to receive treatments, and discuss and observe health techniques with health practitioners. Indeed, attendance at this open day led to further serendipitous opportunities, the principal of which was the chance good fortune at winning a prize for a treatment session. In the event, out of seven therapists' talks and workshops which took place four therapists were subsequently interviewed together with a sample of their clients.

It was while attending the Centre's open day that it became clear that issues of access would not only include a general access to the centre, but also access to each therapist and then further negotiations with their clients. Negotiations of access would, therefore, involved multiple gatekeepers. The first gatekeeper would be the proprietor of the centre, then gatekeepers for each therapy practised. Each therapist would be responsible for their clients, and therefore would be important gatekeepers in the continuity of the study, which aimed to interview both clients and therapists. Discussions of access with gatekeepers, as previously mentioned, were not straight forward. Due to the relatively non-homogenous nature of therapies practised, and therapists' relative independence from the Centre, it was found that access to each therapy had to be gained through each practitioner. Hammersley and Atkinson (1995) observe the importance of identifying the relevant gatekeepers when they comment: 'Knowing who has the power to open up or block off access, or who consider themselves and are considered by others to have the authority to grant or refuse access, is, of course an important aspect of sociological knowledge about the setting' (1995:64). One essential problem which could, and subsequently did, arise was therapists' concerns with client confidentiality in the negotiation of access to interview clients (Lofland and Lofland 1995:43). While talking to both clients and therapists, therefore, assurances of confidentiality were given.

3.5 The Interview Process

The decision to choose the method of focused interviews throughout the research was made relatively easily. Interviewing health and healing participants seemed to be the most appropriate method for exploring contemporary beliefs and practices. Due to the exploratory nature of the research, and the possibility that sensitive and probing questions would be asked concerning informants' belief systems, it seemed necessary to have an in-depth discussion with the research participants. This method would also encourage both spontaneous observations and probing dialogue. This form of dialogue could only be achieved though focused interviewing. Indeed, it seemed clear from my previous encounters with health participants in the pilot work that respondents of new age beliefs would respond more openly in a face-to-face interaction than to a structured questionnaire.[9] Other forms of data collection, such as structured questionnaires or postal surveys would not have yielded such an open dialogue nor enabled the benefit of further probing of specific research areas. Hence, these methods would have placed a restriction on the degree of research exploration.

The decision to choose the focused interview over and above other interview methods came about through the realization that the research was essentially exploratory. Since health beliefs and practices are individualistic, as well as being relatively sensitive in nature, the type of interview method needed to be sensitive to the accounts of each interviewee, while also enabling relevant, 'focused', data to be obtained. In such circumstances, therefore, totally *structured* interviewing would have had a significant impact on the interviewee responses and consequently on the research findings as a whole (Fielding 1993b, Merton & Kendall 1946). Hammersley and Atkinson regard interviewing as an important method which can uncover '...extremely important sources of data: it may allow one to generate information that it would be very difficult, if not impossible, to obtain otherwise - both about events described and about perspectives and discursive strategies' (1995: 131).

The advantage of using focused interviews can be seen through several factors.

---

[9]In retrospect, one of the pleasant findings of the research was participants' willingness to relate experiences and beliefs within a secure environment.

In using a more exploratory approach to interviewing it is possible to identify themes which would otherwise be neglected. Such additional ideas contribute to the depth of understanding while there is a degree of flexibility to probe these new issues. In retrospect, the act of probing interviewees was often beneficial in gaining rich data, as well as uncovering further explanations and experiences not previously foreseen. Fielding particularly draws attention to the usefulness of probing and prompting, when discussing interviews (1993a:140).

Choosing the focused interview also enabled the interviewer to have a distinct frame of reference while simultaneously allowing respondents the opportunity to talk freely about their own ideas relating to health. Merton and Kendall set forth four features of the focused interview which they claim differentiates it from other styles of research interviews. These four characteristics are, to only interview individuals involved in a specific research setting, to form hypotheses from basic analysis of the research environment, to base an interview guide on these observations and finally, to focus the interview on the '*subjective experiences* of persons exposed to the preanalysed situation' (1946:541).

The aim of these four factors, according to Merton and Kendall, is two fold, firstly to test any hypothesis created from the content analysis and secondly to identify any 'unanticipated' responses to the interview situation which could then give 'rise to fresh hypotheses' (1946:541). In order to conduct focused interviewing, therefore, it was necessary to adhere to the features laid down by Merton and Kendall. Through using this initial framework it becomes possible to identify interviewees, structure the interview content and focus on the specific themes and experiences of adherents.

Once identification of setting and context analysis has taken place an interview guide can be constructed. The interview guide acts as the foundation to the interview situation. The guide not only specifies the various semi-structured questions to ask, but also indicates possible areas to probe in order to follow up additional, potentially valuable, research themes. The interview guide would then consist of a number of specific research themes. Lofland and Lofland emphasise the use of an interview 'guide' (1995:85) as opposed to a schedule as a guide allow interviewees 'to speak freely in their own terms about a set of concerns you bring to the interaction' (1995:85). As such

then Lofland and Lofland view the interview situation as a '*guided conversation*' (1995:85).

It was important to the interview situation to encourage a level of informality while asking questions. Several techniques were employed to give this impression. Interview guides were deliberately placed to one side of the respondent and my self. This demonstrated to informants that the interview was informal but there was a specific structure to the meeting. Although the interview guide contained questions in a certain sequence, conversations were usually free-flowing and subject areas often became fragmented. As such the interview guide was not rigidly followed. The guides were employed to follow the natural progression of respondents' comments. This was only possible by listening to the respondent and guiding the conversation to the specific research areas. Indeed, if informants altered the course of their comments to unrelated topics I would guide the discussion back, where necessary, to the research area. The aim was to 'direct the interview as unobtrusively as possible' (Oppenheim 1992: 67). This guiding interview technique yielded positive results from respondents.

Interviewing was carried out with both clients and therapists. Both of these groups were considered important in the research as they represented the two sides of the therapy interaction, that is, the providers and receivers of complementary health and healing. By interviewing both parties, therefore, there would be an additional possibility of a comparison between the beliefs and knowledge of the client and therapist.

The therapists' interview guide began by asking simple questions relating to their practice and their discovery of health and healing techniques. These questions were initially used to build rapport. The following questions focused on the various beliefs which arose both from the daily practice of treatments, and from the practitioner's individual knowledge of their beliefs. These introductory questions also aimed to gain further insight into the role of the therapist and the therapy they offered.

The client interview guide began by asking what treatments the client took on a regular basis and questions relating to the cause of their interest in complementary health. The conversation progressed to enquire whether they were aware of specific notions underlying healing techniques (e.g. energy). These questions proceeded to enquire whether they thought these ideas were important to the treatment, or indeed, if they

themselves found these notions significant in their daily life. Such questioning aimed to explore client's understanding of these beliefs, while also studying the significance of these themes on their own ideas concerning health and well-being. Both interview guides aimed to explore issues relating to health and healing experiences.

I intended to interview a sample of therapists and their clients from each of the three groups identified in Table 1. In total forty one interviews were conducted. Twenty one interviews were conducted with health practitioners while twenty interviews were held with clients. The total number of interviews undertaken was limited by the resources and time available. I interviewed practitioners of the most popular treatments (e.g. Colour Healing, Reiki) first on pragmatic grounds in order to achieve access to the larger number of clients. For further details of interviewees see Appendix 3.5.

Therapists were approached by writing a brief introductory letter explaining the research and why I had written to them. These letters were either sent via the Healing Centre or directly to the therapist. They included an invitation to be interviewed. Chase-up calls were made a week following the letter enquiring about a possible interview date. It was usually on these occasions that therapists' concerns and general questions were asked relating to the study. If the therapist was willing to be interviewed a date was arranged. Even if therapists were not willing to participate they often made referrals to one of their colleagues.

Once therapists had been interviewed, negotiation of client access was discussed. If the therapist was aware of clients who would be interested in being interviewed, a few client introductory letters would be given to the practitioner.[10] These letters would then be passed on, by the therapist, to any interested clients to make contact with me directly. This method of arranging interviews allowed the therapist peace of mind over client confidentiality, as they would not be distributing their clients' details. However, this method also had disadvantages inasmuch as therapists had total control over to whom they chose to give the client introduction letter. Nonetheless due to the concerns for client confidentiality of many therapists it would otherwise have been hard, if not impossible, to make direct contact with clients.

A factor which emerged while performing pilot interviews was the necessity to

---

[10]Each letter contained a reply slip and a self-addressed envelope.

recognise the differences between the client and therapist interviews. In approaching client interviews it was necessary to be aware of the sensitivity of some questions. Hence, I adopted a sympathetic and understanding stance to the respondents' beliefs and ideas. This was necessary as some clients sometimes found it difficult to express or describe their beliefs and feelings towards complementary health and healing. Oppenheim, while discussing exploratory interviews notes the difficulties encountered while interviewing. The interview then 'requires interpersonal skills of a high order (putting the respondent at ease, asking questions in an interested manner... giving support without introducing bias);.. When taken seriously, interviewing is a task of daunting complexity' (1992:65).

Fielding also reminds us of some of the problems which can be encountered while interviewing. He particularly highlights, 'misdirected probing and prompting, ignoring the effects of interviewer characteristics and behaviour, neglecting the cultural context in which the researcher is located, and problems with question wording' (1993a:148), as issues which would greatly alter the quality of the interview discourse.[11] In addition interviewers' 'demeanor should be neither condescending nor deferential, that they should display interest without appearing intrusive' (1993a:139). Indeed, recognition of these prospective problems were important if successful, informative, and sensitive interviews were to take place.

The appearance of sensitivity and interest was specifically necessary in questioning health participants due to the personal nature of the subject matter: health and personal belief systems. Lee and Renzetti particularly focus on this area while summarizing the research process found in studying sensitive topics. They begin by defining a sensitive topic of research: '... a sensitive topic is one which potentially poses for those involved a substantial threat, the emergence of which renders problematic for the researcher and/or the researched the collection, holding, and/or dissemination of the research data' (1990:512). Lee and Renzetti continue by suggesting that certain areas of study are more likely to be perceived as sensitive than other research areas. Such areas include: '...where research intrudes into the private sphere or delves into some deeply personal experience' and '... where it deals with things sacred to those being studied which they do not wish profaned' (1990:512). Hence, it was important to recognise the

---

[11]Indeed, such issues should have previously been addressed throughout the pilot study.

delicate issues which arose in both client and therapist interviews. In retrospect the methodological design had naturally incorporated a sensitive stance into its strategy, while still managing to retain its focus and aims. This is recognised by Lee and Renzetti when they comment: 'Sensitivity, as we have used the term here, affects almost every stage of the research process from formulation through design to implementation, dissemination, and application. Perhaps only the actual process of data analysis is likely to remain relatively untouched' (1990:513).

Therapist interviews were usually conducted more directly as many therapists had a firm understanding of the ideas which underpinned their beliefs in complementary health. Therapists interviewed were articulate at describing and portraying their ideas concerning health issues. An additional observation was made early in the interview process regarding the use of a micro tape recorder. To save time and to enable the continuous, free flowing conversation a micro tape machine was used to record all interviews.[12] Strategies for the placement of the micro machine were learned early in the interview process. By placing the machine directly in front, or between, the respondent and myself it became obvious from the respondents' repeated eye contact with the machine, that they were aware of its presence. Hence, by placing the recorder nearer to the respondent and to one side of them, and therefore out of their direct line of vision, the respondent seemed to forget its presence. I hoped, then, that a more naturalistic conversation would take place. Other observations were made while interviewing. One field note declares: 'Do not turn off the tape machine immediately after the interview. Chat can be very useful additions to research data. Often therapists, and more specifically clients, are visibly more relaxed once "formal" questions are over' (Field notes 16/11/1995).

Finally, interviews were found to yield contacts with additional potential interviewees. Miles and Huberman (1994:28) emphasise a snowball effect when interviewing. This strategy is based on informants' referrals to fellow health adherents. Hence, this strategy reduced the necessity to post further introductory letters as personal referrals were achieved by practitioner recommendations. Such referrals led to additional attendance at a Health Show and a Holistic Fair where prospective interviewees were

---

[12]Permission, of course, was asked prior to recording interviews.

exhibiting. These practitioners were originally based at the Healing Centre, but attendance at these events enabled them to publicise their services to a wider audience. As we can see from Appendix 3.6, interviews were secured principally via the Healing Centre and secondly, through talking to certain practitioners, at alternative health shows and events. The following section aims to explain the significant role these events played in data collection.

3.6 Participant Observation

I had not originally expected to use participant observation as a method throughout the current research. Its incorporation into the fieldwork came about unexpectedly, initially as a result of the Healing Centre's invitation to their open day and my subsequent good fortune in winning a competition to receive a free therapy session. It was these two events which allowed me to see the benefits of participant observation. Subsequent participation in Reiki workshops, attendance at health festivals and exhibitions, and a therapy session, in the pursuit of specific interviewees, bore fruit in the collection of rich observational field notes which were useful in contextualizing the research field. Thus, participant observation could be seen to be a valuable method through which, I was able to achieve a greater insight surrounding health beliefs.[13] My own experiences therefore, became an effective tool in general conversations with subjects. Participant observation then became valuable once the interviewing programme got under way as it allowed a greater understanding of the respondents' answers and allowed me to recognize and probe issues which would otherwise have been neglected. Participant observation became, to some extent, an equally important method alongside that of the focused interview. Likewise participant observation work could then aid the understanding of the Healing Centre's milieu.

Participant observation according to Lofland and Lofland can be recognized to refer:

---

[13]Indeed, participant observation played a critical role in gaining access to both clients and therapists.

to the process in which an investigator establishes and sustains a many-sided and relatively long-term relationship with human association in its natural setting for the purpose of developing scientific understanding of that association. This may not be the person's sole purpose for being present in the setting, but it is at least an important one ...[and] Classic participant observation, then, always involves the interweaving of looking and listening, of watching and asking, and some of that listening and asking may approach or be identical to intensive interviewing (1995:18-19).

Experiences while carrying out participant observation were beneficial as such participation contributed greatly to empathizing with the beliefs of the respondents. The dangers of such empathy and understanding, however, arise when the researcher temporarily loses some objectivity. One should be aware not to lose one's role as an external researcher. Taylor and Bogdan (1984) note the dangers of 'going native' when they say: 'Although there are instances of field researchers "going native," abandoning their role and joining the groups they are studying, the more common problem is over-identification with informants' (1984:40).

Nonetheless, after recognizing the risks of 'going native', experiences from participant observation work enabled me to have a greater rapport with both clients and therapists. One particular method, in building rapport, was to hint at some of the workshops that one had attended. Such shared experiences between the interviewee and researcher enabled respondents to relate greater details of their beliefs without fear of being thought of as eccentric or strange. Taylor and Bogdan (1984) identify the needs of sensitivity and the approach of being humble when they say: 'It is important for people to know that the researcher is the type of person to whom they can express themselves without fear of disclosure or negative evaluation' (1984:38).

A prerequisite to gaining access to two particular Reiki practitioners was to attend a Reiki healing workshop at the Healing Centre. The aim of the weekend was to train attendees into the first stage of becoming a Reiki practitioner. This opportunity extended the possibility of further participant observational work and further access to

Reiki clients.[14] As the participation in the field was brief, only two days, there was a problem of time constraint. On entering the field setting one's pre-conceptions of 'blending in' straight away seemed to diminish. The decision to participate overtly may have been influential on several factors throughout my time there. However, my decision to participate overtly was principally grounded on my own feelings of openness. I would have felt uncomfortable with a covert method of observation. I also believed that my behaviour and doubts as to my 'front management' (Fielding 1993:158) skills in covert participation, would have infringed upon my ability to take-in observations.

Even so, the difficulties encountered in initially blending in were particularly emphasised by two experiences. The first principal factor which may have been significant for the workshop members, were comments made by one male participant. On several occasions, this individual implied that I must have seen the Reiki practices as being very 'weird'. His pre-conception of what I may have been thinking could have influenced other participants' views of me and consequently their relationship towards me. These comments could also have been inferred as reminding the group of my researcher role. A secondary factor which distanced me from other participants became apparent throughout the group lunch. As these meals were contributed by all the members of the workshop I was conscious that I would have to provide vegetarian and healthy food. It was not until after the first meal that I noticed that the food I had contributed had not been eaten. This illustrated that many of the participants on the workshop were in fact vegans. My ignorance of vegan food (and the unexpected eating arrangements), seemed only to highlighted my external role as a researcher. Such embarrassing experiences are thought of as just part and parcel of participant observation. Taylor and Bogdan mention: 'All observers are faced with embarrassing situations in the field... fieldwork is characterized by feelings of self-doubt, uncertainty, and frustration; take comfort in the fact that *you will feel more comfortable in the setting as the study progresses*' (1984:34). It was unfortunately due to my limited time in the Reiki workshop that I was unable to make up for any simple, yet embarrassing situations. Nevertheless this workshop played an important role not only in the shaping of my research skills within the field (probing, note taking) but also in contextualizing the

---

[14] For a greater description and analysis of the Reiki workshop see Appendix 3.7.

research milieu.

Note taking while participating in the field was difficult due to the amount of information one received throughout the course of the day. While participating in the Reiki weekend we were told to go for a short walk over the lunch time period to 'earth' ourselves. As the first day was concerned with expelling all our negative energy from our bodies, we were told we would need to replenish this space by taking in positive energy from our surrounding environment. This could be achieved by walking and receiving the positive energy that exudes from the ground. It was at these times that it was possible to make simple, brief notes[15] relating to quotes or discussions mentioned throughout the course of the first morning.[16] Taylor and Bogdan acknowledges the task of taking notes in the field and the difficulties attached to the process when they say:

> When first entering the field, observers are often overwhelmed by the amount of information they receive. For this reason, you should try to limit the amount of time spent in the setting during each observation. An hour is usually enough time. As you become more familiar with a setting and adept at observation skills, you can increase the length of time in the setting (1984:34).

Although the bulk of the field notes were taken down at the end of each day[17], nonetheless I was conscious of the amount of potentially valuable information which may have been lost due to the highly structured daily programme.[18] The usefulness of field notes has emerged through various writings on social research (Fielding 1993b, Hammersley and Atkinson 1995, Lofland and Lofland 1995). Thus field notes also act

---

[15]away from the research setting and the participants of the course.

[16]Lofland and Lofland (1995:89) remind us of the limits of the human mind in recording events.

[17]Some of the more critical quotes, phrases and discussion, which occurred throughout the day, were noted on the journey home from the research setting. These were essential as much of the data was thought too valuable to lose.

[18]Each day began at 9.00am and ended at 5.30pm with one hour's communal lunch break. The daily course programme provided the initial data and formed the foundation to more detailed field notes.

as prospective factors in contextualizing the research setting and research subjects. The field notes taken throughout the participant observation weekend were both structured and coherent enough to enable a thorough analysis of events to take place.

Such participation could be identified as being important to the present research for it contributed to my knowledge, and hence enabled greater rapport with research subjects. Indeed, access to clients and therapists could then have been furthered by undertaking such participant observation.

3.7 Transcription, Analysis and Grounded Theory

To begin this final section one must first briefly mention the preparation needed before analysis could commence. After forty one interviews had taken place, when resources and time were gradually being consumed, and interview comments were becoming more repetitive, it was necessary gradually to transcribe all the interview material. By this stage several main themes had emerged throughout all interviews. However, before a review could take place an investment of time was given to the transcription process (Arber 1993:45).

The transcription of interviews can be performed in several ways. Each method, however, has a consequence for the eventual data analysis. Heath and Luff (1993) observe the particular use of conversational analysis in the study and formation of transcripts. Conversational analysis principally 'focuses on the interactional and sequential features of talk. It delineates the location and the interrelationship of speakers' utterances within talk by indicating, for example, where those utterances overlap, and it pays close attention to the way in which talk is articulated by indicating, for example, where talk is stressed by a speaker' (1993:309). Thus, there is a high level of detail in transcriptions for use in conversational analysis. However, for the purpose of this present research therapist and client interviews were simply transcribed verbatim. This decision was made for several reasons. The most significant reason for this decision was the research's exploratory nature. As the research was principally concerned with exploring complementary health beliefs it was necessary to place an importance on the lengthy comments made by informants rather than on the interaction which emerged

between the respondents and myself, or the gestures and movements made throughout the course of the interview. Similarly, as the research focused on the exploration of health beliefs, rather than the analysis of conversations it was thought that it would have been futile to include every expression (such as 'yeah') which occurred throughout the interviews (Wooffitt 1993:290). Hence, it was decided that such expressions would not have contributed to the respondents' meanings and comments. In transcribing these lengthy texts verbatim, and omitting non-verbal prompts, I was able to dedicate transcription time to the main body of text provided by informants.

A secondary reason for the verbatim transcription of interviews came about by the selection and subsequent use of an analytical package entitled WINMAX Pro. WINMAX Pro could search and retrieve text segments, by theme, key-word-in-context, or variable (cell group/ therapist or client status). However, in order to perform these searches it was necessary to import complete text segments. When transcription took place, therefore, utterances (such as errs and ums) were excluded. To illustrate the naturalistic flow of participants' thoughts however, pauses were illustrated on transcripts by consecutive dots. Finally, the difficulties in expressing contemporary beliefs were such that it was necessary to allow participants time to comment on the questions posed. As such, pauses which could in conversational analysis be seen as doubts or hesitations as to the inference of their comments, could in exploratory research be regarded as adherents' attempts to articulate their beliefs coherently.

Fielding particularly notes the importance to transcribing one's own interviews when he says:

> ...you have ideas as you transcribe. Transcription is undoubtedly tedious - it can take a day's typing by a competent typist to transcribe a one hour interview. But transcribing makes you very familiar with the data. It helps you to start making connections and identifying themes for analysis. (1993a:147).

Hence, throughout the process of transcription observations and themes were also noted.

In order to apprehend fully the data collected it was thought necessary to use a

qualitative software package to organise the bulk of the research material. Transcription was then carried out with the aim of eventually transferring the data into a specific analytical package. Certain rules were needed throughout the transcription process in order successfully to import the data into the software package (for example relating to font, margin width, paragraph lengths and italic/bold functions). The usefulness of the computer assisted software in social research has previously been emphasised by Fielding and Lee (1991) and Miles and Weitzman (1994). Faced with raw transcription data one can feel overwhelmed by the prospect of organizing, retrieving and eventually focusing on specific research issues. All these issues can be done relatively quickly through the use of a qualitative package. Tesch (1991) emphasises these tasks when she comments:

> It can with enormous speed perform technical tasks that previously had to be done painstakingly by hand. While the difference may appear trivial in terms of scholarship, the gain can be measured not only in savings of time, but in increased accuracy, and the potential for greater thoroughness can actually result in considerable investigative advantages (1991:25).

Fielding and Lee (1991) draw similar conclusions when they note: '...simply by reducing the amount of paper and the extent to which it needs to be shuffled, analytic processes become less unwieldy, more pleasant and less tedious for the analyst' (1991:3). Through the investment of time in learning one's chosen package, one can dedicate greater time into the analytic processes of the research. In using a qualitative package, then, the researcher can, with more efficiency, draw out relevant, new and interesting data. This does not mean that the computer package is able to theorize by itself, for these tasks are still left entirely to the individual researcher. Hence, Tesch says: 'The thinking, judging, deciding, interpreting, etc., are still done by the researcher. The computer does not make conceptual decisions, such as which words or themes are important to focus on, or which analytical step to take next... Thus all the computer does is follow instructions regarding words, phrases or text segments previously designated by the researcher as analysis units' (1991:25-26). Moreover an additional benefit which emerges while using a computer package can be the ability to 'examine comparative contrasts within their case

material more fully' (1991:7).

However, due to the fast moving, continuous development of these packages the decision in choosing a specific package can be problematic. There are several types of qualitative packages which can be used. Briefly these are: text based managers and code-and-retrieval programs which organise data for search and retrieval purposes. These types of packages are designed to '...divide text into segments or chunks, attach codes to the chunks, and find and display all instances of coded chunks (or a combination of coded chunks)' (Miles and Weitzman 1994:312). Examples are WINMAX Pro and ATLAS/ti. Other types of packages also have these code and retrieval capabilities. In addition, however, theory building programs, for example NUDIST, are able to '...develop higher-order classifications and categories; to formulate propositions or assertions, implying a conceptual structure that fits the data; and/or to test such propositions to determine whether they apply' (Miles and Weitzman 1994:312). Finally network builders are able to link data by means of specific relationships. Examples include AQUAD and HyperRESEARCH.

After careful consideration the qualitative package WINMAX Pro (version 1996 Professional) was selected for use in the present research. (My attendance at a WINMAX Pro course also helped to understand the full capabilities of the package). WINMAX Pro can be categorised as a code-and-retrieval program. The particular strengths in using WINMAX Pro were seen in its clear coding and data management functions as well as its ability to link specific data (Miles and Weitzman 1994:316). In addition, as the research was exploratory in form, I aimed to select a package where a degree of experimentation could be achieved on code retrievals and searches. In using WINMAX Pro I was able not only to divide respondents into the categories, 'therapists' and 'clients', but also to categorize individuals according to their relevant cell group. WINMAX Pro, therefore, had the facilities to assist in the comparative analysis of therapies (see Chapter Eight).

Certain steps were essential in order to progress from raw data to grounded theory. The initial step was importing transcripts into WINMAX Pro. This process was relatively straightforward. Two categories of text were created. One category listed all transcripts from therapist interviews while the second list contained all client texts. Pseudonyms

were allocated to each text (transcript) to distinguish the individual respondent. Once each transcript had been imported it was necessary to begin coding each individual text. The coding process in any form of computer assisted analytical package is important. Indeed coding can be seen as one of the primary stages of analysis. Miles and Huberman observe the importance of coding when they say: 'Coding is analysis'(1994:56). Coding therefore, involves 'how you differentiate and combine the data you have retrieved and the reflections you make about this information' (ibid).

Working though an individual transcript, areas of text were highlighted and text passages, whether words, sentences or paragraphs, were categorised. To mark these relevant text segments it was necessary to generate a basic list of codewords through which these text segments could be classified. Several factors contributed to the generation of a codeword list. This list was initially created using themes which had been previously identified throughout the transcription process.[19] As we will see from the following procedures this code list would be amended and redefined throughout the coding process.

The coding of interview responses according to Bryan Wilson's 'Probabilistic Inventory' (1990:279) additionally aided the coding and organisation of transcription data. Many of the questions in the interview guide mirrored the themes from Wilson's 'Probabilistic Inventory' (1990:279). Using WINMAX Pro, therefore, it was possible to classify transcript material according to the themes of the data content. In other words, interview data tended to be coded in relation to the interview guide. Naturally, new codes emerged when topics arose organically from the interview text.[20] Interview material was

---

[19]Lofland and Lofland (1995) note the importance of note-taking while transcribing. Transcription then 'stimulates *analysis* (or at least this is the proper frame of mind to adopt while doing it). When a distinction, a concept, or an idea occurs to you (a **code**) , then write it into the transcription as an analytic note. For out of these bits and pieces of analysis - codes and memos- you will build the larger analysis that will become your research report' (1995:88).

[20]An additional aspect which made an impact on the coding process was my own participation in the interview process. As mentioned in Section 3.5 the researcher's contribution to the interview discourse can greatly alter the type of interview situation, and indeed the level of disclosure which is made between the researcher and informant. The decision to play a minimal role in the interview can also be seen to impact on how the conversations were transcribed, coded and analysed. The inclusion of all verbal prompts, made by myself, while coding was principally to contextualize the respondent's comments and where necessary to

therefore coded thematically.

One of the difficulties with coding is that coding rules may change as the researcher becomes more familiar with the text and themes (Kuckartz 1996:18). Thus one must remember, throughout the coding process, to allocate codes to text passages in a coherent and consistent manner. A secondary aspect which should be noted while coding text refers to coding specific words. If key words are to be coded it is advisable to code these words in the context of its surrounding text. This should be standard as words could be used in a variety of contexts or apply to a variety of meanings. Weber cautions us when coding key words when he states, 'one word may be used in a variety of contexts or may have more than one meaning, ... word frequencies may suggest far greater uniformity in usage than actually exists'. Indeed, Weber highlights the necessity to question the 'validity of inferences from word-frequency data' (1990:51-52). In contextualizing key words, therefore, we are able to retain the various senses and idioms stated in the text.

The list of codes was, therefore, generated initially by the prominent themes which emerged throughout the transcription process. Codes were refined though the content of individual transcripts, and the main themes which emerged from Bryan Wilson's 'Probabilistic Inventory' (1990:279). Hence, segments of text were classified into topic areas and key words. The marking of relevant text segments enabled the generation of a comprehensive list of codes. For example, beliefs in treatment, growth and transformation. Thus a coding tree evolved classifying all transcript material into text segments according to their theme. The main codes which emerged from all interview data can be seen as Appendix 3.8. I will refer to this as a theme tree.

The first coding process was, therefore, through the initial interpretation of each text. Codes were attached to each segment of text which had a significant focus for the research. By means of this process a system of thematic categories developed. Such single transcript analysis encouraged the generation of memos and observations which could be attached to text segments. It was by means of this principal stage that the aims of the analytic process emerged, that is, the discovery of grounded theory (Glaser and

---

clarify their remarks.

Strauss 1967:1) through exploring, interpreting and comparative analysis of complementary health's beliefs and practices. Glaser and Strauss coined the term to refer to the 'discovery of theory from data' (1967:1). Hence 'Generating a theory from data means that most hypotheses and concepts not only come from data, but are systematically worked out in relation to the data during the course of the research. *Generating a theory involves a process of research*' (1967:6). The generation of theory must originate from the results gained through the interpretative processes of raw data. The first stage of coding data was therefore allocated a substantial amount of time.

Once this initial coding stage was complete a list of fifty three coded segments had developed. For example, all text segments referring to therapy sessions were coded under the principle code of 'Client and Therapist Relationships', and then located in the subcode entitled 'Health Sessions' (See Appendix 3.8 for the List of Codes). Two forms of indicators were available while viewing data. These were values and frequencies. Values (or weights) were given to each coded segment of text, while coding, to indicate its relevance and importance in the coding category. Each text segment was therefore allocated a value (or weight) rated from 1 through to 100. Values were assigned to individual text segments which 'are most characteristical or typical for the argumentation or theroretical concept' (Kuckartz 1996:111). Passages with high value therefore act 'like sign posts, like pointers' to particularly interesting or relevant ethnographic data (ibid). Frequency and line numbers also indicated the number of segments and the overall length of lines attached to a particular codeword. When glancing at the theme tree, then, I was able to view the major themes which had emerged throughout the coding process. For example concepts relating to 'Beliefs in Treatment' had one hundred segments of text and 1796 lines of data attached to the codeword. This initial organizational process was critical for the subsequent stages of the analysis. Indeed, each of the following chapters will begin by displaying a summary table of the relevant WINMAX Pro coded segments which will be analysed in the chapter.

The secondary stage of coding came about by the examination of all text segments belonging to one code. Values assigned to coded segments were indicators of importance. However, in order to examine the data thoroughly it was necessary to study all coded segments, irrespective of the value which it had been assigned. Throughout this process

the primary themes of the research emerged. I found, however, that aspects which were originally thought to be critical to the exploration of health and healing beliefs were seen to be less important than other issues which had not been anticipated. For example, notions relating to the belief in holism were originally thought to be important for health participants; on closer inspection notions relating to healing experiences and spirituality were seen to be of greater significance to health advocates.

The study of coded segments enabled a focused perspective to viewing the research material. By viewing coded segments of text by theme it became possible to analyse recurring beliefs and relationships between therapist and client beliefs, and also beliefs according to cell group. By using WINMAX Pro I was able to retrieve text segments in a number of ways. Coded segments could be retrieved by theme (general codeword retrieval), by variable (therapist or client/ cell group), or simply by key word (an exact search or a string match). Thus reviews of relationships between themes and cell groups could occur. The formation of concepts was then assisted by identifying and extracting material from the surrounding data. Tesch (1991) provides a broad outline of data retrieval search functions available in code-and-retrieval programmes. She comments that: 'In standard structured DBM [database managers], the user would ask to search within one field across all records. As a result of the search, the program shows the records in which the specified field contains the search string' (1991:31). Such text searches can also be achieved by highlighting the particular text surrounding the coded segment. Hence, each coded segment can be displayed in the context of the surrounding few sentences.

Throughout this entire process one is constantly interpreting field material. Frequently data links occur whereupon further exploration of texts becomes necessary to exhaust the specific enquiry. For example, while exploring particular therapists' concepts of energy, the term God often arose. By searching the coded segments entitled 'energy' for the keyword 'God', I discovered that a high proportion of therapists related their belief in energy to a concept of God. It was by means of this secondary analysis that a substantial amount of focusing and data reduction took place. Miles and Weitzman recognise the benefits of using computer programs to link data when they observe: 'Programs with strong linking functions...let you "browse" or "navigate" easily through

the database' (1994:312).

Concepts arising from linking such observations and text segments contributed towards my desired aim of creating grounded theory. In comparing therapists' and clients' beliefs, examining differences between cell groups, and viewing these aspects in relation to the themes raised by Wilson's 'Probabilistic Inventory' (1990:279), I aimed to draw out significant evidence to test the proposition that there are significant aspects within complementary health beliefs which enable it to resemble characteristics of a conventional religious belief. The concept which arose throughout this secondary process then aimed to 'mediate between theory and data' (Bulmer 1979:652). According to Bulmer then: 'Concepts in themselves are not theories. They are categories for the organization of ideas and observations. In order to form an explanatory theory, concepts must be interrelated' (1979:652). However, 'concepts do act as a means of storing observations of phenomena which may at a future time be used in a theory (1979:652).

The generation of theory is not, then, a static enterprise. As concepts emerge and evolve so does the potential to generate theory. Hence, the continuous evolution and relatively independent nature of creating theory can be seen to be two benefits to grounded theory. Another advantage of grounded theory is highlighted by Turner (1981) when he observes: 'The theories developed are likely to be complex rather than oversimplified ways of accounting for a complex world, and this quality is likely to enhance their appeal and utility' (1981:226-227).

It is important to note that the stages in performing grounded theory have been implemented throughout the current research. Stages of developing categories, definitions, identifying and linking data, comparative analysis and concept building have all been utilized in the present study.

Finally, I would briefly like to draw attention to the problems encountered in interpreting beliefs held by complementary health participants. Such interpretations have subsequent repercussions when theory building. The principal concern, which arises in almost all social research, concerning the exploration of beliefs and the apprehension of individual's world-views, is whether to acknowledge participants' own views of their beliefs, or whether to re-interpret their beliefs. The social researcher therefore treads a fine line in handling any research data. Questions relating to privileged access,

interpretation of beliefs by the researcher, and informant's own views of their actions all contribute to the problematic nature of social research. Wallis and Bruce discuss this concern when they note: '...since actors have privileged access to their intentions and beliefs, the presumption must be that their characterizations of their actions and their accounts of why they are performing them are the correct ones' (1983:99).

In the context of the present research a dilemma occurred as to whether to interpret participants' beliefs and actions as being predominantly characteristic of conventional religious beliefs, due to the evidence of the data collected, or alternatively to accept actors' own accounts of their beliefs as being more 'spiritual' in form. Although this dilemma, to some extent, rests on the definitional distinctions, as outlined in Chapter Two, there are also methodological considerations to take into account. To begin, one must initially suppose that participants' motives and beliefs 'prevail until evidence is advanced either to show that they are lying, or to show an alternative set of characterizations and reasons unknown to the actor, accompanied by an explanation - supported by further evidence - of why they think they are doing something else, and why they fail to see the real reasons for their actions and beliefs' (1983:99-100). Health participants principally account for their actions by believing that their actions and beliefs can bring about personal change (see Chapter Seven). While researching further into participants' motives for their beliefs, what emerged was a desire to seek meaning through the re-interpretation of their own body, transcendental beliefs and lifestyle. Although such motives are not distinctly obvious to the individual health participant, the accumulation of research material to support such notions must indicate that there should be a move away from a purely subjective notion of participants' motives to a balance between participants' beliefs of their actions and the researchers' own explanations for their actions. Wallis and Bruce (1983) remark on the distinction between accounts when they comment:

> ... that there is an infinitely variable relationship between the reasons and beliefs which produced an action, and the reports of such reasons and beliefs offered by the actors concerned... The discrepancy between alleged beliefs and motives and the reality of the action provides ample grounds for considering the possibility

that the actor's account should be set aside in favour of an alternative advanced by the sociologist which better accords with the evidence (1983:102).

Heron (1986), however, aims to caution researchers from being too complacent when studying research subjects' motives. Heron draws researchers' attention to the principal role that is played by research participants. As a moral critique Heron argues that the recognition of participants' self-perception, of their motives and beliefs, in analysing social settings, should be paramount. Heron also emphasises to researchers that individuals are 'autonomous beings [who] have a moral right to participate in decisions which claim to generate knowledge about them, and the researchers have a correlative duty to include their subjects in the decision-making which generates, manages and draws conclusions from the research' (1986:19). Heron privileges the accounts of research adherents and advocates that the subjective experiences of research participants must be recognised in order to balance the researcher's own, inevitable, subjective opinions regarding their research issues.

The problematic nature of interpreting field material, in the context in which it was disclosed, prevails in the current research. This advocates a balance between evidence of relationships within the data which emerged in analysis and the opinions of the research participants. The current research, therefore, recognises the importance of health adherents' claims, as advocated by Heron (1986), but privileges the stance put forward by Wallis and Bruce (1983). Where there is overwhelming evidence to support claims of implicit religiosity then my decision to recognise, but ultimately to set aside participants' views will be made in order to comply with the research data.[21] Likewise, a similar stance will be taken while viewing adherents' claims of spirituality, as opposed to religiosity. Where the research findings comply with adherents' accounts a similar approach will be adopted. The accounts of adherents will prevail due to the support of the research findings (1983:100). Moreover, I advocate the stance that as both research participants' and my researcher accounts are fallible then caution must be applied in

---

[21]In order to comply with the data collected, disconfirming data must also be recognized. Ethically, therefore, one must give an accurate representation of data while recognizing that these findings may have implications on the generation of theory.

accounting for social action. The repercussions for such caution are consequently seen in the conscientious attempts to balance health adherents' views with the findings of my own data analysis.

The foundations and methodology employed in this present research have been discussed throughout this current chapter. Issues of research development, pilot studies, question design, issues of access, interviewing, participant observation and finally the analytic process all contribute to the building of a sociological theory of complementary health beliefs. My satisfaction as to the chosen methodology and data collection will, hopefully, be reflected in the following chapters which aim to draw together the theoretical and exploratory threads of the research.

CHAPTER FOUR

HEALING EXPERIENCES AND THERAPIST/ CLIENT RELATIONSHIPS

The WINMAX Pro analysis suggested fifty three themes, which emerged while talking to therapists and clients. Many of these themes were categorised under six principal areas. These were beliefs in treatments, beliefs in healing energy, body and lifestyle perspectives, therapist/client relationships, growth and transformation, and finally healing experiences. Data from each of these six areas were analysed using WINMAX Pro. The stages of WINMAX Pro analysis have been previously described while reviewing the research process. However, although many of these categories had arisen from pilot interviews a few unforseen themes emerged. The notions which ground belief in treatments, and the importance of therapist/client relationships emerged as two significant areas of analysis. Indeed, all practitioners and clients discussed their healing experiences and the relationship which is created between the therapist and client. The prominence of healing experiences and therapist/client relationship can be identified on the theme tree (see Appendix 3.8). Due to the considerable importance of these factors an extract of the WINMAX Pro theme tree is displayed below.

Table 4.1: Coded Segments Relating to Healing Experiences and Therapist/ Client Relationships.

Codeword	Number of segments attached to codeword	Line numbers attached to codeword
Beliefs in Treatment	100	1796
Client & Therapist Relationships - Heath Sessions - Therapist Healing Skills	73 97 69	991 1479 701
Healing Experiences - Absent Healing - Laylines, Homes - Psychic Skills - Regression, Past Lives - Visions, Dreams	31 11 7 4 23 14	493 243 223 41 526 329

Analysis of these text segments, (coded text segments, key-word-in-context and relationships between codes) revealed that common issues arose throughout all interviews. Surprisingly these issues came to form the foundations for the remaining

beliefs and practices found in complementary health. As such, these issues, healing experiences and therapist and client relationships will be discussed in finer detail in this chapter. Each of the remaining themes will be addressed throughout the following chapters.

Complementary health and healing beliefs are grounded, initially, in hope that one is able to find healing, to make sense of one's illness, and/or to initiate a sense of change throughout one's life. These beliefs often originate through healing experiences which, in turn, can hint at notions of temporary conversion. This chapter aims to explore health advocates' beliefs in complementary health and healing therapies, drawing particular attention to concepts of hope, health experiences and conversion. The second focus of this chapter will examine the relationship between the therapist and client. This relationship can be seen to play an essential contributory part in the beliefs formed by clients. Notions of trust/intimacy, transference of ideas and the therapists' role of 'echoing' (acting as witness to) clients' problems, all provide additional means through which health advocates come to believe, and have faith in complementary health.

4.1 Beliefs in Treatment

4.1.1 Hope

Hope, health experiences and trust are all of critical importance in complementary health beliefs. Hope arises through clients' expectations of change, while trust becomes an important issue as health participants need to believe that healing sessions 'work', that therapies will 'help', and that healing energies 'exist', in order to continue participating in health sessions. Consequently healing experiences are particularly significant for adherents in the creation of their health beliefs. Health sessions can be identified as a modern milieu through which beliefs are formed. Health sessions can therefore be argued to contribute to a sense of conversion for both therapists and clients alike.

Budd and Sharma (1994) draw attention to hope, while exploring alternative therapies when they comment:

Studies of the resort to alternative therapies suggest that the majority of users do not reject orthodox medicine and 'believe in' an alternative set of medical ideas; rather they find that the treatment they receive for a particular complaint does not seem to be satisfactory and they turn to an alternative therapy in the hope of finding a cure or a better way of managing it. Once there, they may find that the chosen therapy has a rather different view on the nature and genesis of illness... Patients may embrace this new view enthusiastically and refer themselves to alternative therapy for other complaints (1994:9).

Similarly in the present research, clients were found to attend health sessions in the hope of learning new health perspectives. Indeed, hope for adherents can be seen to emerge regardless of whether the treatment has had a substantial impact on the ailments of the client. The following interview extract particularly highlights the emergence of hope, as the client is still willing to participate in health sessions, even though the treatment had not alleviated her own skin and phlegm condition. Although Amanda illustrates her faith in both the treatment and practitioner, and her practitioner's ability to install a sense of optimism, she is still able to recognise the limitations to the treatment. Amanda remarks that her therapist:

> ... obviously has this faith... I guess that has come from other clients that it is working on them, and that what you are doing is having an effect. I suppose if I really felt that she did not know what she was doing, or had faith in it, then I probably wouldn't still go and see her...I sometimes wonder whether Lilly knows that she has not had any direct impact on my problem... Even if it's not working out I will keep trying because it works with other people and this person is not a quack... It is nice to know that they have other clients that are getting better and getting the benefits out of it (Reiki Client 1997: 249-282 & 352-397).

A Colour Healer emphasises the notion of hope while discussing a particular client's inability to believe in treatments. The practitioner remarks 'she didn't particularly believe in my treatment or what I was offering but she wanted so much for

something to help. She was keeping the door open. But that makes sense to me. It was the frustration of her illness. She wanted to give it a go' (Patricia 1995:701-706). Indeed, as we can see from this interview extract hope for clients can emerge from their desire to alleviate illness symptoms.

Kelsey, while exploring the threats of a 'meaningless or hostile world' (1979:221), remarks on the role of faith in illness situations. He comments: 'Obviously, when this kind of meaninglessness and hopelessness is an element of disease, the symptoms can be ameliorated, but confidence in some helping, redeeming factor is necessary before health is restored. This is the function of faith' (ibid).

Not surprisingly, then, the therapist's beliefs are important for their client, for if the therapist does not believe in their skills or their therapy how do they expect their client to assimilate their guidance and to facilitate them in their health progression? Faith in the treatment seems to be essential for the therapist's reputation and an important contributory factor for clients attending treatments.

Kelsey continues his exploration of faith and health when he says: *'It may be necessary to provide the "faithless" one with a world view that offers some hope for meaning.* If one has worked at developing his own faith attitude, he will be better able to help another through meaninglessness to faith and health' (1979:222). The hopelessness which can be felt by individuals suffering from ill health becomes apparent through the adherent's sense of faith. Both therapist and client desire a beneficial outcome, through the use of therapies, and hence faith is a prerequisite. Budd and Sharma reflect on the role of complementary health when they remark:

> ...most people who have consulted a complementary practitioner have already consulted an orthodox doctor for the condition that troubles them. If a patient has run through the gamut of orthodox treatments and come to complementary medicine as a last resort, it will be a very tough-minded practitioner who will find it easy to deny some little hope, and why should a well-trained healer not have faith in his or her own discipline to do some good in such cases, even if a complete cure cannot be found? (1994:95).

However, although clients believe in the treatments they take, they are still able to view treatments objectively and to recognise the limitations of complementary health and healing.[1] Although the previous interviewee, Amanda, felt that the treatment had not worked specifically on her illness problem, it had helped her in other ways, as she had learned relaxation techniques and had made significant dietary changes. These other factors directly contribute towards the client's concept of hope inasmuch as these peripheral factors had provided other, necessary, changes in her personal development. She therefore continued to attend therapy sessions. A requirement, then, to participation in complementary health is to be open to the possibility of hope and development. Hence, as a Colour Healing client comments: '...I think if you have a profound belief, then something will work, you're eighty five percent there... you do have to have an idea that there is the potential for something to work' (James 1997:425-427). Nonetheless, clients still had realistic perceptions as to the limitations of their health sessions. Clients were aware of the possibility of failure, of the treatment, but were optimistic that the sessions would offer an alternative perspective to their body and lifestyle. This, perhaps, becomes one of the major attractions of complementary health.

Faith, according to Kelsey, is 'the basic conviction that the world around one is kindly intended towards one' (1979:216-7). He goes on to say that: 'Faith is the attitude that one's total environment is supportive and caring, that not only those close to one, but even one's own body, the community and the physical world around one can be counted on' (1979:217). Faith in treatments and therapist's skills are therefore needed in order for advocates to feel there is hope for alleviating illness. A sense of hope

---

[1]It is important to note that many individuals attend complementary health sessions only after they have sought help through conventional medicine. These participants had often passed through conventional medicine feeling rejected and offered little hope, time or resources to assist them further. Complementary health does not aim to dominate the medical care system. Complementary health simply aims to supplement its resources by offering aspects (for example greater time, intimacy and touch), which are, unfortunately, limited in conventional health care. However, many clients were still open to both health care systems. Therapists and clients, therefore, saw complementary health as an avenue of hope, which could possibly alleviate illness symptoms. Such practices were also seen to provide hope even in what seemed to be hopeless conditions. What emerges is a health care system based on an optimistic, progressive model of human development, regardless of one's health condition. See Sharma (1994:100) on reasons for complementary health participation.

consequently grounds the possibility of successful healing and encourages optimism. A Reiki client summarises her feelings when she says: 'You probably wouldn't be there anyway if you didn't have some sort of hope of something happening' (Amanda 1997:271-273). Another client sought healing in the hope of a substantial alteration in his physical health and lifestyle. Suffering from clinical depression he says: 'I suppose that if I wasn't so ill I would never had gone to healing in the first place, but it does make, it has for me made, a tremendous difference' (NFSH Client Lee 1997:300-306).[2] He continues by observing the changes complementary health has made to his belief and health. He says: 'I've gone from being very sceptical to quite believing. I've always been sceptical for anything spiritual. I still don't see that term being applied to me, but there's something happening, no doubt about it' (Lee 1997:318-322).

Although there are several core underlying issues which aim to bond health participants[3] there seems to be a great reliance on experiential beliefs (also see Appendix 4.1). Beliefs are created originally through a sense of hope and desire for meaning and order to life events.[4] The most direct method through which these meanings are conveyed, and indeed, believed in, is by means of experiential beliefs, for example energy experiences, visions, dreams and even out-of-body experiences. Beliefs which are created, and sustained, by means of health experiences can take several forms. Firstly, health experiences may portray a specific message to the individual, to communicate a change, and/or a recognition of what is needed within one's life. The following interview extract illustrates the message conveyed to a mother regarding her child's sense of security. The message conveyed relates to how the child was experiencing a sense of insecurity due to his mother's imminent divorce. The mother describes the consequences of the health session. She comments:

> ...he was getting really low, because of the situation with the divorce, and

---

[2]National Federation of Spiritual Healers.

[3]Issues such as beliefs in healing energy (Chapter Five), body perspectives (Chapter Six), issues of change (Chapter Seven).

[4]See Chapter Seven for issues relating to self-identity and ontological security.

everything ...she just sat him on her lap and just put her hands on, and within five minutes he was running around the garden. If I hadn't seen it myself I would never have believed it. He was totally and utterly different (Natural Healing Client Louise 1997:57-65).

Secondly, health experiences were thought to have dramatic consequences on the individuals' present physical condition. Adherents therefore, believed in physical reformation. The following quotes illustrate clients' beliefs of physical change through healing sensations. These adherents all describe their beliefs by reciting their health experiences. They say:

It was just like a river of energy coming through her hands. That is how I can explain it. A warmth flowing into whatever part of my body that she touched. It was just like a river of energy. The heat emerged from where her hands were. The eyes, the back of the head. All the way down the back to the knees and the feet and then the heart centre... It was just an amazing experience for me, and it calmed me down, and gave me a tremendous sense of peace and calm, and I felt really uplifted at the same time. I have had quite a lot of Reiki healing and in fact after that experience I wanted to learn myself .... I just felt elated when I came out because the backache had been with me for quite some time, it was just a dull, muscular, ache... it was almost like a template was being lifted off, and I just felt elated and just totally calm and full of joy... I came out sort of wanting to skip and dance. It was quite a profound experience (NFSH/Reiki Client Julie 1997:31-48 & 70-78).

I started to feel it, quite frankly, in my hands, and when I was doing Yoga. I guess you would call them communicative experiences but they were not like, way out there [indicating sky]. I wanted to know what was happening to me and I was not well at the time. So it was not a completely comfortable experience (Colour Healing/Yoga Client Erica 1996:243-250).

I came out of that treatment and I was just completely stunned. I thought just 'wow' that it was just so incredible what he could do, because it was as though he brought my body back to life. I had gone in feeling 'ahh' and I came out feeling as though I could move, and as though I had been freed, and that things were actually working again (NFSH Client Joyce 1997:140-153).

These healing experiences may produce a curiosity for clients inasmuch as, although no obvious message was conveyed, nor physical changes experienced, the actual sensation of visions or levitations, not previously experienced by participants, may, in fact, stir a greater interest in the practices of complementary health. These new sensations contribute towards health advocates' beliefs as these experiences were often thought to have spiritual interpretations. The interpretation of such new sensations can initiate a process of self-reflection. Examples of such alternative experiences provoking beliefs can be seen from the following interview extracts.

I started to get these violet lights and I couldn't understand it. It was as if... two lights came from behind, merged above me and then went away. So the next time I went to healing she said 'oh, it's your head chakra'. She said that that was very spiritual. And I said, 'oh, come on, I'm not a spiritual kind of person', but she said, 'you are, but you might not recognise it'. Now ever since then almost every time I've been to healing, sometimes I get them as visualisations quite well but I can never hang on to it but, I get these lights all the time. These really vivid violet lights. They come out and then just go away. They might only last ten seconds they might last nearly a minute continually. It's almost like a laser beam. And... I get that an awful lot now. So there's something in it. I'm starting to make contact with something or something, somewhere. ...it's a wonderful feeling. That's the greatest experience. I think that really convinced me that there was something there (NFSH Client Lee 1997:465-470 & 106-127).

I just had this white light just shooting through me. All the way through starting from the top of my head... it was a little white light, a 'whoosh' kind of feeling.

It didn't hurt at all. It was just like a power surge as it were. It was a bit like being plugged into the mains but a lot less painful. It was a 'whoosh' thing with a noise attached. A kind of clang. All the way through, and my body kind of went 'ahhhh'. So I'm convinced that they [healing energies] exist. (Bowen Client Susan 1995:149-165).

Finally, a NFSH client remarks, 'a few years ago I wouldn't have believed it. I thought that these people were just kidding themselves but now I have felt it actually go through me I know that there is something in it' (Joyce 1997:311-321).

4.1.2 Spiritual Experiences

Hay and Morisy particularly draw attention to interpretations of spiritual/ religious experiences, and the consequences of these experiences on people's lives, when they remark: 'The description and explanation of an experience incorporates and gave a scaffold for beliefs' (1985:215). Indeed, Hay and Morisy identify a range of seven interpretations of experience. These are: 'Presence of or help from God', 'Assistance via prayer', 'Intervention or control by a presence not identified as God', 'Presence of, or help from, the deceased', 'Premonitions', 'Meaningful patterning of events', and finally 'Miscellaneous' (1985:216-220). These self-explanatory categories were created to assist in the examination of spiritual/ religious experiences and to explore the impact of these experiences on people's daily lives. In relation to the present research, 'Assistance via prayer' (ibid:217), and 'Intervention or control by a presence not identified as God' (ibid:218), were seen as the most common forms of experience. Hay and Morisy particularly draw attention to the contexts in which these sensations were expressed when they say:

The contexts in which the religious experience most important to an individual occur, are characterized strongly by crises. These are often of an extreme nature, such as the fear of impending death, or serious injury or the loss of livelihood. It is precisely at these points that everyday 'secular' knowledge ceases to have

coercive force and other modes of interpretations, with perhaps more effective ways of coping with chaotic loss of meaning, prevail (1985:224).

What becomes additionally apparent, however, through both Hay and Morisy and the present research, is the meanings which are attributed to these experiences. Hay and Morisy, while discussing, specifically, 'Assistance via prayer' and 'Presence of or help from God' (1985:216 & 217) note that these experiences: 'are most frequently claimed to have significantly altered the person's outlook on life, and so could also be construed as '"conversion" experiences' (1985:221). Likewise, Zinnbauer et al. also highlight one's notions of spirituality in relation to mystical experiences when they examine 'self-definitions' (1997:553) of religiousness and spirituality. They conclude that although religious and spiritual experiences share common themes ('connection or relationship with a higher power' (1997:557)), self-defined religiousness was commonly referred to together with notions of organisation or institutionalised beliefs. Hence, there arises a distinction between what we can identify as self-defined pantheistic concepts of spiritual/divine experiences, as illustrated throughout the current research, and those experiences which are self-defined as religious experiences. Experiences and interpretations of health sensations are therefore seen as unique to the individual. The messages conveyed, physical reformation and interest which consequently occur, from these experiences, are seen as relative to the circumstances of the individual. Indeed, therapists and clients alike interpret experiences according to the unique situation of the individual. Moreover, by analysing the accounts of adherents' experiences and the body of data collected, we can infer that health experiences are predominantly spiritual.

Beliefs deriving from experience, therefore, can be seen to involve a variety of routes through which participants can come to believe in the treatments and their therapist. Although experiential beliefs can be broadly categorised into: messages, physical sensations and curiosity, it does not necessarily follow that these categories are exclusive. Indeed, health advocates can find themselves influenced by any combination of these routes. For example Joyce (a NFSH client) was equally influenced by physical changes and curiosity. All these routes of experiential beliefs, nonetheless, involve self-reflection. Healing experiences automatically involve self-reflection inasmuch as

participants have to interpret these experiences and assess their meaning and/or influence in relation to their health and general well-being. By reflecting on their experience, participants are able to identify their needs at one moment in time and to identify their future expectations. In addition, self-reflection is frequently a product of the health session for the therapist/client relationship is based on an intimate and self-reflective dialogue aimed at encouraging self-understanding. Indeed self-understanding can also enable adherents to reflect on their sense of spirituality.[5]

The majority of clients, (n=11), and therapists, (n=15), mentioned spirituality while discussing healing experiences. The methodology employed while interviewing (sensitive questioning style and probing) can be argued to have contributed to the respondents' willingness to disclose their health experiences. It was through such sensitive questioning that participants disclosed the meanings of their experiences. Health experiences were predominantly viewed as opportunities to gain personal insights. Indeed, these insights often included external and non-physical factors which were influential to the individual, for example, the repercussions of divorce. Healing experiences were therefore seen to provide spiritual understanding by means of additional reflection of oneself and one's life circumstances. The relative uniqueness of health experiences, and the sense of personalisation which accompanies these experiences, were seen to contribute to one's notion of spirituality. The majority of health participants were then found automatically to link health experiences to spiritual experiences. It can be argued, therefore, that healing sessions indirectly offer routes to spirituality.

Stages can be identified while analysing healing experiences. The initial stage is, of course, an experience of a new sensation. This may include visions, feelings of levitation, out-of-body experiences or just deep relaxation. From these experiences there will be a period of reflection and interpretation with the therapist, in order to establish whether there is an underlying meaning to their experience. As a consequence to these experiences health participants may make adaptations to their lifestyle and/or world-view. The following interview extract illustrates a NFSH client's health experience. The interpretation offered, through reflection with the therapist, expresses the client's need

---

[5]See Chapter Two for a comprehensive discussion of religion and spirituality.

for more personal space and greater thoughtfulness towards herself, in her daily life. The underlying meaning of her experience was the feeling of being bound to her daily routine and duties. She comments:

> This last session was quite an experience for me ... I came completely out of my body and experienced like, a past life. I found myself in a sarcophagus which I felt was in Egypt, and my whole body was wrapped in a cloth and then cord tied around it, and it was so real. I mean, for me it was just happening there, and I was lying there in the sarcophagus, and then someone took the lid off and it was almost as if that was a rebirth situation because then I found myself re-birthing and lifting back and leaving that restrictive body, because it was wrapped up tight, and raising up again.... So that was a very very profound experience (Julie 1997:98-171).

These experiences can be argued to have a significant impact on the individual inasmuch as they play a direct role in the building of one's identity, at one moment in time, and contribute to one's futurist plans of growth and change.

Healing experiences can be recognised to have common features. The most frequently encountered health experiences were those which illustrated overt signs of divine or transcendental force. The interpretations which were placed on these experiences all offered some form of meaning, guidance or the portrayal of messages, which, if acted upon, could potentially change one's self-perception. Therapists, and clients, use healing experiences as potential indicators of change, guidance, and even hope. One's individual and, hence, unique experiences become an integral element in creating and sustaining one's beliefs in complementary health. These experiences, however, are temporary and are constantly changing with time and with one's personal development.

4.1.3 Conversion

Hay and Morisy (1985), while explaining the consequences of meaningful

experiences, draw attention to those experiences which have significantly changed one's perceptions. They hint at meaningful experiences as forms of conversion. Within complementary health these temporary health experiences can be argued to represent two principal forms of conversion. These are experiential conversion and passive conversion. These forms of temporary conversion can additionally impact on self-identity. Kilbourne and Richardson particularly identify three factors which are needed in order for an event to be considered a conversion experience. Principally the individual must claim: 'some kind of *special or unique experience* (e.g., a vision of God, meditational tranquillity)', second: 'some kind of *special self effects* that are related to those special experiences (e.g., a new sense of self, new meaning, or a new world view)', and finally: '*a social audience reaction ...that confirms the individual's claim of special experiences and self effects*...'to validate the convert's conversion claims (1988:16).These three 'social psychological events', are specifically represented within complementary health through means of health experiences. Health experiences can, therefore, illustrate a feeling of direct contact with the divine and offer alternative meanings, world-views, body perspectives and even new lifestyle choices, which are witnessed by the practitioner.

4.1.3a Experiential Conversion

While studying health beliefs two principal methods of conversion emerge. The first form of conversion is experiential. Experiential conversion is grounded on experiences of healing, and is often most frequently, but not exclusively, encountered by clients. This type of conversion is grounded in clients' personal experiences within complementary health. Clients are therefore told: 'Don't believe anything until you've experienced it yourself' (Colour Healing Therapist Patricia 1995:153-196). Experiential conversion can be characterised by several factors. These are: beliefs by experience, experiences which provoke reassessment, and the construction of own meanings, which are relative to oneself. This type of conversion can also emerge through a combination of the client's own healing experiences and their subsequent gradual interest in health and healing. The following interview extract illustrates how a client's health experience had subsequently altered his beliefs. The quote originates from the client's discussion

of his group workshop, and his beliefs in his ability to make spiritual contact. He says:

> A lot of the time you can't see it. You can't visualise it, a lot of people can; some of the people I've been with have had the most amazing visualisations of where they've been, and what they've seen, and what's been said to them. It's been quite incredible. I haven't got to that stage yet but I'm getting there, there is something there... I can now believe .. I believe these things can happen as I've experienced it, only to a small degree compared to other people, but it's enough to make me want more. If you understand what I mean. So there's something in it. I'm starting to make contact with something, somewhere (NFSH Client Lee 1997:83-127).

Experiential conversion also emerges while talking to therapists about their own healing experiences. The following extract shows how a therapist is influenced by her own self-healing. She begins by discussing her symptoms. She says:

> I do think that apart from the symptoms being really uncomfortable and not very nice, heavy periods and whatever, sore breasts before your period, you know all the usual hormonal type things, it make me worry about my cyst. About it getting bigger and bigger, what is going to happen. Am I going to have children? And all these things. Whereas if my symptoms are more under control each month then, as well as feeling much better, and holistically feeling better, I also feel more hopeful for the cyst, that it is not actually getting out of control, big or pop or all these terrible fears that I have...There is something hopeful about the fact that it [the treatment] deals with the symptoms. It's like evidence, because however much you believe, or for myself however much I believe, I do need to have evidence. I feel that I do need to see something happening that is more immediate (Reiki Therapist Diane 1997:591-699).

The quote additionally highlights the role that treatments play in reducing fear caused by illness conditions. The belief that treatments are able to control symptoms

enable participants, whether therapists or clients, to make decisions (for example, whether to have a conventional medical operation or to reduce their drug intake); to feel in greater control of their own body (through their own decision making); and finally to reduce fear. A NFSH client notes her feelings of greater control over her life by remarking: 'I am positive that they have brainwashed me' (Felicity 1997:514-515).

A Reiki client also highlights issues of conversion while discussing the discovery of her psychic skills. Kathryn observes the change in her decision process once she was able to acknowledge her inner voice. She comments:

> A couple of years ago when I started becoming aware of things, aware of my intuition, aware of voices, not other people's voices, but aware that my higher self is actually talking to me as opposed to talking to myself. I think when we refer to talking to yourself we're actually talking to our higher self, because it does answer if you listen. And sometimes it can just say things out of the blue. And if you listen to it, it can just guide you in the right direction (1997:346-359).

Clients were frequently found to be experiential converts as they had previously sought external sources of meaning (see Chapter Seven, Section One on issues of seekership), while others were accidental recruits inasmuch as once involved in complementary health, participants became more interested in their own personal development. There is a noticeable differentiation, however, between notions of conversion, and concepts of seekership. Kilbourne and Richardson argue that while conversion was traditionally seen as passive (something that is done to the individual), modern forms of conversion are seen as active, 'self-directed behaviour' (1988:1). Initially health advocates had actively sought treatments, the consequences of which often led to new sensations and new experiences. Thus, beliefs in treatments were formed and sustained, by means of these experiences. In turn, these experiences can be claimed to form a type of conversion. What has emerged from the current research, therefore, is that experiential conversion is reliant on the initial act of seekership. This notion had been previously hinted at by Kilbourne and Richardson in their study of conversion techniques when they comment that 'the seeker is an active agent' (1988:2).

However, Sutcliffe separates the notions of conversion and seekership by highlighting the diversity of choices which are available to us today. That is, seekership can be found in the domain of both the religious and secular while conversion is structured on traditional religions. He comments that:

> Seekers are popular *virtuosi* able and willing to select, synthesise and exchange amongst an increasing diversity of religious and secular options and perspectives. Seekers can be distinguished from traditional roles of religious engagement such as 'regulars', 'converts', and the 'lapsed', as well as from other practitioners of popular or folk religiosity, by their close affiliation to alternative religious models and patterns (1997:105).

Hence, Sutcliffe distinguishes between the rigid, traditional recruitment of converts and the modern fluid perspective of seekership. Conversion and seekership share common ground particularly within complementary health as both concepts are concerned with providing meaning and encapsulate beliefs of personal transformation. The following Reiki client uses an example of a sceptical friend to illustrate how direct experience can impact on beliefs and concepts of personal change. She comments:

> I was actually talking to somebody who knows Suzanne and he has had Reiki done to him, he's a sportsman, he plays cricket and is a total non-believer. I mean total 'ahh what are you talking about'? And he had a bad knee and Suzanne said 'come here', and he actually watched her do Reiki on his knee and he said he definitely felt better. He said he could feel a vibration. He actually described it as a vibration. And he said it definitely felt better and said to me 'I'm a believer now Kath (Kathryn 1997: 388-411).

While experiential beliefs can be seen predominantly to influence clients, therapists can also be influenced by experiential conversion through performing health sessions, by participating in therapist networks, and attending training sessions. Mattson highlights the importance of experience in learning about complementary health when

she observes: 'Holistic health philosophy is typically learned by doing, by experiencing rather than by thinking about experience... In fact, it is hardly possible to conceive of learning the new philosophy without experiencing it' (1982:51). Thus, within the health milieu there can be seen to be a reliance on experiential beliefs. Mattson continues by saying that: 'In holistic health, the mode of learning is mainly experiential; the student is asked to experience the knowledge rather than merely to hear or read about it. Most lectures, classes, and seminars on any given therapeutic method have a high experiential element' (ibid:54).

4.1.3b Passive Conversion

The second main type of conversion which arises within the study is what can be called passive conversion. Passive conversion is a method employed by therapists through which passive, and very often, very subtle indicators are given to clients to influence their self-development. Passive conversion is grounded in a voluntaristic and optional stance, where therapists install a 'take-what-you-need' perspective in their clients. Emphasis is placed on self-discovery, example setting, storytelling and identification of experiences between therapist and client. The ease of this technique is based on the relatively relaxed attitude and non-pressure which therapists employ while talking to clients. Examples of passive conversion techniques can be seen through the following interview extracts:

> I tell them about my own personal experiences and what's happened to me. People can see that and begin to think about it. And they'll take it on board. I would never go about preaching to anybody because it doesn't work. It never works. But if people see an example in their friends, and in their family, and in their therapist, it has a knock on effect (Bowen Therapist Claire 1996:465-478).

> I am always telling everybody not to believe anybody. By all means learn, read and listen to other people but take all the information and then look within, and what you agree with, take in and the rest disregard. I mean even when I talk to

them I say, don't believe me ... But if you feel within your heart it's right what I am saying, then, only then, believe it. You see otherwise I could tell you anything. So you really have to introspect and ask yourself whether it's true what I am telling you or not... everybody has to decide for themselves (Reiki Therapist Emily 1996:207-230).

I say to them, 'this is my truth', 'this is my belief' and I want you to listen to it as if it is a story that I am telling you. And at the end of the day if you decide that this story is true then great, then you can believe it, that's fine. If you decide that this story is not for you then you can throw it away. If you think you want to look at it you can put it to one side for the time being but you must use your own judgement and discernment (NFSH Practitioner Luke 1997:52-69).

All we can do is to show that this is who I am, and this is what I do, and if people come up to you and say that they like the way that you do that, 'tell me what you do', or 'how you do it' then you can show it. All we can do in the meantime is live our example, which is being careful not to go around telling everyone else that this is the way (Creating Prosperity Himal 1996:192-198).

Passive conversion techniques are frequently used by therapists to inform clients of their own beliefs, by means of stories, and their own self-history. Therapists allow clients to 'take-what-they-need' from their stories, enabling the client to identify with the therapist through similar life experiences. Passive conversion techniques are, then, often based on the client identifying with their therapist's life experiences or problems. By identifying significant life experiences, therefore, practitioners are additionally able to offer possible solutions to these life events. Example setting and guidance are also encountered in the exchange between therapist and client. Such features are all characteristics of passive conversion. As with experiential conversion, passive conversion emphasises the client's present situation and presents possible alternative development routes which may be available to them. Therapists, therefore, predominantly use a passive conversion technique to influence clients.

Passive conversion, as outlined within this research, differs substantially from Kilbourne and Richardson's (1998) notions of passive conversion, inasmuch as complementary health techniques are carefully performed by practitioners to emphasise the control that clients have over their conversion. For example, in story telling, clients are seen to be in direct control of whether they absorb their therapist's stories. By contrast, Kilbourne and Richardson's concept is primarily based on an individual's feeling of 'impersonal and powerful forces acting upon them, within them, or both' (1988:2). Thus, therapists' techniques are based on dialogue and on the exchange of ideas, while previous notions of passive conversion dealt with a dominant transcendental force acted upon the individual.[6] Passive conversion, as outlined throughout this chapter, can be seen to represent the factors necessary to fulfil Kilbourne and Richardson's 'social psychological effects' (1988:16) inasmuch as therapists use their own health experiences to identify with their client's 'unique experience', therapists help to interpret the meanings and influence of these sensations and finally, they themselves constitute the 'audience' through which 'individuals claim of special experiences' are substantiated.

Therapists aimed to empower and re-education their clients. However, with re-education come notions of passive conversion.[7] The following interview extract illustrates the links which occur between passive conversion techniques and notions of education. A Colour Healer observes that:

> Often people, spiritually, are searching for something ...so really what you're doing, yes I will talk about different things, I'll talk about life experiences and courses I've done, and you might spark something up in them or I might lend them a book, as I've got lots of different books. And often that opens their eyes to things as well. They think 'oh yeah' (Lisa 1997:484-495).

A NFSH therapist continues on this theme by saying:

---

[6]Hence, implying little choice.

[7]Also see Sharma (1994:88) on information gathering between therapist and client.

> I mean nothing can be accomplished by preaching to people, it's not the way to go. All that I can do is offer them guidance, show them a possibility and if they are not willing to investigate it then that's that, but I would continue to help them as much as I could in other ways too (Luke 1997:500-522).

Therapists' techniques, often encourage a sense of autonomy and relative safety for the client, inasmuch as there is no excess pressure to *believe* in the treatment, or any set practices to abide by. The participants are therefore encouraged to work through their own ideas, discarding whichever notion that no longer applies, or is useful, and taking on ideas which are useful to them, at another moment in time. The fragility of beliefs in treatments is reflected by a Colour Healer's comments. She remarks:

> ..if you're learning something or someone presents something to you, if it doesn't feel right in here [the heart] don't do it, don't take it on board, just put it on the back burner until you've got, sort of either a little bit further along the line, and you suddenly think 'ow that's what it meant, this, that, and the other. I can accept that now'. Or you can say, 'no I still don't agree with that' and throw it away (Ann 1996:340-365).

Experiential conversion and passive conversion are not, however, too dissimilar. Several factors are shared in that both aim to provide meaning, both conversion techniques are individualistic and tailored to the adherent, and finally the underlying aims are the same, that is, to bring about some form of self-transformation. The major distinction between these techniques is one's role as either practitioner or client.

So far throughout this chapter we have discussed the notions of belief, hope and conversion within the complementary health milieu. An important factor which underpins these issues is trust. Trust emerges as an important factor underlying health beliefs as participants need to both trust the therapy as well as build a mutual trust in the relationship between practitioner and client.[8]

---

[8]See Section 4.2 for a further discussion of trust between practitioner and client.

4.1.4 Trust in Beliefs

Beliefs and trust are bound to each other through the nature of faith.[9] Faith in treatments develop, then: 'once you trust it, and once you know that inner essence of it, and you know that it is there...beliefs are important' (NFSH Client Julie 1997:398-401). Susan, a Bowen client highlights trust in the treatment, and the practitioner, when she says: 'I think you have to trust them. There does have to be a certain amount of belief that what they are doing will help...But some of it might have just been that somebody had cared' (1995:226:263). Here, Susan additionally highlights the role of the therapist inasmuch as clients may well trust their therapist, as they have provided care, time, and a safe environment through which they are able to express themselves. A Reiki client also draws attention to trust and notions of safety, while reflecting on her experience of healing energy. Kathryn recites her experience of panic and the sensation of relief once the practitioner had taken control over the healing situation. She says:

> First of all I was really quite scared because it was something that I'd never felt before. It was a sort of panic. I wanted to pull in my feet and I wanted to pull my legs away because it was almost hurting, but it wasn't. It was just such an intense feeling. And I just started to panic and I didn't want to jump or anything because it was just a warm atmosphere. I just didn't know what to do, so I just got a bit panicky. And Suzanne said to me, 'just relax, you're safe, you know'. And she asked me what I was feeling and I said I wanted to pass out and she said, 'then just do it'. And you just go OK, I'm OK now. That's what I first felt and then you realise you are safe and nothing is actually happening to you. You sort of start to enjoy it and feel really calm and at a peaceful intense love for being alive. That sort of thing (Kathryn 1997:83-106).

A safe environment and notions of security emerge once again while discussing

---

[9]Beliefs in treatment and trust in its ability to alleviate illness symptoms are not, however, restricted to complementary health. Conventional medical practices also need this degree of belief in order for patients to take medication, have operations etc.

trust. The following interview extract illustrates a client's sense of trust and security in the health milieu. This sense of security encourages reflexivity and an open forum for dialogue. Clients are therefore able to reflectively learn about themselves through such dialogue. The Natural Healing client illustrates this sense of safety when he remarks: 'It's great to go and sit in a room and calm down, and feel safe, and you can talk about anything, and say anything...It's there and it serves a need' (Daniel 1997:444-445). The client continues by discussing his beliefs in personal evolution and growth stimulated from self-knowledge. Daniel emphasises his need to understand himself and highlights his ability to nurture the relationships with the people that surround him when he observes:

> ... I believe in something.. it's definitely there. I couldn't actually say what it is. It's the energy .. it's a different thing to religion or to anything else like that. It's just .. what's the word? ... evolution ..just earth stuff... We are all just little things. But none of us are really that important, and that we all do what we do anyway. It's a real big relief to know that you're not that important but you could still do a lot of good stuff, a lot of good work, you know. If you start from the bottom and get bigger and that's where it's at. It's like a ladder. You work at things and when you learn to accept that and stop thrashing around like an idiot, and thinking of how self important and brilliant I am, that's when I find it's a lot better. I have a lot more people around me now. I can deal with people because they can deal with me, because nobody knew how to deal with me, because I was such an obnoxious git (Daniel 1997:445-486).

The sense of security, for health participants, contributes to their ability to make sense and order of life events. Giddens draws attention to threats to one's sense of ontological security, and consequently one's self-identity, by highlighting the perceived threats and anxieties originating from one's environment. Giddens notes then:

> Raising anxiety tends to threaten awareness of self-identity, since awareness of the self in relation to constituting features of the object-world becomes obscured.

> It is only in terms of the basic security system, the origin of the sense of ontological security, that the individual has the experience of self in relation to a world of persons and objects organised cognitively through basic trust (1991:45).

The anxieties experienced, throughout the course of one's life, can be seen to have detrimental effects on one's sense of self. Only by making sense of oneself, one's environment and understanding perceived threats, can one develop a sense of security. A Reiki client illustrates this aspect while commenting on how her treatment sessions had assisted her to overcome work and personal problems. She says: 'I had all sorts of problems with the people around me and it actually helped me to understand what was going on... I suppose it's like beliefs, you need something to believe in, and that gave me something to believe in when I was getting myself sorted out' (Elizabeth 1997:438-452).

Indeed, in order to achieve a sense of awareness one must first construct a basic level of trust in the treatment. Hence, trust in the treatment emerges as a contributory factor in the construction of belief. Giddens (1991:242) highlights the role of basic trust in the creation of ontological security and consequently its role in the creation of one's own self-identity. Health sessions therefore provide an environment where trust in treatments and therapists can be formed and where self-identity can be nurtured. By knowing oneself, then, we are more able to make sense of the world which surrounds us.

In summary, this section has discussed the interlocking and interdependent concepts of beliefs, experiences, conversion and trust. The emergence of these aspects, for many participants accumulate in a faith in both the treatment and the therapist. The following section aims to analyse the relationship between the therapist and client.

4.2 Therapist and Client Relationships

The relationship between therapist and client plays a critical role in the development of trust and intimacy within complementary health. Therapist and client relationships must be grounded, to some extent, on basic trust before a level of intimacy can be reached. Moreover, the relationship between therapist and client can additionally

be seen to reinforce concepts of self-identity by means of building loyalties, friendships, trust and intimacy. This section aims to trace the relationship between participants and argue that this interaction plays a decisive role for the establishment of trust, intimacy and self-identity. This section additionally aims to confirm previous literature put forward by Giddens (1990) regarding these concepts and hopefully contribute to this area by suggesting that the modern relationship between therapist and client can be indicative of the construction of identity. By analysing the relationship between therapist and client we are able to recognise the therapist's 'reflector' role within health sessions. This method aims to facilitate clients by means of self-reflective questioning and analysis. The interaction between adherents can therefore be seen to contribute to one's sense of identity.

4.2.1 Trust in the Relationship

To begin it is significant to note that health adherents often sought complementary health as a consequence of unsatisfactory experiences of conventional health care.[10] The majority of health adherents, whether practitioner or client, were therefore seen to attend health sessions initially for purely physical health problems.

Health and healing therapies are popular because they can be tailored to the individual and can be used to identify the individual's unique characteristics (Budd & Sharma 1994:6-7). This uniqueness can only be identified through interaction and dialogue with the therapist. All clients interviewed had one-to-one health sessions with their therapist.[11] Through this interaction information is shared on subjects such as physical states of health, personal relationships, lifestyle habits, life experiences, work, home life, aims, desires and personal beliefs. It is by means of this dialogue that intimacy is constructed. Thus, in sharing knowledge participants are able to make sense of

---

[10]Forty three per cent of interviewees sought complementary health to alleviate physical health problems, twenty seven per cent had previous interests in health and spiritual issues, fifteen per cent had family or personal problems, and finally fifteen per cent had an awareness of healing gifts.

[11]Only a handful of clients took part in other, additional, group activities.

personal issues by means of therapist/client interaction and the support and guidance which is offered within this relationship. Bloom, while exploring relationships in conventional health care groups, particularly draws attention to information sharing through various forms of interaction. She says:

> The social network may influence health outcomes directly by providing access to information or by enhancing motivation to engage in adaptive behaviours. It may also influence outcomes indirectly. That is, support from others may encourage the individual to comply with treatment recommendations, to maintain health promoting behaviour such as exercise and proper nutrition (1990:636).

Thus, Bloom goes on to suggest that various relationships are able to 'facilitate physical recovery ... or rehabilitation' through providing 'resources such as information, assistance and encouragement during stressful times' (ibid:636). The interaction which occurs between adherents contributes to one's self-identity as we are expected to review ourselves in the context of information offered to us from our session discussions and experiences. The dialogue which occurs within health sessions therefore encourages clients to explore their own identity by means of reviewing and working through their own problems. In sharing knowledge participants are able to make sense of personal issues by means of social support offered by therapists. The relationship between therapist and client therefore nurtures issues of trust and intimacy. Through such social ties individuals are offered the opportunity to reinforce (or review) previously held beliefs. This process contributes to one's sense of identity by means of constant social and individual reassessment. Thus, by encouraging self-reflection and by placing oneself (and one's ideas) within an arena where one can safely reveal any aspects of one's life it becomes possible to reflect on one's self-identity. Indeed, the internal/external, private and individual problems of adherents are addressed by means of the mutual support and guidance provided through the practitioner/client relationship (Budd & Sharma 1994:6-7).[12]

Intimacy and trust can only be achieved through the giving of time within the

---

[12]Also see Mary Douglas (1994).

relationship. The present research found that the minimum consultation time was approximately thirty minutes on average, not including fifteen minutes for introductions, undressing and/or discussion. The maximum session was found to be two and a half hours. The dedication of time was particularly noted by a NFSH Practitioner when she observes:

> All the old doctors they used to sit and let you talk for about 15-20 minutes; within that 15-20 minutes they knew what was wrong with you. You unwound half your problems. That's what it's all about. People haven't got time any more. And it is taking time and taking stock of yourself really. And taking stock of your own life to become you. That is what I feel along with the healing, but the healing actually does give you that time to take stock of yourself and become more positive of yourself. Once you start that you start to pick up (Madeleine 1997:1126-1141).

Sharma (1994) draw attention to the dedication of time in complementary health relationships when she remarks '...there is certainly evidence that complementary practitioners spend much longer on the process of examination and history-taking than orthodox GPs; the average length of first consultation in my sample of practitioners was one hour, and for subsequent consultation a little under three-quarters of an hour' (1994:87).

The length of time with a prospective therapist was found to be inconsequential while determining whether clients would continue to visit a practitioner. One session was all that was necessary to discover whether clients liked, or would trust, the therapist. In addition, clients often gave treatments a trial period before deciding whether the treatment had been beneficial to them. Once clients found a treatment they liked then they would persist in their search until they found a suitable therapist.[13] The bond

---

[13]Indeed, over half of clients had encountered difficulties with their previous therapist or treatment. Negative experiences ranged from client's incompatibility with their therapist, painful or emotionally upsetting health sessions, to the lack of symptom alleviation. The inference that can be drawn from client's persistence at attending complementary health can be that beliefs in treatments prevail regardless of negative therapist experiences or the absence of

between therapist and client emerges in Sharma's discussion of the 'equation of responsibility' (1994:91). She comments:

> One suspects that patients eventually match themselves to therapists whose approaches they find acceptable and that some patients simply fail to return to a therapist whose notions about therapy are fundamentally at odds with what they are prepared to accept, or who propose a radical revision of the sense of self when symptomatic relief is what the patient insists upon (1994:91).

The bond which emerges between practitioner and client is highlighted by a Colour Healing client when he says: 'I didn't think of Colour Healing as a particular avenue but rather following someone' (James 1996:29).

Many, if not all, treatments were found to follow the same formula. This begins with an initial consultation, discussing ideas, desires, past and present problems, future expectations and goals (introspective, retrospective). As one client says: 'We'd talk about where are you right now? What happening in your life? Where've you been? Where are you now? By talking about it, it becomes clear in your head. We do some mental sorting out. Or if there's some deep core beliefs' (Reiki Client Kathryn 1997:86-88). The second stage was the treatment itself. Finally there would be a 'setting goals' discussion as to one's temporary aims until the next treatment session.

Specific qualities must be illustrated by the therapist in order to construct a successful practitioner/client relationship. These include: sensitivity, integrity, compassion, therapist's ability to act as a reflector (or 'optical image', Sharma, 1994:102), good listening skills, non-judgemental attitude, good rapport, problem solving skills, and the ability to establish a sense of trust and security. Brody (1992) specifically notes trust as one of the primary obligations of the practitioner. He notes: 'The physician has an obligation to act in a trustworthy fiduciary manner and to view himself as the patient's agent in health-care matters' (1992:45).

Issues of trust, for both practitioner and client, emerged as one of the main factors

---

physical improvement. Beliefs in treatment can therefore be seen to prevail regardless of the non-beneficial relationships encountered while seeking a regular therapist.

in the interaction of adherents. Trust in the therapist/client relationship takes several forms. There was trust of confidentiality, which exists between participants, trust in the therapist's ability to facilitate healing, trust that the treatment will have beneficial effects, and trust that the therapist places in the client by sharing their beliefs and practices. A Reiki therapist draws attention to trust while reflecting on the practitioner/client relationship. She observes:

> ..it takes three or possibly four...sessions to reach a rapport and trust, because after all if someone comes here for a session, I am a total stranger and, the first thing I ask them to do is to take their clothes off. We do have some getting-to-know-you to do...but that is what we do, and they seem quite happy to do it. It's really amazing. So it takes two or three sessions before there's confidence in each other... that's what is happening to really get trust set up, and building trust (Lilly 1997:479-495).

A Natural Healer also discusses trust and building of confidences in the client when she notes:

> Usually people come in here for a massage and then they will start looking around and asking, 'what is this?' 'What is that?' And they see certificates in the wall and they'll say, 'what is that?' And I start explaining, and once they are confident in me and they can trust me, and invariably there is some emotion behind the physical ailments, we get started on their stuff (Frances 1996:169-183).

Clients particularly mentioned trust as a mechanism through which they are able to ground intimacy and communicate personal problems to the therapist. Clients are therefore aware of the bond which is formed between practitioner and client. A Natural Healing client highlights this trust while commenting on her relationship with her practitioner. She remarks: 'I feel in my case that I would totally trust her with my life' (Louise 1997:674-675). The dialogue which takes place in health sessions can

consequently be seen to encourage trust and feelings of security for health participants. Hence, the building of trust emanates from dialogue.

4.2.2 Intimacy

While illustrating the differences between 'pre-modern' and modern concepts of trust Giddens outlines the changes to the notion of intimacy. According to Giddens the transformation of intimacy is just one aspect which differentiates the 'pre-modern' from the modern. As such, Giddens argues that the transformation of intimacy involves a number of issues. He initially begins by drawing a distinction between '1. An intrinsic relation between the *globalising tendencies* of modernity and *localised events*' (1990:123). Here Giddens notes both the separation between one's external forms of intimacy and localised 'day-to-day' events. He notes the following transformations by saying (1990:124):

> 2. The construction of the self as a *reflexive project*, an elemental part of the reflexivity of modernity; an individual must find her or his identity amid the strategies and options provided by abstract systems.
> 3. A drive towards self-actualisation, founded upon *basic trust*, which in personalised contexts can only be established by an 'opening out' of the self to the other.
> 4.The formation of personal and erotic ties as 'relationships,' guided by the *mutuality of self-disclosure.*
> 5. *A concern for self-fulfilment*, which is not just a narcissistic defence against an externally threatening world, over which individuals have little control, but also in part a *positive appropriation* of circumstances in which globalised influences impinge upon everyday life.

Here, Giddens (1990), aims to focus on notions of intimacy which have a direct impact on one's sense of self-identity. Complementary health sessions can therefore be seen to provide an environment where intimate bonds are formed. The interaction and

dialogue which occurs between the practitioner and client aims to contextualise the internal and external factors which are present in one's life. This intimacy consequently impact on one's sense of self-identity. For Giddens, (1990), intimacy is a contributory factor in the building of a pure relationship. A pure relationship, according to Giddens is: 'a social relation which is internally referential, that is, depends fundamentally on satisfactions or rewards generic to that relation itself' (1991:244). A pure relationship is then a relationship which is 'unprompted by anything than the rewards that that relationship provides' (1991:90). Hence, such interaction is grounded simply on the rewards which that relationship can offer each individual. Giddens highlights the 'free-floating' nature (1990:89), reflexivity (1990:91) and commitment (1990:92) of such a relationship. That is, as these relationships develop one is able to initiate greater intimacy and self-assessment. Although complementary health relationships illustrate several features of intimacy, the interaction cannot be seen as a 'pure' relationship. The rewards which are present are unequivocally different as therapists primarily gain financial rewards, while their clients hope to gain rewards of good health. The presence of commitment, to the relationship, is also absent in the practitioner/client interaction. However, regardless of the intimacy which is formed between adherents, the relationship is predominantly fluid. The flexible, evolving, and even fragile nature of complementary health relationships can be seen in clients' ease of severing non-beneficial ties. There are, however, benefits to the fluidity of therapist/client relationships. Severing ties with non-beneficial therapists, in order to experience new treatments, therapists and events, can all be seen to offer health participants an alternative opportunity to seek well-being and self-discovery.

Giddens's concept of pure relationships is not beyond criticism. Mellor and Shilling argue that Giddens has overemphasised the importance of pure relationships in modernity, while simultaneously neglecting their connections to embodiment. They comment: 'In our terms, however, they represent a banal form of association based on talk and transient contracts' (1997:182). Mellor and Shilling (1997) highlight that although 'pure relationships are based on a dialogue' (ibid:182) which aims to enhance self-identity, such cognitive action can be found in a plethora of relationships and environments, for example eroticism.

Intimacy, which is formed between adherents is often intense, especially if illnesses have been alleviated by the treatment practised. Clients can often feel relieved and grateful to the therapist for this respite. Therapists are often aware of this factor and are careful to distance themselves if they feel the therapist/client relationship has become too intense. A Bowen Therapist highlights the gratitude that some clients feel when she remarks: 'I suppose in the beginning it can be quite an intense relationship because suddenly you have taken their pain away and they are usually very grateful and so they ring you up and tell you about what is going on, or whatever' (Kelly 1996: 638-643). Sharma emphasises the tightrope that practitioners must walk in giving treatments. She says: 'The relationship with a complementary practitioner may be quite intense while treatment is in progress, but it is also potentially brittle; the patient who decides that a particular practitioner is doing nothing for the illness need never consult again and the relationship simply ceases to exist' (1994:98). The limitations to intimacy are therefore drawn throughout the period of consultation. Indeed, according to Pilisuk and Parks:

> The limits of the relationship are made clear. In all cases, the social support facilitator clarifies the nature of the contract, what and how much he or she is willing to do, and what is expected of the client... The social support facilitator(s) always checks the understanding between himself/herself and the client(s) (1986:163).

As we have previously seen in Chapter Two, Wilson draws attention to gratitude in his 'Probabilistic Inventory' (1990:279). He argues that expressions of gratitude can represent characteristics of worship. Wilson states:

> Expressions of symbolic obedience, gratitude, obeisance, or devotion are required in particularly circumstances, often in the presence of symbolic representations of the supernatural agency (-ies): such manifestations of attitude constitute worship (1990:280).

Wilson further argues that 'Occasions of worship and exposition of teaching are claimed to encourage a sense of community, goodwill, fellowship, and common identity and reconciliation among devotees' (1990:280). Wilson therefore emphasises the presence of gratitude in worship and the close bonds which are formed between religious adherents. Indeed, the consequence of these intimate relationships in health, and the alleviation of pain, can accumulate a sense of gratitude for health participants. A Colour Healing client expresses her feelings towards her treatment when she says: 'It just seems to be the thing for me. Which I feel very grateful for. It really is like a blessing. And I kind of see it as a way for me to grow more spiritually'(Erica 1996:425-427).

Other expressions of worship arise. Prayers, candles and dedications are all additional features which are performed, especially by therapists to evoke or to thank for the presence of healing forces. A Reflexologist and Colour Healer emphasise acts of worship when they comment:[14]

> ...we write someone's name in a book, or we, say, pray in the morning when we light the candles, we dedicate everybody who is in the book that needs healing, or anybody that needs it. In a way it is like saying prayers because it is the energy behind that thought. You can send good loving thoughts, energy, to somebody which will make a difference (Heather 1997:178-188).

> ... it doesn't matter whether we're a Christian, or whether we're a Buddhist you become a channel, you can pray and link in to whatever you believe in. That's the divine universal energy that is all around, and we pull in the highest light we can and it comes through you (Lisa 1997:106-112).

As we have seen throughout this section the relationship between client and practitioner is critical in the health and healing milieu. The relationship which emerges is based on a number of interdependent notions including trust, intimacy and specifically reflective dialogue. The factors which are discussed in health sessions (lifestyle habits, life experiences, needs and prospective development areas) are all features which

---

[14]See Chapter Five and Appendix 3.7 for further expressions of worship.

increase adherents' sense of self-identification. By discussing issues which are important to the client, therapists are able to emphasise certain development areas and suggest alternative routes in achieving these aims. Reflective dialogue additionally enables adherents to recognise key features which shape their lives. Self-identity, as hinted by Giddens (1991) while discussing ontological security, is only sustained by a wider support offered by the therapist/client relationship. The relationships which are formed then often have a direct impact on how one shapes and sustains one's sense of self in the wider environment.

4.2.3 Reflective Dialogue

While discussing the role of the practitioner a Colour Therapist highlights the presence of reflective dialogue in health sessions. She observes:

> [The client] just wants to air their views. They've got something on their chest and it comes pouring out. Sometimes they will cry .... sometimes you just have to have a listening ear ... You don't get involved with them, you have to stay, this is where counselling comes in, you have to, sort of, stay detached from it...if you can ... then just by saying to them, well 'this, this and this has happened'. 'Have you thought of looking at it like this'? Or sometimes when they're talking and they say how they feel, if you repeat the sentence back to them, what they've said, they will say well 'yes because so and so, and so and so'. And you will say 'so it's that person doing that and saying that'? And they will go 'yes', and then there'll be a silence. And then they'll say 'I suppose if I did this, this, and this, then that won't happen' and you go, and you nod, and what you've actually done is... made them responsible. They've done it themselves without you really saying anything. You're just there like the sounding board if you like (Ann 1996:549-575).

Therapists therefore facilitate the discussion by providing space and a sense of security for adherents to reflect and to contextualise their lifestyle. Indeed, it takes time

to develop under the care of the therapist.[15] This space incubates clients' feelings of development as they have learned new aspects about themselves, and have, to some extent, realised potential development areas. This process encourages self-realization. Giddens particularly highlights the reflective role of the therapist when he remarks: 'For therapy is not something which is "done" to a person, or "happens" to them; it is an experience which involves the individual in systematic reflection about the course of her or his life's development. The therapist is at most a catalyst who can accelerate what had to be a process of self-therapy' (1991:71). The process through which therapists facilitate self development is therefore by reflective dialogue and continuous self-assessment. Giddens again, draws attention to the continuous nature of self-development, through reflective dialogue, when he says:

> In the reflexive project of the self, the narrative of self-identity is inherently fragile. The task of forging a distinct identity may be able to deliver distinct psychological gains, but it is clearly also a burden. A self-identity has to be created and more or less continually reordered against the backdrop of shifting experiences of day-to-day life and the fragmenting tendencies of modern institutions. Moreover the sustaining of such a narrative directly affects, and in some degree helps construct, the body as well as the self (1991:185-6).

The notion of self-narrative emerges in a Colour Healer's account of therapy sessions. She remarks:

> ...as we learn about ourselves and the world so we become our own therapist. ...that is how I see myself, as a midwife in a way... It seems to me that when I am working with somebody I'm working with their ability to heal themselves. So I see people as healing themselves. It's more that I come in to amplify it. Sort of lend an extra focus. Draw attention to something. It's rather like the bible: when two or three are gathered together on a project it's the sum total which is greater

---

[15]The average duration of association between therapist and client was 2-3 years, while a few Cell B clients have been with their therapists for approx 7-8 years.

than the parts. Something else happens and I think that it's that something else that gives it a spiritual dimension in a sense, because it's almost like as if you have a problem and we're sitting together with it, when a solution comes. I never sense that I have solved the problem for you. Hopefully you have the sense that you have solved the problem, or we might both get the sense that something else has come in, some sort of other awareness that has come in to amplify it, to lend muscle (Patricia 1995:885-911).

The strategy of reflection in healing sessions can be argued to amplify notions of self-identity as every issue in one's life is analysed and assessed. Freund and McGuire (1991) discuss the benefits of supportive individuals as they provide 'nets that hold us up or keep us from falling when we are threatened. They function as sources of information and financial or other kinds of aid, and as mirrors that help to reflect back to us messages of self-affirmation' (1991:114).[16] Giddens, additionally notes the importance of 'other persons' (1991:50) in the construction of our own self-identity. While outlining his work on ontological security he draws attention to those that surround us (the reflexivity of others) and their influence on the construction and continuity of one's own identity. Hence faith in the integrity of others, trust in others and the ability to place oneself within a certain context, are contributory factors in our own understanding. Glik (1986), also discovers the effects of healing relationships on one's sense of identity and state of wellbeing when she explores spiritual healing participants. Glik's research leads her to hypothesise that the interaction which occurs between participants 'reinforces a belief system enhancing the individual's feelings of self-worth and suggesting the possibility of "healing"' (1986:584). She continues:

> That is, involvement by the individual in a particular healing system is a dynamic not a static process, where the interpersonal or group process of healing has an effect on the individual going through some personal crisis (illness, stress) or

---

[16]Due to the limits placed on this study issues relating to complementary health networks cannot be fully explored. However, preliminary observations regarding cell groups attendance at social events, and issues relating to mistrust, is discussed in Chapter Eight.

growth process (search for wellness, self-actualization) to reinforce certain norms by which that person views him or herself as well or ill (1986:585).

Health and healing adherents therefore place themselves into a social context where they are able to learn both about themselves and the world which surrounds them. Hence Pilisuk and Parks comment: 'The meaning we affix to people and to things, and the values we live by reflect our place in the network of reciprocal relationships that comprise the social order' (1981:121). Thus one's identity becomes influenced by those people that we associate with. The interdependent and reflective relationships we construct with others inevitably lead us to review and continually to assess our own perspectives. Even if beliefs and experiences reinforce knowledge already accumulated, interaction between adherents still contributes to the participants' sense of individualism.

The role of reflector in practitioner/client interaction is facilitated by a sense of witness.[17] The therapist's role as witness to the clients' problems impacts on the client's sense of self-identity inasmuch as communicating one's thoughts to a secondary party often results in clarity and the organisation of one's own ideas, beliefs and attitudes. By clarifying lifestyle issues, illness symptoms and probable causes of ill health, clients are able to feel that they are able to manage their health status. Indeed, this issue is summarized when a Rebirthing client says: 'When you have a witness and a reflector, the more healing can happen' (Anton 1997:185). A Reiki Therapist continues to highlight the therapist's role as witness when she comments:

> The client may think 'oh she made me feel better', but actually the client makes him or her self better. There is something about the inter-relationship, the

---

[17]Notions of witness between therapist and client, and the dialogue which occurs, can be argued to be illustrative of Wilson's fifteenth requirement in his 'Probabilistic Inventory' inasmuch as therapists listen and respond to client issues (confession), and aim to reward clients by offering possible avenues for self-improvement, self-understanding, and possibly even suggestions for lifestyle modifications. Wilson notes that: 'Adherents accumulate merit or demerit, and a moral economy of reward and punishment operates. (The precise nexus between action and consequence varies: it may posit automatic effects of given causes; judgement and punishment by supernatural agencies; the possibility of demerit being cancelled by self-surrender; ritual acts; vicarious atonement; confession and repentance; or special supernatural intercession)' (1990:281).

plugging in the two people which seems to be a human need in healing. The need to feel a relationship...There is something about the plugging in that's in healing and something about witness and community. Somebody can get better and then I give them appreciation for their progress. There have to be two people involved that choose to be there, and that get on. It doesn't work if there is not a rapport and then really there is no limit to what is possible (Lilly 1997:393-416).

Sharma also encounters the method of 'optical image' while interviewing therapists. She observes:

> A practitioner whom I interviewed recently used a(n) ...'optical' image to describe her practice, seeing herself as a mirror who reflects back an image of the patient's life; to the extent that patients are enabled to see aspects of their selves and lives which were not clearly perceived before, they can make use of their self-knowledge to facilitate healing. According to this healer, it is the patient who heals him-or herself, the practitioner merely provides favourable conditions and resources for this process (1994:102).

The therapist's role of reflector can additionally initiate the organisation of the illness experience inasmuch as it enables the departmentalization of symptoms by identifying underlying problems.[18] The reflector can therefore differentiate between causes of ill health, and between the different aspects of the body where illness may

---

[18]Storytelling was one such strategy employed by therapists. Seven therapists related stories concerning their clients' healing experiences. In each of these stories there was an underlying serious life event which has come to light throughout, or as a consequence of, the session's discussion. These life events ranged from domestic violence, adultery, drug dependancy, rape/abuse, chronic/terminal illnesses and gynaecological problems. These life events are seen by therapists as critical aspects which must be recognised and reconciled in order for the individual to find well-being. These stories illustrate the importance of complementary health's ability to encourage self-reflection, by means of identifying what positive and negative aspects are present in one's life. Reflective assessment can also be used to devise strategies through which modifications of lifestyle can be made. Thus, stories are told by practitioners possibly to hint at strategies for coping with such life events.

originate (for example emotions), and finally relate illnesses to exterior factors.[19] Two Natural Healing clients highlight their therapists' proficiency at drawing out their problems, focusing on their needs, and suggesting solutions by remarking:

> It's good to talk to Frances because she understands about me, rather than what I project, or how people perceive me. She picks out the real stuff, I can't act like a twit around her. I know that, so I don't bother, you know. I don't act up at all so she knows the score, and I can go to her and say whatever is happening in my life... I can go and say anything to her and she see's things from my point of view rather than somebody else in my life. She keeps herself separated from me so she can see how things are going on around me. Which is good (Daniel 1997:429-443).

> I'm always saying to her that I would not be in a fit state I am in now without her being around. I was coming to a peak and then I was told that my mum had cancer and it is terminal, and so she hadn't got very long. And it just felt that everything was on top of me in what's happened in my life this year. I think I could have easily not worked, or tried to get away from it, or even have sold the house... I've got my act together, I've got a lodger in and that is really from the strength that Frances has given me. Not her strength physically, but actually trying to get my mind and my body to the same level. That is the only way I can describe it... I think whatever would have happened without someone like her helping me? (Louise 1997:554-574).

The capacity to step outside of one's own situation and reflect on it encourages new perspectives to core issues surrounding one's life, and offers a possibility of new directions. The problem-solving strategy employed by therapists can, therefore, be seen

---

[19]Perceptions of the causes of ill health are not longer introverted and tied to the body. Complementary health views the individual holistically therefore recognising external factors which can influence health, for example stress originating from work. The consequences of this perspective is a move from a passive patient to an active health seeker.

as a fruitful method in coping with health problems.[20]

Several clients noted the impact of such reflective interaction when they comment: '..she has given me the ability to look at things, and to let go' (Natural Healing Client Louise 1997:288). 'I have learnt how to look after myself and I didn't really think I did that before' (Bowen Client Jane 1996:580-585). 'You get to a stage and everything is OK then you think we're moving on to the next stage. So you go in and do a complete breakdown of yourself and start learning again. Do everything all over again' (Natural Healing Client Daniel 1997:181-190). Finally, while seeking an alternative to a possible hysterectomy operation Erica, a Colour Healing client, emphasises the continuous need to assess and cope with the stress of her illness. She observes:

> ...there has been a definite mind opening in terms of seeing how the body, spirit and mind work together. There was a point where I felt extremely scattered, very worried, because I could not pull myself together and I was not comfortable. After two sessions it was like my energy came together and I felt more centred, better able to cope (Erica 1996:46-52).

Continued self-assessment within health sessions is a significant process through which self-development can take place. Similarly, Sharma identifies this occurrence in the relationship between practitioner and client when she comments:

> Holism in the strongest form is more akin to psychoanalysis in that it sees the interaction between healer and healed as an ongoing process rather than a static relationship. Even in its weaker form it often involves much scope for the revision of agendas and redefinitions of the task in hand by both the patients and the practitioner (1994:92).

Through analysing the interaction between practitioner and client we are able to

---

[20]Reflective dialogue can be seen to be differentiated from counselling by its central focus on the individual's ability to assess their own needs. Practitioners, therefore, do not advise their clients as to possible coping strategies. Emphasis is placed alternatively on the individual seeker discovering their own routes to good health and well-being.

conclude that intimacy, trust, and reflective dialogue are features which assist in the construction of beliefs and, indeed, one's self-identity.

4.3 Conclusion

Throughout the first section of this chapter, one aimed to explore the underlying reasons for adherents' beliefs in treatments (hope), why participants believe in treatment (through means of healing experiences), and how these beliefs have been created and sustained (passive and experiential conversion). In the latter part of section one the issue of trust emerged as a significant aspect which grounds adherents' beliefs in treatments. Notions of trust also brought the discussion to the second significant focus of this chapter, the therapist and client relationship. Here we can recognise the critical importance of trust, intimacy, and reflective dialogue as contributory factors, not only in the performance of health sessions, but also in the relationship which is created between the practitioner and client. The interaction between therapist and client can be seen to encapsulate various issues which are directly influential in the construction of one's identity. Both therapists and clients constructed their understanding of health and healing notions, in the efficiency of complementary health, through direct healing experiences. Information sharing and reflective dialogue between adherents additionally enable the development of one's own framework of meaning relating to beliefs, health issues and lifestyle. Reflective dialogue and witness are especially crucial in the therapist/client interaction inasmuch as beliefs concerning one's self-identity and self-development have originally been thought to emerge from such introspection. The next chapter aims to explore further the notion of self-identity and development by means of exploring beliefs in healing energy.

CHAPTER FIVE

BELIEFS IN HEALING ENERGY

Belief in healing energy was found to be a prominent factor in researching complementary health beliefs and practices. Indeed it became apparent while exploring the WINMAX Pro analysis that many therapists, and indeed their clients, too, had become preoccupied with the notion of healing energy. Table 5.1 illustrates the codewords and numbers of coded segments relating to beliefs in healing energy. The table contents has been extracted from the WINMAX Pro theme tree (Appendix 3.8). Each of these coded areas were analysed using the methods outlined in Chapter Three, Section 3.7.

Table 5.1 Coded Segments of Beliefs in Healing Energy.

Codeword	Number of segments attached to codeword	Line numbers attached to codeword
Beliefs in Energy	72	1140
- Different Types	53	582
- Energy Experiences	33	448
- First Hear or Knew of Energy	34	364
- Function/ Role	89	864
- Illness Theories	89	928
- Importance to Healing	16	161
- Names	47	124
- Negative Energy	29	713
- Origins of Energy	34	335
- Understanding of Energy	76	1248

Beliefs in a transcendental force penetrating the body to indicate healing, communicative experiences and even divine intervention were all seen as significant experiences which ultimately influenced the individual. As such, healing energy can be regarded as one of the most significant beliefs in the whole network of contemporary ideas dealing with one's body, mind and spirit. The idea of energy, or life force, plays a prominent role in the belief systems of almost all complementary health and healing therapies today regardless of technique, style, therapy history and ideology. This chapter hopes to explore the particular role of energy in healing and consider whether these beliefs are contributory factors in the construction of an individual's identity. This

chapter also aims to discuss how energy beliefs provide meaning for oneself and about one's social surroundings.

The proliferation, and popularity, of energy beliefs is reflected in the new age milieu by their presence and discussion at self-help, spiritual, and neo-pagan festivals, workshops, seminars, and literature which have grown throughout the last decade. The influence of these beliefs will be discussed by focusing on the thoughts, attitudes and even lifestyle changes made by adherents at the Healing Centre. This chapter hopes to broaden the interest in energy beliefs and suggest that these beliefs are an important tie to wider health and healing belief systems embraced by new age practices. This chapter ultimately hopes to contribute to the very small body of sociological literature concerned with contemporary beliefs. The chapter therefore aims to make sense of exploratory qualitative data by examining the beliefs which are influential to both health practitioners and their clients.

5.1 Concepts of Healing Energy

The first task while exploring a relatively little investigated area is, of course, to define the principal theme. An outline of healing energy beliefs was formed by asking therapists and clients 'what is healing energy?' An interesting factor to arise from this initial question was the different response rate between therapists and clients. While all therapists were able to give explanations of healing energy, only half of clients were able to discuss their perceptions surrounding this issue. This pattern of therapist and client responses is reflected throughout the chapter. The foremost consideration then is that although clients participate in health sessions, only half of them actually know the methods and beliefs employed throughout the health session. A secondary factor emerged while viewing interview responses. Moreover, although only one half of clients responded to questions relating to energy beliefs these responses did resemble the ideas put forward by therapists. The similarities between adherents' beliefs perhaps gives an initial indication of participants' shared[1] understanding of health and healing ideas.

---

[1]The majority of clients first heard of healing energy through their therapist. See Chapter Eight, Table 8.3 for an analysis of adherents' first knowledge of healing energy. Section 8.3

These similarities could also indicate some transference of belief between practitioner and client groups. The question 'what is healing energy?' yielded various responses. The most significant interpretation of healing energy was in terms of *the divine.*[2] The presence of healing energy, in health sessions, was therefore predominately identified with images of the divine. These transcendental forces took several forms, ranging from healing angels and guides to therapists' personal manifestation of their ideal self or soul. This image of healing energy was reflected by a NFSH client when she says: '..well the energy I tune into I always feel is from God. In fact most healers will tell you that it is God's energy. It is Universal Life Force. It is traditionally know as Universal Life Force which I feel emanated from God, the Great White Spirit...' (Julie 1997:196-201).

The second interpretation of energy was seen in purely *scientific* terms. Nine therapists and three clients used scientific knowledge (the movement of neutrons, protons and electrons) to explain the healing force. This interpretation also includes participants' beliefs of the energy relationship between oneself and one's surroundings. These therapists and clients therefore identified healing energy as a link which bridges oneself and one's social surroundings. Energy was perceived as matter, and, as such, constituting the same substance which forms oneself and one's surroundings. Hence, these participants saw the individual, the environment, and healing forces, as all forms of the same dense energy. As such, this energy was believed to interact between people, objects and one's environment. In relation to the body, people were seen as compressed energy: 'dense energy', which enables us to have a physical presence. A Reiki therapist highlights this perspective when she comments:

> Einstein got it right. He said basically there is an equivalent relationship between mass and energy. So my body, yes people say it's solid, it's matter but it's also energy. It's got a life force. The earth has a life force. Crystals, even water carries energy. We get it from air, sunlight, all different, apparently different forms of energy. But there is an underlying vital energy, a life force that is in virtually

---

illustrates *all* therapist and client responses regarding energy beliefs and reviews the possibility of belief transference between cell groups.

[2]Seven therapists and six clients identified energy beliefs as constituting the divine.

everything (Suzanne 1996:109-113).

This quote also highlights how the body is distinguished into several dimensions. Briefly then, there are several interpretations of viewing the body within complementary health and healing. These body perspectives are often used by adherents to interpret and to make sense of the body and its functions. These beliefs will be described as multi-dimensional body perspectives. The first of these multi-dimensional body perspectives are the *auras*. The auras are also commonly referred too as the celestial body. According to all the therapists interviewed the celestial body comprises of several layers: the physical, etheric, emotional and mental and the level of the soul. The physical body is seen as the most concentrated of the bodies. The soul is identified as the more spiritual and lighter of the bodies. Energy is believed to penetrate and heal through all these levels. The body's auras are described as fields of subtle light which surround the body. These fields of light change colour according to one's personality and illness. The celestial body is also claimed to reflect current emotions.

A second body perspective emerges while discussing one's body's *chakras*. One's chakra zones are located over the seven main points of the body. These seven points extend vertically from the base of the spine, reproductive area, the solar plexus, the heart, throat, brow and the crown. Therapists often claim that once they have become substantially enlightened to their 'path', their human density becomes lighter in vibration and therefore they become more spiritual in form. Hence, therapists ascend the chakra hierarchy moving from the physical base and transcending/ journeying towards spiritual enlightenment which is symbolised by the crown chakra. This personal journey is seen as one's 'path', one's destiny. Once therapists discover, experience and have faith in the forces of healing energy then, it is a transformative process in their personal evolution. A third identification of one's body is simply the mind, body and spirit. The entire human form is therefore seen to constitute three principal areas. These areas are equally significant to the well-being of the individual. As such, the maintenance and alleviation of illness in any of these areas would provide a sense of total well-being. For more details on multi-dimensional body perspectives see Chapter Six.

The final interpretation of energy was seen as *the cosmos*, where energy was

everywhere and penetrated all things but where there was no implication of scientific meaning given. Only five practitioners and one client identified energy as being a universal healing force. Cosmic explanations for energy were then seen in terms of an external universal healing force.

Similarities between client and therapist groups can be seen while asking participants where they believed healing energy originated. The divine (twelve therapists and four clients), the powers of self and cosmos (three therapists and four clients), the universe (four therapists) and the practitioners own healing abilities (two clients) all emerged as the origins of this healing energy.[3]

There arises an inconsistency between therapists' beliefs in what constitutes healing energy (science) and what the majority of therapists identify as the origins of healing energy (the divine). That is, although almost one half of practitioners understood energy in scientific terms, they dis-associated themselves from this notion when discussing the origins of healing energy. This perhaps illustrates a laissez-faire approach to the belief in healing forces inasmuch as there are no presiding image or preferred origin of healing energy. The subjective image of healing energy is therefore seen in the emergence of inconsistencies while scrutinising the substances and origins of energy beliefs. Indeed, the ability of adherents to use both scientific and religious terms to make sense of their beliefs can also illustrate why the term *complementary* is used to describe these health practices. Peters (1994) argues that the presence of energy within complementary health is a mechanism through which practice boundaries are drawn between health care systems. Hence, the presence of energy, or the 'language of energy' (1994:187), in treatments therefore defines whether a practice constitutes a complementary health technique. Peters draws this distinction by saying:

> The word 'energy' is often used by practitioners of complementary medicine as though it described something objective. But it is actually metaphorical, implying some substrate through which complementary medicine's homeostatic interventions might act. It is part of complementary medicine's 'ecology of ideas' to the extent that one can be sure a therapy is complementary medicine-like if it

---

[3]One therapist and eleven clients could not express the origins of healing energy.

> uses the 'energy metaphor'. It also illustrates the sense in which we are searching for a construct capable of authentically underpinning and uniting the disparate complementary therapies (1994:187).

Although energy concepts for practitioners do involve a level of shared language and use of various metaphors for practitioners, further exploration would be needed in order to fully comprehend the foundations, and distinct features, of practitioners' and clients' beliefs in healing energy. Thus, it is only by exploring beyond the assumption of energy as a metaphor and investigating health adherents' concepts of energy that it becomes possible to build knowledge concerning contemporary health beliefs. Indeed as we have previously seen throughout Chapter Four, health experiences greatly contribute to the construction of belief. By studying adherents' health experiences, and exploring the underlying concepts which define energy beliefs, we become able to ground subsequent health beliefs. For example, an energy experience can stimulate an individual's sense of change or personal development.

Surprisingly then, both scientific and transcendental explanations of energy were thought to impact on participants' total world-view.[4] A Rebirthing Therapist illustrates this perspective when he observes:

> For me that is what God is. It's the matrix upon which all creation is built. It is a universal force of energy. It's not separate from everything, it is everything. I think one of the best words for energy is light. People talk about light a lot in the new age or therapy and I think that quantum physics supports that. We are just solidified light; we are denser light which has slowed down enough to be seen and that is what I understand the life force to be (Anthony 1997:293-311).

A Natural Healer also links science and religion when he says:

---

[4]Chapter Eight will distinguish energy beliefs by cell group. Section 8.3 will particularly highlight Cell Groups A's distinction of energy beliefs and discuss this cell group's inclusion of both scientific and divine explanations for ill health. The incompatibility of scientific and divine explanations for health practices will also be explored.

> ...when the quantum physicists talk about the physical body they talk about it as trapped light. It is light that is slowed down to the level that the atoms are vibrating at a speed so that we can be physical. And if you speed it up and let our electrons spin then I will start dis-corporating in front of you.... So in actual fact the extension of that is to say that this [one's body] is God slowed down. This is me. This is you. That takes us to another way of looking and thinking about our experience, our existence. But most people are not ready for that so we tend not to talk about it (Himal 1996:323-362).

The compatibility between sacred beliefs and science seems, initially, to be confirmed by health participants' ability to simultaneously adopt holistic health notions as well as scientific explanations. These shared interpretations can be used to give meaning to illness experience. For example a client may be diagnosed to have low energy around their solar plexus chakra which could either be interpreted in a holistic way, one's emotions are in turmoil causing anger, fear or hate, or simply in a scientific fashion where dietary changes may be needed.

The striking feature which emerged from this enquiry was that almost all therapists and clients identified energy as originating from external forces. These external forces were either divine, universal or combined in form. Adherents' concepts of energy therefore illustrate the distinct relationship between notions of divinity, the environment and the human body. The body can be seen to encapsulate and perpetuate notions of 'sacredness' inasmuch as the human body becomes the medium through which transcendental forces can be identified (one can identify with one's spiritual guide and one's soul) and experienced (where physical sensations are believed to originate from deities). The body also becomes a catalyst in the movement of healing energy between the divine and one's environment.

5.2 Diagnosing Illness

In interviewing practitioners and clients it was important to enquire as to the specific role that energy performs in the health session. What becomes apparent is that

many adherents believe that energy forces are able to cleanse and unblock misplaced or negative energy located throughout the body's auras or chakra zones. Peters again highlights the use of language while discussing energy. He comments 'Linking energy to well-being is now part of a vernacular health language; we may lack it; have too much, or an imbalance of it. It is sometimes said to be blocked, or disordered, and we all know what it feels like "to have too little"' (1994:187). Hence, alleviating, unblocking and rebalancing energy was seen as the main function of using energy for therapists and clients.[5] Various methods were employed to diagnose energy levels throughout the body. Misplaced energy was believed to be rejuvenated using the earth or dispelled using candle light or essences. Illness, then is seen to be a malfunction of one or more of the body's multi-dimensions. A Natural Healer outlines the role of healing forces when he says:

> It's always been my belief, and the belief taught to me by my spiritual teachers and guides, that any form of ache or pain or illness originates from a mental or emotional imbalance. So if the person is suppressing anger, suppressing envy, or is depressed, or feeling insecure, or not having enough self-love, then this creates a blockage in the flow of their own personal energy. In order to have their attention drawn to it, the body's consciousness will create, will manifest a physical problem. And the physical problem will try and mirror that mental or emotional imbalance. So depending on where the pain is on the body it can be translated, it can be interpreted as a mental or emotional disorder. For instance, if people have problems with their neck it can be interpreted literally as if you're saying 'it's a pain in the neck', so it could be connected with someone around them which is a pain in the neck, who they are not dealing with, who they are allowing to be dominant over them, or who they are ignoring when they should be confronting (Luke 1997:188-217).

This interview extract also illustrates how practitioners distinguish between the many different causes of ill-health. Indeed, many practitioners believe that energy

---

[5]Twenty therapists; nine clients.

blockages of the soul constitute one of the main causes of ill-health. (See Appendix 5.1 for further details of clients' and therapists' ill-health theories). The *blueprint*, which is synonymous with the soul, is believed to have a dual role. Its first role is to record all events, actions, traumas, thoughts and illnesses throughout one's life. The record of these events are registered onto a soul template.[6] The blueprint also represents one's guide, one's perfect self. Practitioners claim to be able to tap into one's higher self by using energy. Moreover, such experiences are also believed to enable one to discover one's *path* in life and hence to discover and fulfil one's potential. This ontological perspective is reflected by a Reiki Therapist when discussing the removal of energy blockages. She remarks '... and by clearing yourself out you find actually why you're here. You find out about yourself and what your actual reason is for being here' (Emily 1997:151-153).

For one Colour Healer in particular the blueprint represents a learning experience. She says:

> So we all have the potential to be our perfect selves. Whatever that is. There is a blueprint of us which manifests on one level of the aura .. which is the perfect manifestation of the whole of us, but on a soul level. But the soul comes down here, it comes into incarnation to develop and grow. Yes. In order to develop and grow it sets itself various challenges and obstacles to learn from (Annabel 1996:190-200).

Annabel's interview extract additionally highlights the optimistic perspective of practitioners for once one's path is discovered then healing and a sense of well-being can be achieved. Direction and meaning can therefore be provided for the individual through the discovery of one's path.[7] The secondary function of energy was believed to be the cleansing and support of one's multi-dimensional body. These body images, as previously mentioned, are the auras, chakras and one's mind, body and spirit. These health participants identify healing forces as a means for purifying one's multi-

---

[6]Illnesses and traumas can also be inherited and stored onto one's blueprint as can events from other past lives.

[7]See Chapter Seven for an analysis of concepts of change and potential transformation.

dimensional body and enabling individuals to function, temporarily, free from toxins and pollutants. Pollutants are viewed as any external source of anxiety, food, or circumstance which is detrimental to one's well-being.

Different methods are employed by practitioners while summoning and using healing forces. A common feature between disciplines, however, was the employment of therapists' own bodies as conductors for healing forces. An example can be seen in Colour Healing where therapists are guided in healing through their sense of intuition, touch and sensory skills. These senses are believed to be heightened while acting as an energy channel. Alternatively, practitioners of Reiki are guided to areas of pain and illness by their communication with their spiritual masters. These practitioners often use prayer to initiate this communicative process. The Bowen Technique and Reflexology base their use of energy on a greater awareness and manipulation of energy points on the physical body. These practices are thought to bring about the body's own healing mechanisms to alleviate illness to all multi-dimensions of the body. Intuition and channelling are also incorporated into Bowen and Reflexology but are not considered the primary methods in gaining good health. A common belief shared by practitioners is the movement of healing energy descending from above and penetrating the healer's body through the crown chakra. Hence, the therapist's body acts as a catalyst in the flow of energy. These forces are believed to pass through the therapist's body, to the hands, where it is then transmitted to the client. The giving of energy can either be performed by physical touch or through aura healing (non-touch). Practitioners therefore consider themselves as catalysts, 'pure' channels in the facilitation of healing.[8] As one Reiki practitioner states:

> I'm just acting as a jump lead ... I don't *give* Reiki, my concept is that I just offer myself as a jump lead to the person I'm working on. They draw as much energy as they need. They draw it using me as a bridge between them and whatever, however they perceive that infinite cosmic battery in the sky (Suzanne 1997:271-

---

[8]Practitioners additionally believe that it is necessary for themselves to be clean (purity is achieved by all chakra zones being open and balanced) channels in order to catalyse healing forces.

278).

Healing forces are believed to penetrate and alleviate pain in body areas where chakra zones are blocked and are in a state of *dis-ease.*[9] Glik (1988) while studying healing groups encounters similar healing explanations. She says 'Most persons involved in healing agree that the healer did not heal; rather it was God, the forces of nature, or man's potential for innate healing that was catalysed by the healer' (Glik, 1988:1201).

What becomes apparent while studying therapy methods was the different focus in treating the multi-dimensional body. For example, while Reiki practitioners predominately focus on one's divine soul or higher self to cleanse impurities, Bowen Therapists and Reflexologists use energy to manipulate the physical body to initiate change. Colour Therapists tend to focus on both aspects. This is perhaps the obvious difference of these treatments; nonetheless all treatments use the common aspect of healing forces to initiate a sense of well-being.

The relationship between oneself, the environment and the divine emerged, once again, while talking to practitioners about one's multi-dimensional body. One's relationship with the cosmos and the earth is important in complementary health for the cosmos represents one of the origins of healing power and is considered the location of one's higher self or blueprint. The earth represents the rejuvenating source of all negative energy. The cosmos and earth are therefore energy polarities where humans mediate between and utilise their resources in order to heal. The physical placement of the body, and one's multi-dimensional body, between the cosmos and the earth, therefore completes the oscillating movement of healing energy. Indeed, a central premise in complementary health beliefs is the balance of all these aspects. The polarities of cosmos and earth provide the ultimate balance. One offers spiritual awakening and awareness while the other is the 'grounding' on which to base one's daily existence. The phrase which is often used by therapists while summarising this belief is, 'as above, so below'. In other words, total balance should prevail between one's body, the cosmos and one's

---

[9]The pronunciation and usage of the term *dis-ease* is significant in the research circle for it indicates a disassociation between the mind and body. The mind therefore becomes unsynchronized to the wishes of the body (or visa versa) which can consequently lead to illness.

environment. Moreover, therapists particularly identify this phrase to mean that the human form should simply be a reflection of the soul.

Terms to describe healing forces were considered important while analysing energy beliefs. In his study of new age adherents, Rose (1998) analyses the terms employed by participants concerning their concepts of spirituality. In undertaking this task Rose aimed to develop a definition of spirituality. Rose concluded that new age adherents defined spirituality as a relationship with 'an all-pervading "force", or "energy" which is seen to be sacred and which is not believed to be separate from each individual' (1998:13). While Rose's definition specifically relates to new age practices, a range of terms is shared and is employed by complementary health adherents. The analysis of terms used by therapists and clients provides an important indication as to participants' perception of this healing force. Indeed, in analysing energy terms we can discover that the majority of participants identified notions which emphasised the sacred. Although there seems to be some unanimity between terms employed, what becomes apparent is the relationship between the individual, the environment, and the universe/divine. That is, all therapists and clients seem to identify with a structure of healing forces which oscillates through these aspects. Hence, energy beliefs are seen to relate the individual to sacred and transcendental forces.[10] Thus, terms implicating *the divine* was by far the most frequently used category in labelling healing energy.[11] This category was formed to describe all terms which were used to mean a divine healing force. These terms included, Angels, God, Higher Power, Greater Force, Christ Consciousness, Father, Goddess, The Creator, Prana, Spirit, Chi, Life Force, Universal Life Force, Divine Energy, Heaven, Divine Parents, Qi, Ascended Healing Masters, and Light. The divine category is seen to include a range of religious images. Thus, it would be too simplistic to identify this belief solely in Christian terms such as God, Father, and The Creator for it can be seen that energy beliefs materialize in the Eastern Hindu sense as Prana and also in Buddhist terms such as Qi, Ki and Chi. Energy concepts are not then limited to purely Eastern notions. Beliefs in energy may once have been thought to have

---

[10]A comparison of transcendental beliefs between complementary health and Wilson's 'Probabilistic Inventory' (1991:279-281) can be seen in Chapter Nine.

[11]Seventeen therapists; twelve clients.

originated solely in the East but have now emerged from all directions. Energy beliefs in complementary health today can be seen as an almost pantheistic notion whereby ideas and beliefs are shaped according to one's own personal perception and healing experiences. The manifestation of life force can, therefore, take on different guises which are then personalised according to the individual. This perhaps becomes the attraction of such a belief inasmuch as there are relatively few rules imposed on the recipient. Faith is gained by experience and meaning is provided to many daily events according to therapists' interpretations. Even characteristics of worship can be identified while praying and giving thanks for healing forces. The emergence of worship also takes form in ritual practices when therapists burn essences, light candles and on some occasions chant. The fact that many participants choose to name energy in supernatural terms was somewhat surprising considering the varying views of the content and origins of healing forces.

Although divine intervention is seen as the most popular interpretation of healing forces one additional term arose to describe healing energy. The term *Healing Potential Energy* was also used to symbolise an energy force which originates from within oneself and which can be mobilised by an individual's own healing process. All of these responses originated from adherents who advocated physical treatments. Hence, a Bowen Therapist comments: 'It's believed that we can have the potential to heal ourselves and that's what we're doing. We're stimulating these long forgotten memories for the body to get on and heal itself .. You're tapping into their own healing energy, healing potential' (Claire 1996:79-100).

5.3 The Review of the Body

The effects of energy in healing are also believed to be similar regardless of therapist/client distinctions or therapy practised. The most prominent influence of energy on everyday life was through its ability to initiate a change of perspective for health adherents.[12] Adherents believed that changes in attitude, behaviour towards the body, and a modification or change in lifestyle and world-view perspective, were the

---

[12]Fifteen therapists; seventeen clients.

consequence of attending health sessions. A Colour Therapist highlights these potential changes when she says: 'It has very far reaching effects, actually, sometimes. It's like a seed can be sown and even if they don't react there and then, it will later. But for some people healing has the most profound effects on the way they think and the way they act thereafter. It changes their lives quite dramatically' (Ann 1997:280-286). A second Colour Therapist draws attention to prospective change and the potential cause of lifestyle dissatisfaction when she remarks: 'More people are looking at their lifestyle. People are looking for more meaning in their life ... I think they are a bit disillusioned with their lifestyle and a lot of the work that they do' (Lisa 1997:367-371).

The implications of lifestyle and world-view perspective are essential in constructing and maintaining a sense of identity and ontological security for complementary health adherents. Due to complementary health's ability to focus attention on one's body, lifestyle and world-view we are then able to study the influence of these health beliefs on one's sense of self and self-identity. Giddens particularly draws attention to the relationship between one's body and one's lifestyle when he discusses the construction of a modern identity. Giddens begins his discussion by stating that: 'What might appear as a wholesale movement towards the narcissistic cultivation of bodily appearance is in fact an expression of a concern lying much deeper actively to "construct" and control the body. Here there is an integral connection between bodily development and lifestyle' (1991:7). He continues by arguing:

> Body care means constantly 'listening to the body', both in order to experience fully the benefits of good health and to pick up signs that something might be going wrong. Body care delivers 'body-power', the increased capability to avoid serious illness and the capacity to deal with minor symptoms without drugs. Bodypower can help a person retain, and even improve on, her and his appearance: understanding how the body functions and closely monitoring this functioning in an alert fashion keeps a person's skin fresh and body slim (1991:102).

Giddens develops his argument by remarking that it is by means of this

continuous body awareness that individuals are able to have a 'plurality of choice' (ibid) in lifestyle options. Consequently then a lifestyle 'involves a cluster of habits and orientations, and hence has a certain unity - important to a continuing sense of ontological security - that connects options in a more or less ordered pattern' (1991:82). In utilizing healing forces, then, health adherents are thought to develop greater body knowledge and hence, greater self-knowledge.[13] Indeed, the adoption of energy beliefs and practices (prayer, worship) have potentially far reaching consequences for participants' sense of self as these practices are often performed regularly throughout adherents' daily lives. Hence, these practices impact on adherents' routine actions and behaviour. In addition to body, lifestyle and world-view perspectives, a number of participants also believe that energy encourages a sense of heightened body awareness.[14] Such awareness was thought to influence adherents' perceptions of their own bodies, e.g. diet, nutrition. McGuire and Kantor highlight this theme while discussing the transformation of the self. They say:

> Many alternative healing approaches encourage a reflective and reflexive attitude towards oneself, one's body, and emotional and social life. They affirm the right and power of the individual to choose the quality of experience of the body and emotions, to choose how to achieve health and healing, to choose and assert identity (1988: 257).

The body is, therefore, scrutinized and assessed by refocusing on the habits, beliefs and attitudes towards the body. It is through this re-evaluation that one's health status is reviewed. This constant self-evaluation is often tied to adherents' sense of change and prospective development. Specifically, Reiki therapists are seen to highlight the decline of client addiction habits while using energy in treatment sessions. These practitioners particularly note the adoption of beneficial activities, for example exercise, while noting the reduction of harmful habits, for example smoking and alcohol. This

---

[13]See Chapter Six for further issues relating to ontological security and lifestyles.

[14]Three therapists; three clients.

decline of addiction habit is believed to be caused by the energy's ability to purify the body. A Reiki practitioner observes the decline of addictive habits when she notes:

> So eventually people do tend to moderate their lifestyle; they change things, they develop different interests, interests which may be less destructive. Maybe they get environmentally aware. It's private changes that people do go through; they seem to start trying to solve their own immediate problems, physical problems, and as a result of that they start being better people (Suzanne 1997:668-776).

In discussing healing energy with practitioners and clients what emerged was a distinct belief regarding the relationship of energy between the earth, the body and the cosmos. As previously discussed, the body is identified to be the medium between the earth and the cosmos. The body is therefore seen to mirror not only the strengths and weaknesses of the surrounding environment but also transcendental forces emanating from the cosmos. The interdependence of this relationship is observed by a Reflexologist when she notes:

> ...we have energy on a cosmic level. That energy creates universes and planets and stars. They all form through energy.... Breaking that down and coming to the human body I think we have ... this is my thinking and it may be wrong but I think ..what exists outside of us, externally as a whole, exists within the body. I think the body contains the whole universe. The whole universe is mirrored within the body but perhaps on different levels (Samantha 1996: 296-308).

This symbolism again highlights the relationship of oneself to society. The body then becomes a reflection of wider ills. As such there is an identification of oneself in relation to society. One's body image and portrayal of oneself, one's role and one's deeds are all recognised as factors that can be changed and hence can have an influencing effect on the wider environment. This discussion will be explored later in this chapter.

5.4 Faith in Healing

Therapists believe that healing can be preformed on individuals, animals, plants, houses and geographical areas such as continents. Healing has become a preoccupation at all levels in the search for a happier daily existence. In order to discover that well-being one has first to change or improve factors such as behaviour, attitudes and belief. Belief is the cornerstone to complementary health and healing. Therapists need to have faith in the therapy they practise and clients need at least some faith in the treatment and their therapist. Practitioners also deemed it necessary to be open and have some understanding, of the beliefs and practices involved in the health session. This is considered necessary if illness alleviation is to take place.[15] Throughout the therapist interviews, energy beliefs played a significant role in the practice and philosophy of each treatment. Indeed, the importance of these beliefs, in health sessions, therefore, led to questions regarding the necessity for adherents to believe in healing forces. Moreover, interviews also enquired as to whether the presence of energy beliefs had any impact on the healing results. Interestingly, one third of therapists thought that they themselves *did not* necessarily have to believe in the ideas behind complementary health to facilitate healing. Nonetheless all practitioner respondents highlighted the importance of commitment and the adoption of a reflexive approach to their work. These therapists were all particularly concerned with defining health practices not so much in terms of a specific belief system but more in terms of whether the treatment is having a beneficial effect. The following two interview extracts highlight practitioners' concern with viewing complementary health practices as a belief system. The first extract illustrates a Reiki therapist's view that experiential belief occurs independently of ideological or religious belief. In other words, experience of a transcendental force prevails over the notion of 'belief'. The second extract originates from a NFSH Healer, who defines

---

[15]All therapists interviewed believed in health energy as a contributory factor in their health practice. Although this interview sample may not be representative of all practising health therapists today, the interviewee sample represents the proportion of practitioners which did rely on the summoning of healing energy. Indeed, it can be argued that as the Healing Centre's philosophy relied on a holistic perspective of human ill health then therapists and indeed, clients, would perhaps be more inclined to adopt the centre's philosophy, and hence energy beliefs.

religion not so much in terms of its belief content ('its all one at the end of the day' 1997:808-810), but rather by its location and structure. Hence Madeleine advocates that all beliefs have similar belief content and therefore can only be differentiated by how the faith is worshipped and performed. They comment:

> No. You don't have to believe in it at all .. it's not a belief system, it's not a cult. It's nothing like that, you don't have to believe in [it], all you have to do is know that it works. It's like when Jung was asked if he believed in God. He said 'I don't believe in God. I know'. You know of the existence of it because you can feel it. (Dawn 1997:1039-1049)

> I'm not really religious. I know that if I want to pray I don't have to go to church to do it. I pray here if I wish. It doesn't matter what religion you are anyway, it's all one at the end of the day. (Madeleine 1997:804-810)

The connection between experience of treatments and faith seems to be an important relationship in healing. Faith in the treatment is only acquired through direct experience of healing energy. The remaining therapists all identified the necessity to believe in healing forces. These practitioners discovered these forces through their own spiritual and healing experiences.[16] McGuire and Kantor (1988) mention belief and experience while discussing how healing 'works' (1988:187). In their discussion they draw attention to the efficiency of clients' healing through reinterpreting life events and 'by giving believers cognitive tools for managing the illness experience' (1988:187). Practitioners therefore promote faith in the effectiveness of healing energy, and its supposed influence on the body, in order to offer meaning to clients' illness experiences. Hence, enquiry into therapists' beliefs, into healing energy, showed that therapists thought that their practice was sustained by a *degree of faith*. This belief manifests itself in the therapist's ability to channel energy while having faith in their own intuitive healing skills. Another expression of practitioners' beliefs emerged. This was considered to be their relationship with divine healing forces, i.e. angels and guides. A Rebirthing

---

[16]See Appendix 4.1 for a table illustrating Client Healing Experiences and Appendix 7.5 for a table illustrating Therapists' Skills.

practitioner highlights the necessity of faith in healing when he says 'When Jesus said "faith can move mountains" I think he meant that literally. It's not a metaphor. Just look at what belief can do. ... I think it does make a difference' (Anthony 1997:420-426).

Similarly, therapists in the main thought that *clients did* need to believe, to some extent, in the use of energies in order to receive healing. These therapists emphasised the importance of clients' willingness to be open about the treatment and the surrounding ideas. Clients were also thought to demonstrate a level of willingness in order to develop themselves physically, mentally, emotionally and spiritually. Therapists drew attention to clients' receptiveness to change by the clients' ability to be open and flexible about their beliefs. Clients, therefore, need to be sympathetic to the notions in complementary health in order to gain fully any benefit from the therapy. These therapists particularly drew attention to energy beliefs and emphasised their clients' need to understand the concepts involved in health sessions in order for recipients to come to terms fully with their health problem. It is through this process that meaning is given to many illnesses. However one third of therapists mentioned that *clients do not* necessarily have to adopt beliefs in energies or indeed even have to know about healing forces in order to receive healing. These practitioners emphasised the treatment's ability to work regardless of belief. A few practitioners also claimed to see a distinct difference between the health of those clients who fostered the ideas and those who did not. A Body Worker summarizes this distinction when she says: 'I found that with my work I found that the person who wants to shift their energy or heal themselves or get better has a higher percentage of achieving that, than a person who comes in and asks you to fix them up' (Claire 1996:242-247).

This enquiry developed by asking clients whether they themselves necessarily have to believe in healing forces in order to receive healing. From the responses given almost one half of clients thought that beliefs in energies emerge automatically after healing and energy experiences. This perhaps gives an indication that clients themselves are willing to take on ideas once they have experienced some form of change in their health status. Hence, the significance of experiential belief emerges once again, while discussing clients' faith in energy. As one NFSH client notes:

> ... once you have freed yourself from other restrictions, and the healing process

has begun, then you begin to experience. It convinced me, really, that these energies are there and that they are real. And once we actually accept that, it can have such a profound effect on you... It is just an amazing experience and I now lap up that feeling when I can get it (Julie 1997:185-194).

What particularly emerges while studying energy beliefs is the practitioner beliefs that they are enhancing participants' concepts of their physical, mental, emotional and spiritual well-being.[17]

Although therapists tend to shy away from viewing complementary health and healing as a belief system, it does seem that therapists (and occasionally clients), develop a world-view based on their ideas and experiences of these divine forces. As we have previously discussed in Chapter Two, regarding definitions of religion and complementary health and healing, we can see that although beliefs in healing forces are individually interpreted[18] there does seem to be some degree of commonality between therapists' and clients' notions.[19]

5.5 Healing Energy and Life Journey

A prominent factor shared by all health participants is their potential ability to change and to transform their perception and sense of self. Therapists, particularly, note

---

[17]The consequence of such revisions is, of course, the review of one's sense of self-identity.

[18]Beliefs in energy are initiated from a relative standpoint inasmuch as one's illness, or health session experience have specific spiritual interpretations. These illness and healing experiences are frequently interpreted by the therapist. This raises questions of therapists becoming 'gurus' or at least partisans or interpreters of higher meanings over and above *lay* clients. A contradiction occurs when reviewing complementary health's philosophy as these practices do not advocate a health *professional* but rather co-operation between two equal parties, the practitioner and the client. Equality between the practitioner and client could however never be totally achieved due to the interpretive role of the therapist.

[19]One commonality, previously discussed, is adherents' sense that energy is the medium through which one can bridge the gap between oneself and the divine. Hence, adherents believe that the divine can be reached or at least experienced through the forces of healing energy.

the connection between concepts of change and one's life path or journey.[20] The majority of therapists[21] believed that changes can take place for the individual as a result of the healing forces' ability to connect and communicate with an individual's blueprint or higher self. That is, through contact with healing forces, adherents are thought to be able to discover their role in this lifetime. Consequently, then, adherents' sense of self-identity is heightened by their perceived awareness of their lifetime purpose. Indeed, while energy communication encourages participants to discover their path in life it is also believed to alter lifestyle and world-view patterns. A Colour Healer briefly remarks on one's potential lifestyle change when she says '... as I say, the more you get into it the more it then does effect your path and the way you live and everything' (Ann 1997:858-860). It is the recognition of one's role and path in life which enables a substantial change to occur for the individual. Van Hove encounters the concept of one's individual path while exploring the new age. She says:

> In the Networks the autonomy of the individual is an absolute value and everybody is assumed to find his/her own 'path'... Professionals do not say they are spreading the truth, they say they want to give people the opportunity to experience the value of this particular discipline. Anybody can drop in and let that discipline become a part of his/her own spiritual path (1996:3).

Communicating with healing forces was, initially, seen to impact on adherents' sense of awareness and lifetime purpose. These factors are consequently linked to the second substantial form of change, these being world-view and lifestyle perspectives. The remaining ten therapists recognised that simple changes in lifestyle could have enormous effects on one's perception of the world. Changes in thoughts, attitudes and even perceptions of one's own body all encourage an alteration of one's personal perception and view of the world. These changes were all thought to inspire positivity and the furthering of one's personal development. A Bowen Therapist draws attention

---

[20]This journey is naturally seen as the journey of life, beginning at birth, or a new incarnation and progressing throughout that lifetime.

[21]Eleven therapists.

to basic lifestyle changes, and the influence of these on the individual when talking about a male client. She says: 'I think if you can get someone who realizes the benefits of their own lifestyle .. For example he gave up the coffee and he gave up smoking and the drink. His body changed. His mood swings changed. His energy level changed. You know, all for the better' (Claire 1996:301-308).

Clients' concepts of change cannot so easily be distinguished into categories. Clients interpret change in a much more fragmented way insofar as they interpret their sense of change not only through their ability to modify lifestyle, world-view and body perspectives but also in how these factors can influence the individuals which surround them. Indeed, these changes do not automatically mean that one's whole sense of self is irrevocably changed, more that subtle changes can have long lasting and gradually momentous influences on how individuals identify with their sense of self and how they interact with their social surroundings.[22] Although beliefs in energy were thought to promote various forms of change, clients have realistic perceptions as to the degree of possible change available to them. Clients are additionally aware of the limitations to the treatment.

What emerged in studying the consequences of healing energy was adherents' beliefs regarding the social and even global influence of this healing force. Energy for the majority of therapists and clients was thought to penetrate those people closest to them. Therefore partners, siblings, friends and even work colleagues[23] are all seen as recipients of healing forces. It is through this perspective that therapists, particularly, identified themselves as healing the world around them. Healing oneself becomes synonymous with healing the world as family, friends and one's society are all linked to an interdependent flow of energy. Benoist and Cathabras identify a body-world link when they say:

> ..through the body, a person is in tune with the world. The construction of the universe reciprocates an echo of what composes the body. But the body does not

---

[22]See Chapter Seven regarding notions of change and an exploration of health adherents' concepts of self-identity in relation to their social surroundings.

[23]Twelve therapists; seven clients.

> merely symbolize the world; it is made of the same substance, and the order of the world manifests itself in the body and directs it. Even here, the person no matter how incarnated it may be, is not entirely confined to his body (1993:859).

Adherents therefore relate their body to the surrounding environment. In doing so participants believe they are themselves part of the natural world and can consequently influence its development. The body is then seen to be influenced by one's environment as well as those individuals which constitute one's social surroundings. Moreover, adherents believe that both positive and detrimental factors can be communicated via one's own body.

Clients are specifically concerned with the impact of their own sense of change on their partner, family and friends. Hence as individuals change they become more responsive to those people nearest to them. Self and societal change were therefore seen to be interdependent. Interestingly, both clients and therapists specifically mentioned societal and global change on a mass scale. This is illustrated by a Reiki practitioner's comment:

> ... it's almost like there's a gathering group consciousness that we need to clean up our act, we need to clean up our environment. To clean up the way we interact with our fellow human beings or with other life forms on the planet. It's almost like when that comes to some sort of critical mass, maybe something is going to happen (Suzanne 1997: 864-881).

Societal and global changes are regarded as major consequences when utilizing healing energy. A second Reiki therapist mentions this theme when she remarks '.. we're heading towards the year 2012. A major change from that point .. It's another coded point when something will happen' (Dawn 1996:1418-1421). This societal change will be marked by coded days which have special energetic significance for society: 11th day of the 11th month at the 11th hour.[24] These coded days will mark the presence of societal energy surges. These surges are believed to cause social change that will lead

---

[24]It is a coincidence that one coded day falls on Armistice Day.

to the next stage of our evolution. The significance of coded days was recognised by Lyon while discussing the New Age. He says:

> As for New Age, while some devotees apparently spend little time thinking about it, a strong thread of hope for the coming 'Age of Aquarius' is still in evidence. At 2000 locations around the world at 11p.m. (GMT) on the 11 January, for instance, New Agers joined forces to 'open the door to global harmony' (1993:121).

5.6 Conclusion

To reiterate then, healing energy can be defined as an energy flow which is seen to originate from external and/or divine sources. The principal use of healing energy is to facilitate healing through the cleansing of the body's multi-dimensions: chakras, auras, mind, body and spirit. Although the summoning and use of energy is different between therapy styles all practitioners used energy as a means to interpret body ailments and to assess an individual's health needs. In interpreting the body's energy level adherents are directly offered meaning and explanations for illness experiences. To acquire good health therefore, participants are required to have a free flowing energy system throughout their entire body. Energy beliefs additionally highlight the relationship between oneself, one's social surroundings and even the divine. Hence, beliefs in energy are seen to be a direct means through which individuals are able to interpret not only aspects of themselves (through the re-evaluation of one's health needs, one's sense of identity via the review of one's body, lifestyle and world-view perspectives) but also aspects relating to one's surrounding environment (family, friends and work).

The study of energy beliefs, in a healing environment, can be seen to offer a significant insight into a contemporary belief system which is available to everyone, regardless of conventional religious belief. Indeed, the significance of energy beliefs can also be paramount as notions of energy can become relevant to *everything* one does. As such health beliefs are often promoted to offer meaning and guidance to everyday events. Throughout this analysis it can be seen that complementary health and healing ideas are very important, firstly to the structure and therapists' implementation of the treatment,

secondly to the therapists themselves, and thirdly to the clients, for energy beliefs offer participants a perspective through which to understand and make sense of their health and their wider social surroundings. What becomes apparent from these interviews is a subtle reflection of ideas between therapists and clients.[25] The responses of adherents therefore hint at some degree of belief transference between therapists and clients.

Therapists ultimately offer energy beliefs as a perspective to interpret illness. This simultaneously aims to alleviate any physical ill health problems as well as directly or indirectly bringing about a greater awareness of one's spiritual self and self-identity. In contrast to this, although therapists aim to promote a sense of empowerment in their clients they also seem to impose a belief system which implies causation, self-responsibility and experiential beliefs. As such, beliefs in healing energy can promote, to some extent, an almost fatalistic interpretation of illness and events as energy communications are considered to be messages from oneself, from one's social surroundings and even from the cosmos. In relation to the individual, energy experiences were thought to encourage participants to recognise their health needs, to identify their strengths and weaknesses and place an emphasis on self-transformation through positive action and behaviour. The consequences of such actions are thought to offer direction and sometimes even hope to those who seek physical, emotional, mental and spiritual well-being. It is in this environment that many health practitioners and their clients identify and embrace beliefs of personal, social and even global change in order to facilitate a sense of wider well-being. Healing energy in this chapter can be evaluated as an important factor for health participants in understanding concepts of health spirituality and their own relationship with the divine. It is through these notions that many adherents believe they have found meaning and a sense of direction in their lives. Energy in complementary health is a life-giving and a life-taking force. Energy provides the direct experience with an ultimate power, whatever therapists and clients choose to name it. These health beliefs, therefore, enable adherents to come to terms with their health problems and ultimately identify with their own health spirituality. Individuals are then able to feel a personal and very specific life meaning.

This chapter has aimed to highlight how energy beliefs are a mechanism through

---

[25]However, as this thesis does not aim to be quantitative but qualitative in form, a caution should be noted as to the extent of this transference of belief.

which health practitioners and clients relate to contemporary concepts of the divine. By studying these beliefs it has become possible to outline the contributory beliefs which assist in the formation of our sense of self-identity. Chapter Six will focus, more specifically, on one's self-identity by discussing lifestyle and world-view perspectives.

CHAPTER SIX

THE BODY, LIFESTYLE AND WORLD-VIEW PERSPECTIVES

While reviewing the codewords present in the WINMAX Pro analysis it became apparent that practitioners and clients view body, lifestyle and world-view perspectives as relatively important in their interaction with complementary health practices. The table below illustrates the coded segments of ethnographic work relating to body, lifestyle and world-view perspectives. The first column indicates the number of interview segments attached to the codeword. The second column indicates the total number of line lengths allocated to each codeword. Primary analysis took form by reviewing all text segments (regardless of value/weight allocated to each coded segments) within each code word. Secondary analysis involved analysing data through key-word-in-context, therapist/client group distinctions and search for recurring themes through all text segments by performing and retrieving search strings (groupings of keywords). The data from this table is extracted from the WINMAX Pro theme tree, Appendix 3.8.

Table 6.1 Coded Segments of Body, Lifestyle & World-View Perspectives.

Codeword	Number of segments attached to codeword	Line numbers attached to codeword
Body Perspective	51	819
Lifestyle and World-view Perspectives	95	1231

These coded segments were of considerable importance while reviewing therapists' and clients' beliefs in complementary health and healing. This is indicated by the frequency of relevant coded segments attached to the theme tree.

The issues of body, lifestyle and world-view perspectives were originally seen to emerge while discussing beliefs in healing energy. Body, lifestyle and world-view perspectives were seen to accompany energy beliefs insofar as healing experiences were seen to provoke body, lifestyle and world-view modifications. These factors are therefore regarded as one of the principal consequences of participating in complementary health therapies. Moreover, the review of these issues within the therapy session directly impact on one's sense of self-identity. To begin then, one's self-identity is formed by the

accumulation of several core aspects in one's life.[1] The initial factor which shapes one's sense of identity is, of course, one's body. Analysis of the body is therefore the beginning point, within the health session, in assessing one's sense of identity. Hence, body imagery, for health participants, emerges as a central factor to beliefs underlying one's self-identity. As we have previously seen throughout Chapter Five health participants, whether therapists or clients, identify with certain images of the body. These body images (chakras and auras) subsequently ground one's understanding of one's body and can consequently lead to the review and modification of both lifestyle and world-view perspectives. To explain then, the assessment of one's body is the initial process for one's introspective analysis and the subsequent grounds through which one can identify required body, lifestyle and world-view changes. The assessment of one's body, lifestyle and world-view perspectives consequently shape what the adherent knows about the world and aim to clarify and to 'make-sense' of daily events, circumstances, illnesses etc. The health session is therefore the forum in reviewing these factors. Indeed, the review of oneself in the therapy session can additionally be seen to organise the perception oneself while serving as a basis for further action and belief. As such, to take cognizance of one's body, lifestyle and world-view inevitably leads to an awareness of one's identity. This chapter will begin by exploring health participants' view of the multi-dimensional body (chakras and auras) and argue that these concepts lead to greater self-awareness. The process of self-awareness is initiated by questions which health participants ask themselves throughout the course of their treatments, and by specific interpretations of the body. Section Two will therefore highlight the role of self-awareness and question its impact on the various existential issues raised by Giddens. Hence, the process of self-identity will be analysed in relation to Giddens's notion of ontological security and more specifically Giddens's concepts of threats and subsistence which constitute one's identity. Section Three will continue to discuss the threats to one's sense of identity by examining the effects of illness on one's sense of stability and control. Section Four will concentrate on therapists' and clients' concepts of lifestyle and world-view perspectives and examine the impact of these issues on health adherents' lives. Finally, Section Five will summarize the

---

[1]As previously discussed in Chapter Four illnesses and difficult life events are two factors which motivate a review and re-assessment of lifestyle habits, attitudes and body perspectives.

key factors discussed throughout the chapter.

6.1 The Multi-dimensional Body

Health adherents are initially concerned with illness, body pain, physical awareness, self-reflection and even attitudes towards one's body. In order to assess these aspects complementary health adherents view the body as a multi-dimensional entity. The multi-dimensional body is defined using a variety of body images. The most frequently used images were the chakras and auras. These images advocate a view of the body which transcends the physical existence of the individual. Hence, the body is believed to be present in the physical world, and yet, also to exist in a number of other body dimensions including the emotional, mental and as a spiritual[2] entity. Each dimension is able to experience illness. (See Chapter Five, Section 5.1 for a brief summary of chakra and aura body zones.) In the same terms these body dimensions can be alleviated from suffering by applying complementary health practices. The immediate implication of the multi-dimensional body perspective is body imagery. Within complementary health the body's ailments can be diagnosed by interpreting the chakras and auras which are believed to constitute the body.[3] The body, within complementary health, can therefore be seen to exist in a variety of dimensions. A second commonality between body images is the divisions which are made to the constituent parts of the body. As such each chakra zone and aura layer is believed to contain specific qualities which are believed to transmit certain health messages to the individual. For example the reading of the etheric aura surrounding an individual can mean a diagnosis of high or low energy (and hence the assessment of one's level of well-being), and reflect current emotions and upsets while the third eye chakra can represent more specifically problems such as tension, eye problems and headaches. Thus, adherents believe that they are able to review their health status by interpreting these multi-dimensional body perspectives. On closer inspection these diagnostic tools are media for the creation and sustainment of participants' beliefs insofar

---

[2]'..the term "spiritual" ..is a concern which goes beyond the material' (Hamilton et al 1995:498).

[3]Each therapy has their preferred method and body image for interpreting illnesses.

as they provide explanations for physical ailments as well as offering the means to enquire into their self-identity. The interpretation of one's body (via multi-dimensional body perspectives), therefore becomes inevitably linked to concepts of self-identity as both the body and one's identity have 'to be created and more or less continually reordered against the backdrop of shifting experiences of day-to-day life' (Giddens 1991:186). Giddens goes on to say '...the body is not just a physical entity which we "possess", it is an action-system, a mode of praxis, and its practical immersion in the interactions of day-to-day life is an essential part of the sustaining of a coherent sense of self-identity'(1991:99). Hence self-identity and body perception are co-dependent and potentially self-perpetuating.

These body imageries are also used to interpret one's wider, personal and social circumstances. Although the body is initially believed to communicate certain messages to the individual, the body is also believed to pick up messages from one's environment. The communication of societal messages, via one's body, is described by a Reiki client when discussing the underlying causes to accidents and illnesses. She begins by outlining the interpretive process of societal messages.[4] She says: 'It's getting to the bottom of why they are causing the car to crash or leg to break. Accidents happen to them. [Complementary health is about] understanding what their bodies are trying to tell them or what their surroundings are trying to tell them' (Elizabeth 1997:387-399). This interview extract illustrates how health participants predominately use multi-dimensional perspectives to give meaning to their illness or personal circumstance. This meaning is ultimately deciphered from messages originating from one's body. A NFSH practitioner highlights the consequences of interpreting body messages when he remarks:

> ..instead of thinking 'oh that hurts I'll have to go to the doctors' they think 'oh so what does that mean?' 'What is that trying to tell me?' So it often does lead to change in perception.... So it's to try to get them to perceive themselves and perceive the world around them in a complete broader perspective and through that broader perspective to have more control over their life (Luke 1997:490-496).

Luke outlines the interpretive process of illness as a means to question reflexively

---

[4]For further discussions of self to society links see Chapters Five & Seven.

one's needs, one's attitudes and indeed one's surrounding environment. Freund and McGuire discuss such interpretations of illness by saying: 'The interpretation of illness is an ongoing process. People reinterpret their situation at various stages of their illness. They look back at earlier experiences and actions, and reinterpret them to make sense of subsequent events and new beliefs' (1991:150). The individual is therefore seen to be in a constant process of body assessment. This analysis subsequently encourages a perspective that one's body is a continually changing entity. Hence the most prominent understanding of the body, particularly by therapists, was in evolutionary terms. While discussing body representation within Buddhism, Mullen (1998) draws attention to the composition of the body and how this image constantly changes. He says:

> A key issue is the idea that everything can be viewed as forms of energy. Not only reduced to forms of energy but also transformed from one type or modality of energy to another. Notions of solidity are thus counterbalanced with ideas of change and mutability. The attempt is always to move away from the fixidity of the normal mind and its attitude towards the world. This is also reflected in the description of the composition of the body. The Buddha is seen to be physically present but not solid. To be of light and similar to a rainbow, to be luminous but not solid... There are then elements in this practice which attempt to undermine our notions of a fixed and rigid self-identity, to show rather that it is changeable, mutable and constantly shifting. (1998:6)

Mullen's conference paper entitled 'Illusory Bodies' can be seen to illustrate how multi-dimensional body perspectives impact on one's sense of change, and also the consequences of these beliefs on one's sense of self-identity. As such, the awareness of different body perspectives (chakras) contribute to the recognition of required body changes. These changes subsequently impact on one's self-identity.

Reiki and Natural Healing therapists were particularly concerned by how the body represents the essential evolutionary, progressive development of man in time and space. To explain, the body is believed to represent different stages of life and different developments achieved. The body illustrates this evolutionary progression by means of

these multi-dimensional perspectives. The body's chakras and auras are therefore seen by therapists as useful tools for understanding, not only one's current physical health at one moment in time, but also the means to discover one's path to prospective development. Space is present due to complementary health's ability to place each person into a holistic (individual, social and global) framework. Each individual is therefore present in the health session as a unique physical entity placed in context to one's surroundings. The body, although initially seen as one entity, is therefore interpreted by health participants to consist of multiple dimensions and qualities. (See Appendix 3.7 for a discussion of body perspectives in a Reiki Healing workshop). Such body perspectives initiate a process of internalization whereby participants are offered not only meaning to their illness but also answers to specific life events. Adherents therefore identify each individual as being a unique social system which is principally concerned with his/her own progressive development.[5] Indeed, this development is initiated by the body's ability to interpret personal and external events.

A Natural Healer outlines his belief regarding the body's state of constant assessment and development when he describes the chakra zones.[6] Himal additionally highlights various external factors (the divine, money) which impact on one's evolutionary development. He comments:

> If you think of the crown [top of head] as the will of God. If you think of it like that then the third eye [forehead] is the place where you concentrate the will, and the throat is the expression of yourself, and the expression of the divine. The heart is the unconditional place of love, which is divine love as well as personal love, and love for yourself, and your self-esteem... The solar plexus tends to be about intelligence and sense of self and personal power. The sexual chakra tends to be bisexual energy, any power there. That's free flowing energy and getting expression of yourself as a creative being at that level. It also about gut level

---

[5]See Chapter Seven for issues related to change.

[6]The chakra zones can, as noted previously, be seen as an hierarchical and evolutionary scale. Individuals develop and ascend this scale once certain levels of self-discovery have been achieved.

> reactions. And the base chakra is about survival, getting food and enough money in the bank or whatever .. So that is one level where they [the chakras] operate and where you are as a human being in your evolution... (1996: 551-622).

This interview extract therefore illustrates how the body is viewed in a multi-dimensional way which allows, particularly, therapists to understand both themselves and the world around them. However, although the body is seen in evolutionary terms, where the body is seen as a developing social system in itself, the body is also seen to represent the development of humankind. Human evolution, like the body, is also distinguished into different levels of development. These levels of development are identical to the body's chakra system. The chakra plan then represents the evolution of man from the beginning of time (represented on the body by the base chakra) to the future spiritual existence to which human kind will eventually develop (represented on the body by the crown chakra). The development of human kind is then distinguished into seven stages of time. As with the body's evolutionary scale, human evolution is believed ultimately to strive for spiritual enlightenment. A Natural Healer illustrates the prospective development of man when he comments:

> Humanity as a whole is actually coming up to the solar plexus level but if you think of that as a power level, like 'get what we want and to hell with everyone else'. That has been going on for a long time. But now most of us are moving up to the heart to say that the values of ourselves are much more important. The value of love and the value of being able to have the divine flow through us. Spiritual values are more important. So humanity as a whole is beginning to move up here [to the heart chakra] and those of us that are pioneers are way up here [indicating the throat chakra], we've done this stuff and most of us are operating on the throat. But that is another way of saying that we are now able to express the divine better and our creativity and our expression. We don't have to worry about survival stuff or about what is going to happen to us. We take it for granted anyway so we are not turning our attention to power issues, more to power sharing so that we can begin to think of ourselves as equal first. And then as your energy rises then

obviously you're beginning to get more spiritual attention (Himal 1996:224/240).

This extract highlights how one's body is linked to time and human evolution. Such beliefs are important for practitioners for it is the means through which self and social identification can be improved and functional frameworks of development can be created.[7] Giddens discusses everyone's ability to create a framework of development in his discussion of ontological security. He says:

> All individuals develop a framework of ontological security of some sort, based on routines of various forms. People handle dangers, and the fears associated with them, in terms of the emotional and behavioural 'formulae' which have come to be part of their everyday behaviour and thought. (1991:44)

By adopting certain body perspectives then individuals are able to retain a sense of ontological security by developing coping strategies. Coping and managing stress, painful events, family matters by means of developing one's own action plan all contribute to one's sense of control. Indeed, potential plans for development are also fundamentally empowering for it is believed that they can act to promote self-improvement, and can possibly limit the fear associated with health problems. Freund and McGuire highlight the ability of illnesses to threaten one's sense of control when they say: 'Illness disrupts the order of everyday life. It threatens our ability to plan for the immediate or distant future, to control, and to organise. Even a relatively minor malady, such as a head cold, can disturb the order of daily life' (1991:137). Health adherents are therefore seen to reduce the threat to their health status by creating action plans which are designed to manage and control their illness experience.

---

[7]For example, adherents are taught to assess their needs at one moment in time. Strategies are then devised to enable adherents to fulfil these current requirements.

6.2 Existential Issues

Awareness of one's body, and the self-knowledge that adherents gain through participating in complementary health techniques, can particularly be analysed in relation to Giddens's notions of ontological security and self-identity. According to Giddens, ontological security consists of four specific existential questions which are asked while enquiring into life meaning. For Giddens, an understanding of existence itself (1991:48), the exterior world and human life (1991:48), other persons (1991:50), and self-identity (1991:52) are all aspects which must be queried in order to have ontological security. These four existential issues are seen as the essential features present in achieving a sense of ontological security.[8] Giddens comments that: 'To be ontologically secure is to possess, on the level of the unconscious and practical consciousness, "answers" to fundamental existential questions which all human life in some way addresses' (1991:47).

Giddens illustrates the first of these existential issues by outlining the gradual awareness and development of a child, that is, the discovery by the child that she is conscious and part of the world. An 'understanding of existence itself' (1991:48) is therefore grounded in awareness and the 'nature of being' (1991:48). Principally, health adherents can be argued to be searching for individual meaning by means of interpreting the body, lifestyle and world-view. As such participants hope to gain greater self-knowledge by enquiring into all personal, social and lifestyle issues. Indeed, the discovery of one's 'nature of being' may well be originally created in childhood but such enquiry can begin at any time of crisis.

The second existential issue to be raised concerns the relationship between one's environment and human life. That is, one must understand that we, as humans, are unique and different entities, but are, at the same time, part of a wider social system. Giddens draws on this apparent contradictory relationship of 'human being to nature' (1991:242), by saying 'we are of the inanimate world, yet set off against it, as self-conscious beings aware of our finite character' (1991:49). In examining oneself, within the health environment, one is encouraged to create a sense of order and control to one's life. These

---

[8]Ontological Security is defined as 'a sense of continuity and order in events, including those not directly within the perceptual environment of the individual' (1991:243).

strategies in turn have repercussions on one's approach to the exterior world. What becomes apparent is not so much the contradictory relationship of humans to nature but rather health adherents' ability to minimize any exterior threat, which this environment may create, to one's sense of order. In contrast, health participants view one's relationship to nature as harmonious for one is seen to be part of the wider social system.[9] One's awareness of our 'finite character' is relevant, then, if beliefs are held regarding the separation between ourselves and the natural world. Armstrong, while studying holistic medicine, emphasises the interdependent bond between oneself and the natural order. He says: 'The whole-person exists in a natural world, indeed is a part of the natural environment. Holistic medicine therefore has tended to focus on the relationship of the whole-person to the natural order' (1986:28). What emerges from both therapist and client interviewees was the belief that chronic body pain has the ability temporarily to distort one's view of this world. A state of ill health, therefore, initially causes one constantly to look in upon oneself, too concerned with our own condition to be fully aware of our surrounding environment. Hence once we are at ease with our own body then we are able to look outside of ourselves. A Shiatsu therapist draws attention to the ability of illness to alter one's outlook and subsequent coping strategies when she says:

> [Illness]... certainly alters your view of the world. ... If someone has had terrific shoulder pain ... and ... you are holding on to this tremendous sense of the body in tension, if you actually relieve that, they can actually look out at the world a bit. Their body is a lot more settled. It means that they can cope with whatever is going on around them. It is much more immediate. I very much believe that if you have aches and pains in your body you are not at ease with your body (Sally 1997:312-340).

The relationship between oneself and one's social surroundings is highlighted, in this example, by complementary health's ability to place the individual into a wider 'holistic' framework. This framework allows participants to view themselves in the

---

[9]See Chapter Five regarding the interdependent relationship between the divine, oneself and one's environment.

context of a wider, interdependent social system.

The third existential issue which Giddens poses concerns 'other persons' (1991:50). Here Giddens highlights the essential role of the people surrounding the individual. Awareness of others, trust in others, 'reliability and integrity of others' (1991:51) are all aspects which shape our understanding of who we are and how we fit into the wider social framework. One's relationship with others and the surrounding 'other persons' therefore contribute to one's own self-identity for they are the points of reference which differentiate and shape one's own sense of self. As such, one's own sense of identity is moulded by one's interaction with others.

Finally, and most importantly, we come to Giddens's final existential issue: self-identity. Self-identity, according to Giddens:

> .. is not something that is just given, as a result of the continuities of the individual's action system, but something that has to be routinely created and sustained in the reflexive activities of the individual...Self-identity is not a distinctive trait, or even a collection of traits, possessed by the individual. It is *the self as reflexively understood by the person in terms of her or his biography.* Identity here still presumes continuity across time and space: but self-identity is such continuity as interpreted reflexively by the agent (1991:52-53).

If we draw particular attention to issues of self-identity (and its encompassing aspects of risk and trust[10]), we can see a distinct parallel between health beliefs and Giddens's writings on identity and modernity. In using Giddens's usage of self-identity we are able to highlight the distinct relationship between complementary health beliefs regarding the body and its contributory role in the construction of identity.

An interesting example of the use of an alternative body perspective in relation to identity (and consequently ontological security) emerges from field notes and interview

---

[10]I will define risk as threats and causes of instability to one's sense of identity through the preoccupation of uncertainties in one's daily life. Trust represents a 'confidence in the reliability of a person or system, regarding a given set of outcomes or events, where that confidence expresses a faith in the probity or love of another, or in the correctness of abstract principles' (Giddens 1990:34).

extracts following an interview with a Natural Healing client. These extracts illustrate the significance of body perspectives on adherents' sense of identity and indeed, their wider sense of ontological security. This sequence of notes begins with field notes relating to Louise, a hairdresser and mother of one. Louise takes Natural Healing sessions in an attempt to reduce the panic attacks caused by her imminent divorce. Louise also takes her four year old child Matthew. Matthew has difficulty sleeping. Matthew's irregular sleep patterns are thought to be caused by his father's absence from the family home and his growing feelings of insecurity. These extracts begin with field notes and continue with Louise's comments regarding her son's therapy session. Louise relays the actions and narrative which occurs between Matthew and the practitioner, Frances. The therapy session involved the placement of certain objects on Matthew's body. The field notes observe:

> The mother seems to want to know what is going on inside the mind of her four year old child. As the child is so young and cannot communicate his feelings on his parents' intended divorce she cannot hope to get any further details of his thoughts or feelings. By taking the child to a therapist the mother believes that she, and the therapist, will be able to understand what the child is thinking and feeling by interpreting and reading the child's body auras, energy levels and remarks (Field Notes 24/01/97).

The client says:

> ... he said that he could feel it tickling him and 'oh Frances is this ready to come off?' She checked it [the crystal stuck to one part of the child's body] and said that it needed to stay on. But this one [crystal] on his head, 'oh Frances this one has got to come off'. And Frances said 'oh no Matthew it's not ready yet'. He said 'no .. it's got to come off it's crying'. And she said 'why is it crying?' 'It's sad it wants to come off Frances'. And she said 'well it has to stay on there a bit longer'. So she was trying to speed it up with her crystal [pendant]. A couple of minutes later Matthew said 'it's got to come off .. it's got to come off now'. Frances said 'no,

no, it's still not ready'. 'It's crying it wants to go home to mummy' and she said that it was all his sadness coming out. But why a child of four, when everything else either tickled or felt warm, to actually describe something coming off his head that was crying I find quite amazing. I mean it wasn't once it was about four times he asked her to take it off because it was crying and I just find that absolutely amazing. I am so pleased I take him somewhere like that because I feel that when he is older that he won't have all this gump left inside of him. I was in tears. This was my little boy, like, but she said that that was all his sadness coming out (Louise 1997:473-504).

The child's comments of 'crying head' are interpreted as the child missing his absent father and is suffering from an idea of abandonment and insecurities. The mother's intention is to purify and cleanse the trauma of her divorce from the child's infancy so he does not suffer these feelings later in life. The mother also highlights the view that her child will grow up with a different perspective of his body and the medical establishment. She also hopes Matthew will grow up with an alternative perspective in treating ill health. (Continuation of same field notes 24/01/97).

Giddens, therefore, distinctly uses infancy fear as an example to illustrate the foremost existential issue which constitutes ontological security. The previous notes illustrate, specifically, the parallel between Giddens's notions of the 'nature of being' (1991:48) and adherents' beliefs in the attainment of self-knowledge. This is demonstrated by the therapist's and mother's ambition to initiate a sense of security and trust in the child. The child's personal awareness can only be established then, if his feelings of abandonment are quashed.

Indeed, the issue of trust emerges again while viewing these extracts.[11] Trust is given to the therapist as she is the sole means through which Matthew's body ailments can

---

[11]In addition, these notes also address Giddens's secondary existential question. Hence: 'Trust in others, in the early life of the infant and, in chronic fashion, in the activities of the adult, is at the origin of the experience of a stable external world and a coherent sense of self-identity' (1991:51).

be interpreted and his emotional and mental state assessed. Hence, the mother and child rely on the therapist's ability to give an accurate 'reading' of the child's feelings and hence allow the mother to feel, not only that her child's emotional needs are catered for, but also that his future development and beliefs will be shaped by the healing experience. Giddens's comments are therefore particularly apt when he remarks: 'Trust in others is the key to the development of a sense of ontological security in the young child ...' (1991:66).

Giddens's notion of ontological security is therefore demonstrated throughout the beliefs and practices of complementary health and healing. However, complementary health practices can also illustrate an additional factor which impacts on one's sense of ontological security that is, an individual's sense of development and change. Individuals within complementary health aim to achieve certain goals and modify certain perspectives (body, lifestyle and world-view). It is these aspects which enable them to journey towards futuristic goals, namely a sense of well-being. Hence, a sense of ontological security could also include an individual's sense of personal development and fulfilment of one's futuristic expectations. In other words one's sense of ontological security might not be entirely grounded on one's past and current (emotional, mental, physical and spiritual) state for one's future plans and goals can also contribute to one's sense of ontological security. This additional factor is demonstrated in the previous field notes for Louise's sense of ontological security is aided by her acknowledgement that her son's health sessions will assist his body development and his ideas regarding the body and the medical establishment. Hence, Louise's sense of future expectations contribute to her own feelings of ontological security. The recognition and planning of one's future goals could, therefore, constitute a fifth factor in Giddens's discussion of ontological security.

The 'reading' of the multi-body, in the health session, therefore enables us to again identity how the body is linked to notions of identity. Giddens, while discussing threats and strengths of self-identity, draws attention to issues of trust in early childhood. If we draw upon the previous mother and child example we can see that the mother needed an external source of meaning to interpret her child's sense of insecurity, and his need to regain his sense of trust in his family (his growing fear of abandonment), and consequently the world around him. Such an example illustrates the notion that the body plays a distinct role in the creation and development of self-identity. Once again, various

similarities can be drawn between the characteristics of Giddens's existential queries and health participants' beliefs and practices. While discussing their experiences of receiving health treatments, clients particularly expressed their ability to relax and to think about issues which were important to themselves. These issues may not always be existential in form but it is the process through which health participants are able to step back from their problems and to reassess both their body and lifestyle issues. A Reiki client highlights this reflexive process when describing her health experiences. She says: 'All sorts of things just pop into your mind. You start wondering, wondering how life began and just all sorts of questions' (Kathryn 1997:82-84). The complementary health milieu can therefore provide the forum through which health participants are able to question aspects of themselves, their surrounding environment and their social circle. Indeed, such reflections also enable participants to perceive and often shape their own identity, health status, lifestyle and world-view perspectives.

Issues of trust are also central in the construction of identity inasmuch as clients need to trust their therapists' ability to steer their development in a productive manner.[12] Therapists also need trust, to fulfil their role as healers, for they need to trust in their ability to heal and trust their ability to communicate with healing forces. If we take this point further, trust in one's sense of self, one's biography, one's futuristic expectations (of both physical development and social progression) all contribute to the development of ontological security. Risk can emerge through various choices made by clients when deciding and taking part in health sessions. Risk emerges in deciding which therapy and therapist to choose, whether to absorb any guidance given from their therapist, and whether to believe in their therapist's interpretations of their body. Elements of risk also arise for practitioners. Practitioners' sense of purpose can therefore be threatened by misdiagnoses of clients' health status and ultimately the risk of their beliefs not being taken seriously by their clients. All these aspects involve issues of risk and trust as each choice has a contrary effect. Issues of trust and risk are then potentially important in the health milieu as each element has an impact on the beliefs and actions of the health adherent.

---

[12]Therapists could therefore be argued to fulfil Giddens's concept of 'caretakers' (1990:95).

6.3 Illness and Instability

Awareness of one's body, through constant assessment has been argued to encourage a state of empowerment and consequently a sense of control and security. A NFSH practitioner emphasises his treatment's ability to install a sense of introspective analysis in the client when he says: 'So it's to try to get them to perceive themselves and perceive the world around them in a completely broader perspective and through that broader perspective to have more control over their life' (Luke 1997:493-496). The inability to develop awareness, for health participants, is believed to result in anxiety and distress. A Shiatsu practitioner highlights these concerns while discussing her own illness. She comments:

> I think what I needed, for my ME, was to get back into my body because if you are not settled your whole sort of sense of you, the spirit of you, the actual stuff of you, the thing that is you, is not actually settled in this vehicle [the body] then you don't deal with life at all, as it happens, and you are not able to see your way through and so things become very unclear, very anxiety producing (Sally 1997:345-360).

Freund and McGuire highlight the threat of ill health to one's sense of self when they say:

> Illness is upsetting because it is experienced as a threat to the order and meaning by which people make sense of their lives ...For the individual illness and affliction can likewise be experienced as assaults on the identity, and on the ability to predict and control central aspects of one's own and one's loved ones' lives. Healing, in all cultures, represents an attempt to restore order and to reassert meaning (1991:137).

Body awareness and stability is emphasised again when a Reiki practitioner discusses clients' ability to segregate the problem areas of the body. Lilly emphasises particularly the client's ability to divide the body into sections. These areas are viewed as

inconsequential to the functioning of the entire body. As such, the practitioner believes that one cannot achieve full body awareness while some body areas are disregarded. These divisions are thought to lead to a sense of instability. She observes that:

> For ...people it is about having a body that only reaches from their throat to the top of their head and they don't have a body that engages with, an awareness of the rest of the body. [People's inability to see their whole body] can make people sick in any manner of ways and so another aspect of healing can be a recognition that the body includes every bit of them and not just their heads. People have cuts in different places, where they cut off their bodies. So by introducing or re-introducing themselves to the bits that they have cut off can be a very major part of the process. People that have eating disorders come into the category of that or sexual abuse, often major cuts in those two circumstances (1997:538-557).

The concept of body imagery emerges again while discussing notions of risk. The following interview extract originates from a Rebirthing Therapist who identified the physical form as the vessel for all memories and social conditioning. The interviewee notes his beliefs that memories become impressed on the body and thus cause the individual to feel insecure and at risk in the world. He comments:

> And you will find for example classical traumas at birth, like being born with the cord around your neck. That experience impresses itself upon the body locked into place by mental patterning which may be expressed through perceptions of the world. It is like a sense impression of the world that it is not safe to go forward because when I go forward I'll die or I am strangled (Anthony 1997:190-196).

Anthony continues his discussion by advocating that it is by means of complementary health treatments that feelings of risk are minimized.

Health sessions enable clients to change their lifestyle and body perspective as they are taught to become aware of their body. By reassessing oneself one is able to be empowered and to minimize potential threats to one's self-perception. In turn participants

feel that they are able to feel 'safe' in the world as well as finding strength to take risks. This is illustrated by a Shiatsu Therapist when she says:

> ..it is wonderfully nourishing and nurturing to be able to do that [assess one's life] and it means that you are able to take care of yourself and you are going to feel much more safe about moving out into the world. And then you might feel much more safe about being intimate, about taking on some things that are going on to truly fulfill your potential. You are actually going to try out, take some risks and that is tremendous and that is what life is about. And those things are the things that we back away from. Fear takes over (Sally 1997:360-375).

For therapists and clients, illness was regarded as a learning experience. However, although health participants were not initially glad of their poor health at the time, participants did, in retrospect, appreciate some of the changes that were made as a consequence to their illness experience.[13] Such changes enhanced participants' awareness of their body as well as impacting on their sense of identity. A Rebirthing client draws attention to his illness experience and his eventual new insight when he comments:

> When I was in Asia I had hepatitis and was for a period of time down to bones. I was so weak I had to crawl from the bed to the toilet, and back. Now people say 'horrendous, terrible'. No. For me it was an experience, like before I was like indestructible, invincible; I could do anything. Inexhaustible, super energy. Suddenly you are nothing. From one day to another gave me a complete new insight of what happens. It showed me how life can be from one moment to the next. Total change and how to cope with that and at the same time my body changed totally, my body was down to bones. It took me three months to build up and when I did my shoulders had broadened, my hips, I was looking like a different person. You see at the time it was 'a terrible thing to happen' but it was great. It was a wonderful experience (Anton 1997:314-343).

---

[13]None of the interviewees had life threatening or chronic illnesses.

6.4 Lifestyle & World View Perspectives

So far throughout this chapter the body has been discussed in relation to multi-dimensional body perspectives and existential questions. As a consequence of these issues, and what has emerged quite prominently throughout the therapist and client interviews, is their capacity to re-assess lifestyle and world-view perspectives. Thus from becoming aware of themselves, lifestyle and world-view perspectives can be altered to complement their new body perspective. Hence by acquiring a new body awareness one is able to provoke new thought processes. Indeed, what arises from adherent interviews is the inevitable link between body-awareness and self-identity and consequently the adoption of new lifestyle and world-view perspectives. A Rebirthing client draws attention to the influence of body awareness and lifestyle habits when he says:

> I think people become more aware, maybe they want to be more aware of their health, they eat differently, they stop smoking or drink less. That makes room for something else. You also become more open to certain concepts from other people and as we are computers ...our brains are computers, you bring in a new thought which you accept and that makes your own highways open to allow a different way of thinking (Anton 1997:520-539).

Giddens mentions health practices' ability to alter lifestyles when he comments: 'To opt for a form of alternative medicine, particularly of one of the more esoteric varieties, might signal something about, and actually contribute to, certain lifestyle decisions which a person then enacts' (1991:141). Moreover Mattson contributes to the discussion of holistic lifestyles when she says: 'Holistic health advocates attempt to be "here and now" oriented. They wish to live in the present, aware and participating to the fullest every moment, whether it is pleasant or not. This existential view of life had many ramifications for lifestyle choices and for health' (1982:51).

Before continuing in this discussion it is worth distinguishing between notions of lifestyle and world-view perspectives. Lifestyle perspectives can be argued to be more than

simply an outline of lifestyle put forward by writers such as Giddens[14], Polsky (1969) or Mattson (1982). Lifestyle perspectives are not only the routine set of practices which are performed daily but also the attitudes and beliefs which accompany such practices. The lifestyle perspectives which have emerged from health adherents include regular meals at midday, regular fresh water, abstaining from smoking, alcohol, meat and sugar, dietary changes, more physical exercise, greater independence and mobility, prioritizing and manageability of work and home life. These patterns were believed, most noticeably by clients, to be a critical step towards finding good health. Indeed, adherents believed that by addressing lifestyle issues they would also be contributing towards their own personal development. The adoption of beneficial lifestyle factors were also seen to impact on adherents' sense of purity and pollutants. While discussing lifestyle habits, and consequent changes in daily routines, several adherents express their lifestyle perspective as a means to expel malignant factors which could harm the body. Susan, a Bowen client begins by remarking that it is beneficial to try and: 'put less toxins into your body voluntarily' (1995:167-170). A Bowen Therapist highlights illness's ability to provoke self-reflection and its consequences on lifestyle when she comments: 'I think it's up to the person who's been through that [illness] to decide what they want to take on board and what they don't. But I've found the minute you begin to do emotional work and body work your lifestyle changes. It sounds a bit dramatic but it really does' (Claire 1995:155-158). She continues by outlining the purification rituals of certain cultures in the preparation and consumption of food. Claire notes the absence of these rituals in Western Culture. She says:

> If you look at Buddhism and you look at the way the Muslims sit down and prepare their food and eat their food. There are certain rituals, there are certain things to be done. The whole ceremony. Even the Arabs do it. There's a whole ceremony before you sit down and eat your meal. In the Western world we've forgotten all of this (1995:190-195).

---

[14]'A lifestyle can be defined as a more or less integrated set of practices which an individual embraces, not only because such practices fulfil utilitarian needs, but because they give material form to a particular narrative of self-identity' (1991:81).

Lifestyle perspectives can therefore be seen to focus predominantly on the internal substances (food), attitudes and habits formed around the physical body.

World-view perspectives are not centrally concerned with daily lifestyle behaviour; rather these were philosophical perspectives. World-view perspectives include the ability to retain good mental attitudes towards everyday events, objectivity, reviewing habits and socialization processes, stress and panic attack management, setting goals, and if such goals are broken, the adaptation and renewal of goals set, the belief that one is able to control aspects of one's life by managing life events better, relaxation and sense of calm and order, letting go of painful memories and emotional baggage through retrospective analysis, and ultimately the ability to find peace. Examples of world-view perspectives can be seen in the following interview extracts. The first of these extracts illustrates the difficulties encountered by a Colour Therapist while trying to promote a client's sense of positive mental attitude. The client's aversion to her husband was therefore seen to impact on her sense of well-being, and indeed, her physical health.

> I had a patient where my heart sank... I went to see her three times. She was absolutely riddled with Arthritis...Well Arthritis had made her quite bitter and twisted. She was 'I am right', you know, not matter what. No matter, come hell or high water... She wouldn't back down, she wouldn't change her views and she wouldn't accept that perhaps someone else might be right, you know. I mean the hate that was coming out of her over our chat... I thought this is amazing that this has even happened to her, I mean what a lesson. And I was trying to tell her not to think quite so venomously about him [her husband] and perhaps try and think of what the lesson was. I mean it's very difficult when you've just met someone for the first time. And she said 'you mean think of him like Father Christmas'. And I burst out laughing and I said 'well not quite like that but if you could just think differently (Ann 1996:276-288).

The Colour Therapist again illustrates world-view perspectives when discussing relaxation and stress management techniques. Here Ann outlines her client's ability to obtain a sense of calm and order through the adoption of simple meditation exercises. She says:

I had one client recently who came to the Healing Centre...if you'd seen him the first day his face was all pinched and everything. He was really stressed out because of a real pain across his shoulders. His wife came as well as she was talking to another healer. She was saying that he was very bad tempered and was horrible to the children and everything, and he was at the point where he was going to change jobs as well. And I talked to him and he knew nothing about healing whatsoever. It was his wife that had dragged him along. I explained that stress is so much part of life at the moment and it's that part that you've got to overcome. And it's a mind game, it's the mental bit, it's the 'we need the money, so and so has got this, so we've got to do this and that' and it's the stillness, it's the centring and I told him about the chakras and I gave him one or two meditations. I said if you could sit in your office just once a day for five or ten minutes and he said 'aww', and I said 'even if it's at lunchtime or something'. He said he'd give it a try. He came back the first week and said that he felt better and the second week he just said 'bloody brilliant'. He said 'the feelings have gone, the stress has gone' and he bounds in now about once a fortnight for what he calls a top up. And he said he doesn't shout at the kids any more, the kids don't seem to get to him. He said 'I just sit and close the door to have a quiet few minutes and just sit and meditate' (Ann 1996:192-209).

A Bowen Therapist highlights everyone's ability to review world-view habits. She remarks: 'I mean psychology plays a certain part of the treatment. From my own experience of being sick I wanted to go to someone and find a cure. And really the only cure, the real cure lies within me. And coming to terms with what was trapped inside my body'(Claire 1995:92-95). World-view perspectives are defined by the external factors which impact on one's body. Indeed such problems are believed to originate from the strains and influences of one's exterior social circumstances.

Therapists and clients noticeably identified that lifestyle and world-view perspectives would need to be addressed and ultimately brought together if any significant personal change was to take place. A Bowen Therapist remarks on both lifestyle and world-view perspectives while discussing diets. Claire illustrates the underlying world-

view of meat consumption, the methods of animal slaughter, and the nutritional impact of meat consumption on one's body, and consequently, on one's entire diet. She remarks: 'If a client comes to me and says "should I give up meat?" "Should I do this?" I'd say well if you look at the way animals are brought up today, if you look at what they're fed, the steroids that are injected into them, the way they're killed. Do you really want to be putting that into your body? They have to do their own research otherwise it doesn't work for them' (Claire 1995:224-232). The amalgamation of both lifestyle and world-view perspectives illustrate complementary health's claims of a holistic belief system whereby one's body is believed to work in harmony with others and with one's surrounding environment.

There were, however, several distinctions between therapist and client groups. The foremost distinction was that therapists concentrated more on possible world-view changes. This can be principally due to therapists' beliefs that good health is only achieved by changing both beliefs and attitudes, rather than just modifying lifestyle behaviour.[15] In contrast, although clients predominantly made lifestyle changes various world-view modifications were also made. A Colour Healing client emphasises the impact of world-view perspectives while reviewing painful memories. He says: 'There are whole acres of my life when I could hardly look back on them without getting choked in the throat or tensions in various parts. Now I can look objectively and see things from several different angles which is how we [his therapist and himself] work on me' (James 1996:250-257). A Bowen client discusses lifestyle perspectives and the placement of these issues on other, external factors. He begins by describing therapies' ability to offer introspection. He says:

> ...physical type therapies ... all ... have a core of understanding that adds to a picture that we can look at and say 'this is how human beings function'. And they all give us a clue as to how we can function better, function more comfortably, physically function more comfortably in our material and lifestyle sense. Function more comfortably, be happier, have greater self-esteem and all of those disciplines gives an insight into some of the ways that we can use them, but none of them are

---

[15]This was corroborated by the therapists' view of the causes of ill health. See Chapter Five.

isolated in themselves as the perfect way of resolving health problems or mental problems. They can all be looked at as part of a jigsaw and should be looked at as part of a jigsaw (Martin 1995:235-257).

Many health and healing practices maintain that they can offer an alternative and more comfortable way of life. These practices give an indication as to how human beings could possibly function and provide an alternative view of lifestyle and world-view. What becomes apparent, while studying lifestyle and world-view perspectives, were the influences of these factors on one's sense of self. These alternatives, by their nature, can consequently influence our beliefs regarding both our sense of self and our surroundings. These perspectives are not, however, stagnant; lifestyles, world-views and identities are created and perpetuated by one's belief of potential, and constant change and growth. Indeed, Giddens draws attention to one's constantly evolving lifestyle and identity when he remarks: 'The more post-traditional the settings in which an individual moves, the more lifestyle concerns the very core of self-identity, its making and remaking' (1991:81). A Bowen client summarizes the consequences of lifestyle and world-view perspectives on one's identity when he says: 'We come to conclusions and feelings about ourselves and what we think, and what we feel about ourselves, and how we fit into this world' (Martin 1995:431-441). The bond between lifestyle, world-views and identity becomes apparent as they each play a major role in one's life. All these factors are evaluated throughout the health session in an attempt to assess areas of weakness and to identity areas of possible development.

6.5 Conclusion

Health and healing concepts are grounded in a holistic understanding of one's body. One's physical, mental, psychological, emotional and spiritual states of health are all interpreted by means of a multi-dimensional body perspective. [16] In conceptualizing the

---

[16]However one must also note a caution as to the legitimacy of body interpretations by the therapist. In extreme cases such body messages and symbolism can be counter-productive insofar as health therapists' beliefs regarding the responsibility for illnesses can often place the blame for illnesses on the individual sufferer (Kopelman and Moskop 1981).

body in such a perspective health adherents believe they are better able to understand their body and create personal development strategies.

In deciphering one's body messages certain questions arise which may lead the health adherents to query specific aspects of themselves. Questions posed by Giddens relating to the nature of being, one's relationship to the natural world, those people surrounding us, and issues of identity are all bound together to enable us to give order and meaning to events. Indeed, these aspects are directly reflected in complementary health and healing's body, lifestyle and world-view perspectives. It is by addressing these existential notions (and by posing a possible fifth factor of ontological security), and issues relating to risk and trust, that adherents can construct a sense of self-identity. Throughout this chapter, therefore, I have endeavoured to draw parallels between Giddens's notions of ontological security and complementary health's notions relating to the body. In making these distinctions I hope to have made sense of contemporary beliefs regarding the body.

The re-assessments of one's body and identity often lead to reviews and modifications of lifestyle and world-view. Complementary health sessions can be potentially helpful inasmuch as they enable health participants to take on an alternative perspective of their body, lifestyle and world-view. By focusing on lifestyle issues adherents are able to review their body's needs for example, dietary changes. World-view perspectives, however, are more concerned with strategies for managing the external influences which may effect the body, for example, managing work related stress and achieving a sense of calm by contextualizing the chaotic world which surrounds one's social body.

The following chapter continues to discuss issues of self-identity by analysing health adherents' concepts of personal, social and global transformation.

CHAPTER SEVEN

COMPLEMENTARY HEALTH AND CONCEPTS OF CHANGE

The final major theme to emerge from the WINMAX Pro theme tree (Appendix 3.8) concerned concepts of change and transformation. Concepts of change arose frequently while talking to practitioners and clients for their attraction and participation in complementary health practices stemmed from their desire to initiate a process of change. Indeed, while reviewing adherents' relationships with the divine (healing energy) and body and lifestyle perspectives it became possible to identify several areas where prospective change occurred. These areas of change were personal, family, societal and universal. By categorizing all interview extracts, regarding concepts of change, into these areas it was possible to examine clearly the relationship and impact of these notions on adherents' lives. The following table illustrates the coded segments, from the theme tree which are analyzed throughout this chapter.

Table 7.1 Coded Segments Relating to Concepts of Change.

Codeword	Number of segments attached to codeword	Line numbers attached to codeword
Growth and Transformation	96	1529
- Personal	57	842
- Family	13	170
- Societal	19	492
- Universal	7	103
Movement to Health & Healing	51 Appendix 7.1	1087
- Aims	36 Appendix 7.4	460
- Illnesses	27 Appendix 7.3 & 7.4	319

This chapter aims to analyse health adherents' concepts of change and question how these factors impact on their sense of self-identity. This analysis will be performed by questioning participants' desire for change, adherents' sense of seekership, and examining their sense of placement and contribution to their wider social environment. This analysis was undertaken by initially reviewing all coded segments which referred to concepts of growth and transformation. The table above indicates the total number of coded segments and line numbers of ethnographic data which related to concepts of

growth and transformation. The table therefore refers to all ethnographic material present in the WINMAX Pro analysis. The data present in this table is extracted from the WINMAX Pro theme tree (Appendix 3.8). By recognising and retrieving all recurring themes (notions of seekership) further analysis could then take place by distinguishing any possible differences of these themes between therapist and client groups. These differences were drawn out by undertaking key-word-in-context and key-word-string searches throughout all therapist and client interviews. This chapter will therefore be divided into four principal sections: seekership, self-awareness, self & society, and finally original and developed sense of self. Section Five will draw together the threads of the discussion by contextualizing the placement of these notions within the entire study. This chapter also hopes to outline the impact of these factors on adherents' belief in complementary health and review whether these aspects contribute to the construction of a health spirituality.

As we have seen previously throughout Chapters Four (reflective dialogue), Five (divine healing energy) and Six (body and lifestyle perspectives) complementary health and healing techniques offer new ways of thinking and frequently initiate a process of self and social re-evaluation. Such revisions provoke a sense of development and a desire for personal change for the individual. Indeed, change is consequently the underlying goal for many health adherents. As such, concepts of change are recurrent while reviewing new age beliefs. Melton illustrates this by identifying individual transformation as the central premise to the collection of organisations, individuals and businesses which constitute the new age movement. The new age therefore:

> ...involves an awakening to such new realities as a discovery of psychic abilities, the experience of a physical or psychological healing, the emergence of new potentials within oneself, an intimate experience within a community, or the acceptance of a new picture of the universe. The essence of the New Age is the imposition of that personal vision onto society and the world. Thus, the New Age is ultimately a vision of a world transformed, a heaven on earth, a society in which the problems of today are overcome and a new existence emerges (1986:113).

The major attraction of health therapies is also illustrated in this quote as each health session is principally designed to fit the needs of the individual. As such, each participant is given the opportunity to review their needs and to construct a sense of social and universal order. The tailoring of the health session to the client's needs therefore enables a wider range of people to be attracted to complementary health practices. The health session therefore enables each individual to review his/her own needs[1] and to identify a strategy to bring about a sense of change. Hence there is a 'tailored' effect.[2]

We begin this chapter by discussing the notion of seekership. A seeker can be defined as 'someone who is on a path of self-discovery, a course of self-actualization that includes all the knowledge earned and all the skills gained along the way' (Lash 1990:367). Seekership in relation to health and healing is the process whereby both clients and therapists originally sought some form of change. This sought change was commonly initiated by a desire to alleviate physical pain. Section Two focuses on the initial sense of self-awareness which provokes an individual to seek change. Although concepts of change were frequently initiated by a desire to control physical ailments additional concepts of change arose. Growth for health participants was therefore not exclusive to the individual. Participants believe that growth and potential change can occur not only on an individual level but also throughout the social system, consequently influencing family and friends. The relationship between self change and societal change emerges as a significant belief system for clients and therapists. This discussion will constitute Section Three of this chapter. Finally the chapter aims to discuss notions of personal change for clients and therapists by identifying their notions of an original and developing sense of self, that is, a new state of self which can evolve through one's continuous desire for self change.

---

[1]These needs can range from simple relaxation techniques to managing stress, regaining one's personal confidence to controlling illness symptoms. These needs are all relative to the individual.

[2]One must note, however, that there is a wide range of health seekers with varying states of health. These ranged from the chronically ill to individuals who simply wished to alleviate skin or back problems.

7.1 Seekership

What becomes apparent while studying adherents' movement to complementary health practices (Appendix 7.1) was their desire to work through certain issues. There was an assumed understanding between therapist and client that both parties wanted some form of development from the health session. Forty three percent of interviewees believed their interest in complementary health was initiated by physical health problems while other interviewees became interested through other factors such as an interest in health and spiritual issues (twenty seven percent), family or personal problems (fifteen percent) or an awareness of their healing gifts (fifteen percent). As we can see from Appendix 7.1, therefore, many participants desired additional, non-physical benefits from the health session.[3] What emerges from studying participants' movement to complementary health was their desire for a greater understanding of their bodies, their lives, and their social circumstances. Adherents therefore sought therapies which would enable them to make sense of these issues. In making sense of these aspects both therapists and clients sought to modify lifestyle and world-view perspectives and set prospective goals. Change occurs for the individual in setting and fulfilling these goals.[4]

There were, however certain differences between therapist and client concepts

---

[3]See Appendices 7.1, 7.2 & 7.3 for breakdown of clients' and therapists' initial interests in complementary health and healing. In addition, see Chapter Nine for parallels drawn between Wilson's Probabilistic Inventory (1990:279) and complementary health notions of change.

[4]Clients attend health and healing therapies in order to achieve certain goals. These goals are relative to the individual seeker and can constitute one or more of the following factors.
1. Alleviation of specific physical problems.
2. Space/time/security offered in health sessions.
3. Advice/friendship/communications and touch.
4. An enquiry or curiosity into the prospective spiritual dimensions of health sessions.
5. Desire to improve lifestyle factors, for example diet, and related issues such as managing work and family life.
6. Attitude changes/ adopting an alternative world-view perspective.
7. A means of acquiring self-awareness; allows individuals to focus on their own needs without being thought of as selfish or narcissistic.
8. Adherents' enquiry into their own healing ability.

of change. The first distinction can be made in relation to adherents' notion of seekership. That is, clients seem to search for an inner peace, a calming influence on their lives, while therapists predominately sought enlightenment and spiritual insights. A NFSH client summarizes her sense of seekership and search for serenity through complementary health practices when she comments:

> I was always, what I recognise now as, frantically searching for something that I couldn't find and was never finding. The inner peace that I craved for. And years ago I used to look at certain people and be actually angry because I would see that they were serene and that they had serenity with them. What I wanted and didn't have, and now I feel I have achieved that state and it is through healing and releasing that anger and letting go and trusting people, and it's just like an inner calm. Which is lovely, once you have it you never want to lose it (Julie 1997:350).

Practitioners overall practice aim was to educate and empower their clients into believing that they can obtain a sense of total well-being. However while viewing practitioners concepts of change, and specifically the recurring theme of seekership, practitioners were seen to encourage these factors by promoting a sense of divine cause and meaning to their work.[5] As such, therapists predominately sought to understand their work in terms of the spiritual insights which could be gained by participating in healing practices. Thus therapists gave meaning to their work (and educated and empowered their clients) by advocating their role as facilitators to this process of spiritual enlightenment. The following two extracts illustrate practitioners' approach to their work. These quotes originate from interview discussions regarding their aims and ambitions for their clients. The first quote illustrates a Reflexologist's intention to install a sense of meaning and order to clients' lives by provoking a sense of self-knowledge and spirituality. The second extract notes the practitioner's role in the search for personal change. They comment:

---

[5]See Appendix 7.4 for an table illustrating therapists' aims for their clients.

...we are looking at the person growing spiritually as well as getting better physically and that means, to me, finding peace within themselves and being happy with themselves as a person. It doesn't mean turning to religion or anything like that but just feeling that they are at one with themselves (Heather 1997:554).

I am here in service to humanity, but I am also here at the individual level as one person at a time coming to me. Now they will want whatever they want, and if they want to grow with me, which tends to be the case, then they will. If they want a thing done then that will happen. But inevitably, whatever happens there is a growth (Natural Healer Himal 1996:678).[6]

Therapists' concept of seekership is additionally characterised by the absence of boundaries while seeking change. Hence, therapists believed that seekership was not restricted by the legal system or even death. Illegal acts were permissible if the seeker of change felt it was necessary to fulfil their potential and result in the accomplishment of their goals. Complementary health practitioners, therefore, believed that death would not necessarily mean the end of one's development. Death was then recognised, not as the final stage to one's development, but as a possible opportunity for further growth in one's next stage of life. The following interview extract particularly draws attention to illegal acts and death while discussing the possibilities and variations of change. Suzanne, a Reiki therapist, begins by illustrating the consequences of change by highlighting adherents' perpetual desire to acquire self-knowledge. She begins by discussing her aims. She comments:

Sometimes the result that we get is not what people would think that we should be aiming for. We're aiming to do the best for that person. And if it means that they end up throwing bricks through someone's windows and ending up in jail

---

[6]This interview excerpt also hints at a practitioner's view as to the scale of potential change. Therapists were therefore seen to identify their role as essentially facilitating a sense of change at all levels, that is, to facilitate personal, social and even global forms of change.

and learning the lesson of life that way, well you could say that you didn't help that person, did you? But maybe they were suppose to learn that lesson. If the person just keels over and dies very shortly after a health session then you've failed. No. They were just able to let go of physical existence to go on to the next stage of their life. It's not a difference between life and death it's just a different form of life. So, some people would say that sometimes healing and therapy work fails when, in fact, maybe it's actually helped that person to go on and do whatever they are supposed to be doing, even if it involves making a pig's-ear of life. But maybe by making a pig's-ear of life they are actually doing the lessons that they're here to learn (1996:712).

Indeed, Suzanne's quote also highlights how practitioners believe in the ultimate success of treatment sessions irrespective of whether the treatment has impacted on the alleviation of clients symptoms or personal circumstances.[7] As such, Suzanne demonstrates her faith in complementary health practices. Her comments are therefore indicative of practitioners' comments regarding beliefs in treatments (see Chapter Four). This extract also demonstrates how complementary health practitioners view death. While discussing death in the new age Walter (1993) emphasises the beliefs and meanings surrounding reincarnation. He comments:

> All New Agers believe in an inner essence or soul...It is this inner being or soul that continues after death, leaving the outer body and personality behind. On dying, as evidenced by near death experiences, the soul typically travels towards the light, which is interpreted as the inner being merging, unencumbered by body and personality, in infinite love, or God. Hence, New Agers at the bedside of the dying are likely to observe 'He has left us', rather than 'He has just died'. This is not a euphemism, but a statement deriving from a belief system... Clearly the New Agers hope is that it is only our material body that dies' (1993:132-133).

---

[7]Suzanne's quote additionally illustrates the absence of 'failure' in the alleviation of clients' symptoms. Briefly, then, therapists are cautious to admit to the failure of therapy sessions for they believe all acts of healing were inevitably leading to a process of change. This change was irrespective of whether their clients recognise it or want to recognise such a change.

Death within the new age is therefore seen as one's ability to transform one's sense of self. Emphasis is thereby placed on one's personal and individual experience, the meanings derived from one's lifetime, and the new incarnation and transformation of oneself. Practitioners were seen to promote the belief that even death was a form of personal transformation which enabled participants to: 'construct their own death, to draw on their own framework of meaning' (1993:129).

Although practitioners aimed to bring about change at all levels (personal, social and global), clients seemed to search for an initial reflective experience to help resolve specific problems. Therapists facilitate this process by employing problem-solving strategies (for example reflective dialogue, interpreting body ailments/ messages).[8] In performing this role both therapist and client hope to achieve a greater level of self-knowledge. Indeed, what joins therapists and clients then is their desire to seek ontological meaning. As previously discussed meaning is principally assessed through adherent's interpretation of the body. The body, then, does not only represent the medium through which clients' inner peace and practitioners' enlightenment is sought but it is also the means through which any prospective sense of change occurs. Ferguson (1980) draws attention to one's physical well-being and its consequence for an individual's sense of self-awakening while discussing Aquarian Conspirators. She says 'an involvement in health care was a major stimulus to transformation. Just as the search for self becomes a search for health, so the pursuit of health can lead to greater self-awareness' (1980:282). Health and healing techniques are thus commonly used by health adherents to re-evaluate factors of their lives and to make significant lifestyle changes. Indeed, this assessment also becomes the means for discovering one's strengths and exploring one's potential areas for development. It is through this process that one questions, and often re-assesses, one's role and sense of identity. The essence of growth, then, for clients and therapists alike, is a search for meaning and order to life events. In other words, by discovering one's needs it becomes possible to construct a sense of purpose to one's life. Indeed, a sense of ontological meaning for adherents was seen as equally important as alleviating any physical health problems. Health participants

---

[8]See Chapter Four for a discussion of reflective dialogue and Chapter Five for notes relating to body interpretation.

therefore equate the notions of healing with notions of self change. Two practitioners highlight the link between their clients' sense of change and the health session when they observe:'...for some people healing has a most profound effect on the way they think and the way they act thereafter. It can change their lives quite dramatically'(Colour Therapist Ann 1996:286), and 'I suppose the idea of healing is about change'(Reiki Therapist Diane 1997:722). Finally a Bowen client notes complementary health practice's ability to provoke change when she claims: 'I think we are all here to transform ourselves' (Jane 1995:470). These interview extracts also demonstrate how notions of change are present throughout all therapy cell groups.

7.2 Self-awareness

The search for meaning and good health are two factors which prevail in complementary health practices insofar as both aspects are needed in order to discover a sense of well-being. In acquiring an awareness of one's body and one's potential development areas adherents can then devise strategies to bring about these changes. A Rebirthing client discusses his desire to become more self-aware by outlining the introspective process through which he was able to re-create himself. Anton begins by reviewing his health sessions. He says:

> It's been quite inspiring ...you think about what we are here for. What is our purpose here? Is our purpose to make vast amounts of money or to have kids? What is it? And if you've done it then ...well what's next? And the solution is definitely not a material one...you find that people definitely change. It's an awareness. Awareness is the key to everything. We have awareness on whatever the thing is. Before it's been something in the cellar with cobwebs and you don't look at it. And then you put the light of awareness on it and suddenly it can't dwell in the dark any more. I might not like it but there is a process of cleansing, of understanding, of change, of integration and, well you will be different. And that's great, you know, this is the evolvement. It's not just about healing the physical body. It's really about healing the mind to be more. I think humans

should have an aspiration to become like God (1997:465-477).

A Bowen client also observes the impact of complementary health practices on one's sense of self while discussing therapy sessions. Martin draws attention to these factors by advocating that he is sharing a belief system. Although this interview extract illustrates the presence of a belief system it can also demonstrate how health beliefs are perpetuated by tailoring beliefs according to the client's own experiences, illnesses and life circumstances. Martin begins by observing client experiences.[9] He therefore notes:

> As far as I am concerned they often experience insights because I use what's happening to them as a way of sharing a belief system, educating them in terms of how their body and mind function works, and I am lucky enough to do that quite effectively and in such a way that they suddenly begin to realise how things that they took for granted, that were separate and nothing to do with the problem that they came to me for, which was a bad back or bad digestion or whatever, are all interactive. They are all associated with one another. All of these ...their lifestyle, their perception of themselves and the world and how they fit into it and their physical body are all interactive and therefore not only is the problem that they have got perhaps more complex and subtle than they had thought but the resolution can mean considerably more changes than just relieving them of a back problem (1995:213).

Clients' concepts of change therefore focus on a development of the body through modifications in body perception.[10] These changes can materialize through the adoption of a new world-view surrounding the body (for example attitudes towards body pollutants and toxins or simply though changes in lifestyle habits). Therapists illustrate a more spiritualized awareness in as much as they equate change with their ability to channel divine energy (see Chapter Five). Change for practitioners is therefore bound to

---

[9]Martin was additionally training to be a Bowen practitioner.

[10]See Chapter Six for a more detailed analyses of body perspectives.

their ability to channel and to catalyse healing energy. Hence all but one therapist showed great respect and illustrated a sense of being humbled by the experience of giving healing. Reverence was illustrated by practitioners as healing became almost a direct communication with the divine. Practitioners therefore provoke a sense of change by achieving a state of communication with divine sources. Moreover by maintaining a state of divine communication therapists believed they were more intuitive in their healing abilities,[11] were able to maintain a greater interest in the health discipline, be more accepting of all types of people and their problems, and finally set lifestyle patterns by example setting. Indeed, almost one half of practitioners aimed to guide and to educate clients to a state of better well-being (See Appendix 7.4). Such example setting and guidance is illustrated by Glik (1990a) while highlighting the role of the healer. Glik focuses on healers located particularly in spiritual healing groups. Healers then:

> ...represent[ed] heroic role models to participants. Having themselves often gone through suffering, pain, distress or illness and having achieved a modicum of purpose and balance, healers were seen to be 'special'... Within the context of healing groups these charismatic individuals were outwardly committed to the development of others' attainment of self-realisation, success or healing (1990a: 153).[12]

A theme which arose throughout participant interviews was the belief in a *path* of continual change. That is, once you begin to make change then it is impossible to divert from the process. Hence, self-awareness is the starting point to all possible change. In recognising one's problem and achieving a state of awareness, self-identity improves. Giddens, while discussing late modernity, draws attention to the process of self-identity in therapies and highlights how these practices can induce a process of self-transformation. He comments that: 'Living every moment reflectively is a matter of heightened awareness of thoughts, feelings and bodily sensations. Awareness creates

---

[11]Appendix 7.5 illustrates the wide range of skills claimed by practitioners.

[12]See Chapter Nine for a comparison between 'specialist' (Wilson 1990:281) religious and health functionaries.

potential change, and may actually induce change in and through itself' (1991:71).

Therapy thus became the avenue for therapists and clients to seek potential change. Such a reflective process enables clients and therapists alike to believe in the prospective benefit of health therapies. A Homeopath draws attention to the transformative effects of health therapies when he says:

> Massive changes can happen with the healing process. Complete changes in ideas, thought forms, lifestyle, emotional energy. People can transform. I've seen people change within months on remedies. Within weeks they think completely differently ...They are the same person but ...they may even look different. Look more happy, buoyant. Everyone responds differently though. People often start changing their diet, and thinking a lot more in harmonious ways. Good will towards their fellow man and so on while they start healing physically because with more energy, more vitality there is more choice as to what to do with that extra energy. Most people choose to enjoy their life more; they spread their enjoyment about their family and friends (Harpal 1997:311).

The consequence of seeking self-awareness manifests itself in participants' ability to take on an awareness of others. This influence is self-perpetuating in so far as participants believe that this knowledge can be influential to those people around them.

7.3 Self and Society

The link between self and society emerges in healing by means of a wider inter-dependent flow of healing energy. The self is not seen as an autonomous organism, independent of one's social surroundings. One's health, lifestyle and consequent future happiness is all linked to a wider social 'eco-system' (Bowen Client Martin 1995:160) where one is constantly aware of family, social and even global links. By placing oneself within the social system, then, one is then better able to understand one's role and one's contribution to the wider social network. Indeed Martin, a Bowen client, illustrates the self and society relationship while describing his vision of an independent social system.

He states:'My perspective is one of a constantly changing human eco-system. Each of us being a self-organising organism, and eco-system within ourselves that is in a relationship with our environment, whether it's other people, our immediate environment or the world beyond us' (1995:160). Moreover, Martin also draws attention to the constantly evolving nature of our self change and its impact on our surrounding environment.

Analysing therapists' and clients' concepts of self-to-society change can be discussed in two ways. Firstly, the individual self is seen as a reflection of one's environment. Secondly, there is a belief in an interdependent social system where the self is believed to be linked to the cosmos. Both therapist and client groups identify systems within systems. The body constitutes one system (where balance of chakras and physical, emotional and spiritual needs are addressed) and the wider environment (family, friends and one's society) constitutes the second relational social system. These systems are linked interdependently.

There was no differentiation between therapist and client groups in their beliefs regarding the relationship between the individual and his/her social surroundings. While clients were concerned with their own state of health and this impact on their family and friends, therapists drew attention to a wider circle of people who are influenced by complementary health techniques. For one Natural Healing client going through an acrimonious divorce, healing contributed greatly to her sense of family security. Here the client discusses her growing feelings of control over her body and family. She relates that:

> If I didn't know someone like Frances or the equivalent of Frances I reckon that I would be on tranquillizers to have kept me calm, which would not have done me any good. I don't know, I might even have been in a situation where I would have lost my son because I would not have been able to get out my anger, would not been able to do certain things, would not have been able to keep the house .. I don't know how she does it. I don't know how she's got the power but she does. She is a little miracle maker she is. I must explain that of course I would still be here but I think that I would be quite a zombie. I would be drugged up to the

eyeballs. I don't think that I would be on a sane level (Louise 1997:601).

Clients' concepts of change are not restricted to the individual. Although clients' concepts of change may alter according to their needs at one moment in time, clients believed their own personal change can consequently effect their immediate environment. What became most apparent, therefore, is a sense that health participants identify themselves as reacting to, and in certain circumstances reflect, specific messages from their environment.

As we have seen from the previous interview extract a sense of ill-health for clients represents lost power, lost identity and a sense of weakness. Family members are thus directly influenced by a family member's illness. As such a small number of clients attend health and healing sessions to overcome problems encountered by their family members. Hence there is an interlocking cycle of influence between the clients and their families. Regaining good health, then, is not only about addressing the physical complaints of the individual but also viewing the consequent effects of illness on one's family and one's family unit in society. An example of an individual reacting to a life event can be seen in divorce. Louise, a hairdresser and mother of one, suffered from panic attacks as a consequence of her imminent divorce. She observed further effects of her divorce on her family lifestyle (sleeping arrangements), her own body image and confidence.

Although therapists identify with the effects of illness on the family they are equally concerned with the societal influences an individual can command. Two practitioners express the relationship between the self and the environment while discussing the causal influences of self-change. A Rebirthing practitioner comments: 'What is within is without. Your external reality is a reflection of you. So if you want to change the world then change yourself' (Anthony 1997:591). A Colour Therapist also expresses her belief of change in societal terms. Patricia begins by outlining her perspective on the steps necessary to initiate self-change. She remarks:

> ...what it often seems to me is that we are offering a perspective, we are offering an attitude which is to respect yourself. And to actually understand yourself. By

that, microcosm by microcosm we learn to honour ourselves...I mean it also spills out into the world. So we should take care of our environment better...you can imagine that if each person on this globe or even every second person really honoured themselves they will also, in a true sense, start to cultivate their own patch. I mean then we will start taking care of our world... I mean if enough people changed their attitude and start actually listening to themselves and paying attention, by definition, by listening to other people and what they do... and allowing the life force to flow and so on, it will eventually change the environment (1995:756).

Such an interdependency between self and society illustrates therapists' beliefs of the importance of their work in as much as their service to the individual becomes synonymous with a service to society. Again this issue was raised while talking to a Natural Healer. Frances briefly makes this remark while discussing her belief in the bond between self and society. She comments: 'I can see things in a different way ... So starting from one point the whole life changes and because they change, people around them change. So it has a knock on effect' (1996:257). Hence, the consequence of self change is the inevitability of change to one's surrounding environment.

Therapists draw a great distinction between the body and the environment by distinguishing between participants' conscious and unconscious states. An individual's conscious state is thereby an acknowledgement of one's current physical state and an understanding of potential areas for development. One's unconscious state is recognised by practitioners to be an individual's state of ill health and their inability to diagnose an illness's underlying meaning or to devise development strategies to alleviate these problems. Aspects of consciousness vs unconsciousness seem to be a critical notions for therapists in as much as they almost offer justification for an illness experience (the individual is therefore unaware as to their physical needs and of possible routes to greater well-being) and provide factors of change for the individual (this being the state of physical awareness promoted by complementary health practices). The duality of both factors simultaneously acts as a balance between ill health and well-being. Four-fifths of therapists believed that one's awareness of conscious and unconscious states were

critical to any prospective change.[13] The health session initiates this progression from the unconscious to a state of awareness through the various methods of introspective analysis. Indeed such analysis is believed to enhance the client's sense of self by introducing a sense of prospective development for oneself and consequently one's social surroundings. Thus healing, regardless of therapy employed, is believed to alter one's consciousness. Therapists believe, therefore, that by raising the consciousness of the individual, societal changes can take place. A Rebirthing practitioner notes the starting point of personal change, and how these factors can influence one's behaviour in the social environment, when he says: '...consciousness is the first starting point in terms of personal growth as well, and changing your habits and your presentation of yourself in the world. Recognising that there is a problem. Being conscious of that problem and then seeing how you might change that' (Anthony 1997:130). Anthony hints that one's sense of self-awareness impacts on one's presentation and portrayal of self in the social world. This presentation (or 'performance', Goffman 1959:26) can therefore be influential to one's social environment. Heather, a Reflexologist, also emphasises the causal effect of self-change when she comments:

> It is like dropping a stone in a pond because ...you can see the change in some people and then the next thing their friends are coming in or their family. It is that sort of reaction because they have benefited because they can see that sometimes they are looking at their lives in a different way and perhaps they are not stressed. It is very much a ripple effect with it, so because of that energy around us, they have become much more positive. That is the big thing. They become much more positive about what they are doing and where they are going and that is a chain reaction (1997:363).

This belief enables adherents to believe that they have emerged from a state of unconsciousness to a conscious state through the process of being ill, seeking health and healing, learning awareness, changing through lifestyle or world-view beliefs and finally emerging from this process in a state of awareness and understanding. This process,

---

[13]These notions are grounded in Freudian and psychoanalytical doctrines.

however, is not static for these actions can occur at any time of illness or difficult life event. Hence adherents tend to view their '...lives as an evolving consciousness' (Colour Therapist Patricia 1995:1083).

Participants therefore identify with a sense of journey and personal development through which one is able to distinguish between one's original and newly developed sense of self.[14] Further illustrations of therapists' understanding of the relation between self and society are summarized by two practitioners. The first remark is made by a Reflexologist while discussing the factors necessary to initiate a process of change. Hence, the '... notion of open systems ...cannot work without actually being conscious of the interconnectedness of everything' (Samantha 1995:138). The second extract demonstrates an individual's ability to connect with a societal consciousness.[15] Madeleine, a NFSH practitioner, therefore comments '...we have a mass conscious mind. What we think effects everything. Thought goes out. It goes to the mass conscious mind' (1996:291).

Therapists' concepts of change are therefore distinguished by their ability to envisage an all encompassing social system. Therapists advocate this perspective not only to facilitate a client's personal progress but also to initiate a societal transformation. While studying concepts of self in relation to society a secondary aspect emerges. This is surprisingly represented by both therapist and client groups. This is the connection between oneself and the cosmos. The relationship between oneself and the cosmos has previously been discussed in Chapter Five. However, one's place in the cosmos also seems to arise while analysing health participants' concepts of change. Health advocates believe that they are tied to the cosmos through one's body (chakras), through energy beliefs and finally through one's surrounding social system. Moreover health participants believe that they are bound in an interconnected relationship with all things and that they are able to contribute to a developing, more harmonious social system. Beckford draws attention to the relationship between self-transformation and the cosmos when he says:

---

[14]Concepts of original and developed sense of self will be discussed later in this chapter.

[15]Madeleine incidently highlights practitioners' views regarding the impact of their work on their social surroundings. Hence, one's individual thoughts and actions directly impact on one's collective surrounding environment.

'Transformation' is the term which most frequently refers to [an].. optimistic image of the self as an entity which can freely choose to change and to grow. But self-transformation is usually located in the context of cosmic, cultural and social forces which are believed to be ushering in a New Age. Thus, ideas of growth for the self are rarely separated from ideas of universal or cosmic progress... (1984: 262).

One's relationship to the universe is thus bound by one's ability to analyse one's own needs for development and to react by developing strategies to bring about this transformation. Indeed, beliefs in transformation are frequently addressed by examining one's circumstances, assessing areas of potential development and reviewing illness experiences in context to one's surrounding social system. Thus, in order to fully contextualize one's individual circumstances, it becomes necessary to reflect on one's surrounding social, and even global, influences. The individual consequently becomes tied to the social world through a belief in the interdependency of self and society. Transformation of one of these factors can therefore have repercussions throughout the related social system. A Reiki practitioner illustrates the effects of illness, on the entire social system, while commenting on the interdependent nature of oneself and the cosmos. She remarks:

> We are part of this planet, we are part of the solar system, the universe. If one bit isn't right, it's like if there is a small part of your body that's not right it can affect the whole system. Like if you have a tumour, one of your endocrine [glands][16] that can have a major effect all over. If one part of the overall universe is not right, it causes ripple effects through the whole system (Suzanne 1996:791).

Clients also seem to be particularly conscious of this self to cosmos relationship. A Colour Healing client illustrates this link while noting the influences of therapy sessions on the individual. Health therapies' ability to bring about change therefore

---

[16]The endocrine glands secrete hormones into the blood.

'...impacts on the entire world. It is a sort of a ripple effect. If we don't actually change at least it shows a different way of being. Even if they [other people] think you're nuts. You know, a different way with dealing with the world' (Erica 1996:148).

To summarize this section, then, clients were seen to focus on the influences of their own transformation on their lifestyle, family, social surroundings and social networks (e.g work colleagues). Alternatively, practitioners identified with general concepts of global and universal transformation.Therapists intentionally aim to educate clients by advocating a perspective that contextualizes one's role, responsibility and place within both a social and cosmic environment. Hence, self-identity goes beyond the initial physical problem experienced by the client.

7.4 Original and Developed Self

As we have seen throughout this chapter so far, many participants have sought a greater sense of serenity, spiritual insight, and a greater awareness of one's social environment since participating in health sessions. A consequence of this awareness is a greater focus on the physical body and a questioning by both therapist and client of 'who do I want to be?' This section aims to highlight participants' conscious attempts to develop their sense of self.[17] The foremost consideration is that growth, for both the client and therapist, is not about being a completely different person but merely to shape one's original self (or ill self) into a newly developed form. This journey does not rely solely on a transgression from being in a state of ill health to becoming physically well for the individual must also understand the external factors which are effected by this sought change (See Section 7.3). For some individuals, change from original to developed sense of self could be grounded in a deeper sense of spirituality, while another individual may find solace in the fact that daily work stress is manageable.

---

[17]The self will be defined as '...our experience of ourselves as unique and distinct persons. Our self-concept refers to our thoughts and feelings, both positive and negative, about ourselves as individuals. Much of our sense of self is developed during socialization in response to other people's attitudes and treatment of us. How we feel about ourselves depends very much on both the extent to which various social interactions validate or affirm our sense of self and our social position (e.g., class, gender, and age)' (Freund & McGuire 1991:100).

As we have already discussed in the previous sections, an illness experience may re-shape an individual's concept of self and their social functioning. A consequence of such a re-evaluation is a fundamental change in the client's portrayal of self. This section will therefore focus on the transition of the individual from an original to a developed sense of self. Indeed, what became particularly noticeable while researching health adherents' sense of personal change was their eagerness to express their beliefs by relating their stories of illness and health session experiences. Thus many testimonies of change arose. One cannot possibly list all these remarkable stories but a few would be needed to illustrate participants' beliefs of change. The first interview extract recounts James, a Colour Healing client, who believed that his health sessions had literally saved his life. A freelance professional musician, stress and gradual decline into depression had eroded his confidence and eventual health. The second extract originates from a Natural Healing client while discussing her imminent divorce. Suffering from both panic attacks and bouts of anger, Louise, narrates a brief commentary regarding her personal transformation. James begins by saying:

> I think I would have had a heart attack by now if I hadn't found it. I could have stopped after a couple of months and I would have been OK but the progressive work that we are doing is quite remarkable and is reflected in almost every aspect in what I am doing...in turn it has given me other options which I didn't imagine would be available to me... I didn't think that I had the talent for that sort of thing. It is just realising things that were there. My potential is extending all the time. What was there anyway is having more manifestations. Opening different avenues (1996:71b).

> I was managing to let go and to get rid of all the anger. So many people, like in divorce, or anything that happens in their life, the anger stays in your body it can really get to grips with you and make you ...like... end up turning quite bitter and twisted. And I just feel that Frances has actually given me the opportunity to get rid of so much stuff that would have been left inside me and like twisted me against other people ... I feel I just let go of everything. Sometimes I have bad

times but she has given me the ability to look at things, and to let go (1997:266).

The following interview segments also emphasise complementary health's ability to provoke a sense of personal change. The first of the following excerpts derives from a Bowen client who originally became interested in complementary health after the separation from her husband. Here she recounts the gradual process of change and her desire to move away from her original, and unhappy, sense of self. She remarks: 'I have done such a lot of work on myself over, certainly over the last couple of years. I really wanted to change. I wanted to get out of all those old patterns and ways of believing and so I have done a lot of work' (Jane 1996:343). The final passage originates from a medical doctor whose gradual loneliness and isolation accumulated in her seeking a Homeopath. She comments, 'I've changed a lot over the last four years... I think people have noticed a change because of the different things I am doing. My life had changed a great deal' (Client Janine 1997:161). These four interview passages particularly demonstrate how complementary health practices provoke forms of personal change in the individual. Such change results in a developed form of self.

Indeed, these excepts additionally highlight the presence of a health spirituality insofar as adherents' introspective analysis is the means through which they are able to address certain issues (loneliness, illness) and are able to initiate a process of change. In other words, complementary health practices provide the means through which adherents can review and construct a sense of relative meaning to their lives.

The nurturing of confidence and empowerment also accompanies beliefs in personal change within complementary health techniques. As such practitioners advocate, and clients are taught, that each individual has the ability to find well-being and a sense of personal power. This power manifests itself in devising personal development strategies. By understanding one's original self then, the individual is more able to implement plans to bring about an improved and developed sense of self and empowerment. Complementary health's concept of change, therefore, does not only involve the exploration of the self and one's own identity, but also an expression of present and future expectations. Original and developed senses of self allow individuals to assess themselves at one moment in time and assess their future plans. Such

introspective assessment for the individual encourages a spiral of constant re-evaluation and consequent change. McGuire, while discussing chronic illness, identifies with the process of re-evaluation. She says:

> Chronic illness and pain, in particular, force the sufferer to come to new terms with *time*. Sometimes life-threatening acute illness or serious accident has this kind of impact, but acute illness is by definition temporary. Chronic illness often leads to a radical re-assessment, in light of changed and yet-changing capacities, of one's self in relationship to past and future (1990:287).

Hence there is a cycle of assessment and change. Assessment starts once a problem is recognised and change occurs when the issue is worked through. One's sense of self, therefore, is constantly changing according to this cyclical pattern. Hence, one's sense of self is fluid. This pattern does not constantly mean a 'new' sense of self, a transgression to a totally different person, but rather a revival and development of one's original form. As one Colour Therapist remarks: 'The idea is not just to transform into something else. It is just to become fully you. It is a realization' (Annabel 1996:744). Thus, in analysing clients' and therapists' constantly changing notions of self, it becomes possible to identify how health participants construct their sense of self-identity.[18]

Throughout the current literature within Sociology there have been several attempts to analyse images of the self. Beckford and Suzara (1994), Charmaz (1987) and McGuire (1996), particularly, identify different concepts of self while studying health and healing groups.[19] A common feature throughout all three writers is the presence of a constantly changing and re-evaluation of one's sense of self. In researching health and

---

[18]The concept of self-identity throughout this chapter will be based on Giddens's definition. Self-identity then 'is not something that is just given, as a result of the continuities of the individual's action-system, but something that has to be routinely created and sustained in the reflexive activities of the individual' (1991:52). It is then '*the self as reflexively understood by the person in terms of her or his biography*' (1991:53).

[19]Beckford and Suzara identify the notions of the 'restored self', 'empowered self' and the 'released self' (1994:129). Charmaz discusses 'the supernatural identity', the 'restored self', 'a contingent personality identity' and 'the salvaged self' (1987:287). Finally McGuire identifies the 'body/mind self' (1996:102).

healing it is inevitable that one discusses issues of change and self-identity for these issues are centrally addressed within the health milieu. Complementary health is especially preoccupied with issues of self change, and consequently changes in identity, for illness and personal development issues (Appendix 7.1) were seen to be the principal reason why individuals attended complementary health sessions. Notions of change, throughout this section have been discussed in terms of two distinct categories: the original and developed selves. Although these categories may not be exclusive to complementary forms of health care, for these factors can be present in conventional health care practices, they do emphasise the individuals' present and future expectations. This is particularly identified while discussing the notion of the developed self. Indeed, the notion of the developed self can be comparable with Charmaz's identification of a developing self when she says:

> ...individuals restore a *developing self* out of their sense of how they should shape their lives. Here, the direction of their lives concerns them as well as the *character* of the self they shape, rather than commitment to specific prior activities and prior identities. Instead, these individuals commit themselves to growing and developing in the future. They typically do not know exactly what kind of outcome their direction may lead them, but they have a sense of the kind of person they wish to be (1987:303).

Charmaz here identifies with the individual's present and futuristic expectations and draws attention to the individual's desire to revise and re-shape their sense of self. Martin, a Bowen client illustrates the possible changes in one's sense of self when he remarks: 'You could use an illness as a mean of or a vehicle for changing the self as well as changing life experience, changing one's perception of oneself' (1995:205). Anthony, the Rebirthing practitioner, continues on this theme by discussing his clients' ability to transform. He says: 'They do change because they tend to find that they can see a bigger picture of their life. They can understand how they came to be and who they are' (1997:726). The original self is, then, the individual before assessment and future plans of development have taken place. The developed self (or developing self) represents the

individual's future expectations of growth. Health participants therefore identify with an original and developed sense of self.

Health adherents are aware of two other possible perspectives which impact on their self-identity. These are lifestyle and world-view perspectives. There is a distinct difference between lifestyle changes (daily, routine events such as diet, exercise and work) and changes of world-view (personal perception of one's body in the social environment, social attitudes). As we have previously discussed, health participants are interested in personal development and link their development to the influences present in their social environment. While the majority of participants initially attended complementary health therapies out of a desire to alleviate illness symptoms what emerged is their gradual interest in factors (body, lifestyle and world-view perspectives) which could influence their sense of well-being. As such, adherents reflect and revise these factors and consequently modify their personal and social world-views. The development of the self is thereby initiated, in the complementary health milieu, by one's introspective analysis and one's review of influencing social factors. McGuire and Kantor, particularly, draw out the influence of a health world-view when discussing healing recipients:

> Respondents spoke of experiences or renewal, new directions, renewed close ties with loved ones, fresh visions or hopes for the future, purification, and insight. Resolutions [or amelioration] of suffering came from understanding its larger meaning, taking control in the face of their problems, gaining insight into how they could change their selves accordingly, experiencing the support of others who empathized with their situation, and perceiving how their lives and suffering were linked with something larger, interpreted variously as God, cosmic energy, universal Mind, and so on (1988:243).

What becomes apparent while studying adherents' perspectives of lifestyle and world-view changes is that world-view changes are of equal importance as lifestyle

modifications.[20] Naturally, to some extent lifestyle factors (changes in daily routines such as diet and exercise) need to be addressed if substantial development is to take place, but emphasis is equivalently laid on the promotion of positive thoughts and a healthy holistic world-view. Indeed Beckford highlights the impact of a holistic world-view when he remarks: 'The holistic image of the self is active and optimistic in so far as it holds out the possibility of greater satisfaction in personal relations; greater achievement of inner potentials; and a greater sense of belonging to a higher, integrated order of things' (1985a:81). This prospective transformation is not about forced change but a willingness to bring about self, societal and global changes. The possibility of mind/body improvements is only achievable if clients are willing to take on some advice or acknowledge that changes could be needed in either their world-view or lifestyle (or both). What has emerged throughout the research is that specific changes in world-view and lifestyle attitudes take place once clients are taught to be in tune with their own bodies.

7.5 Conclusion

The aim of this chapter was to identify and analyse clients' and therapists' concepts of change since participating in complementary health techniques. Several differences between these groups have emerged. These are in clients' and therapists' sense of seekership, self-awareness, concepts relating to their relationship to their family and social surroundings and participants' shared perspectives of their original and developed sense of self. Concepts of change were seen to emerge regardless of therapy employed, or role as either client or practitioner. Indeed what is fundamental for health participants is the belief in one's ability, and willingness, to develop. Achievement seems an important issue for health adherents. This sense of achievement emerges once goals are accomplished and plans for future development are set. Growth, then, is dependent on the individual and can encompass a multitude of goals and aims. This encourages a

---

[20]See Chapter Six for an analysis of health adherents' beliefs concerning body, lifestyle and world-view perspectives.

wider market as goals are relatively set.[21] Even illegal acts were permissible if these guide adherents to develop a greater understanding of themselves.

The implication of participating in health sessions, then, is that once changes are made to one's own health then one is able to make additional changes to other aspects of one's life. For example, one client mentioned vegetarianism and his changing attitude towards his body. In changing his diet he believed he had rediscovered his body's strength and had consequently changed his lifestyle and body attitudes.

Viewing complementary health beliefs concerning notions of change can additionally illustrate the presence of a health spirituality insofar as forms of change originate and are performed individually rather than as a communal or public demonstration of religiosity. The interview extracts throughout this chapter illustrate this individuality since life events and illness problems are all relatively defined and resolved. Hence, health sessions are individual forums for introspective analysis and are the means through which many health participants develop a sense of health spirituality. It is strange to think that complementary health sessions have such an effect on the individual participant. The power of such a 'safe space', time and confidentiality given in health sessions enables the participant to focus, not only, on their broader aims, but also encourages adherents to discuss issues which they might find difficult to express in other environments.[22] Therapists also believe that they benefit from the health sessions as many admit that they not only receive the same healing as their clients but they also themselves develop as a consequence of their frequent encounters with a wide diversity of clients.

It is important to note, however, that many health participants, clients and therapists alike, were faced with difficult illnesses and personal problems. Many of these health participants did not initially turn to complementary health practices to resolve these specific problems. The rigid and unsuitable structure of certain environments and

---

[21]Heelas (1994).

[22]See Chapter Four for an analysis of client/therapist relations and the health session environment.

the failure of others[23] to address their needs provoked adherents to search for a supportive environment which was better suited to their needs. These participants then actively sought a supportive environment where their experiences and sense of powerlessness over their body could perhaps be transformed into a positive learning experience.

Clients and therapists are realistic about the possible benefits and limitations of complementary health and healing. Regardless of this, however, many do identify with the benefits and long term influences that health sessions have on their lives.

Complementary health sessions were seen to teach participants to accept aspects of their original self and promote the benefits that self evaluation can offer. Health sessions therefore enabled participants to probe prospective problems, to discuss issues of change, to express their needs, and finally to devise strategies for further development.

These experiences for adherents can produce very powerful feelings for those who seek a deeper understanding of themselves. For clients and therapists alike, the re-creation of self and asking oneself 'who does one want to be?' enables participants to explore may aspects of themselves. Such ontological enquiry ranges from an understanding of self and how one sees the world, one's physical, psychological, spiritual self, to one's lifestyle and world-view perspectives, one's body perspective, and notions of potential change. For many clients and practitioners this process is a journey to being a happier, healthier person.

The next chapter will draw together the threads of the discussion so far by focusing on the different therapy cell groups. Through such an analysis I hope to distinguish the similarities and differences of beliefs and practices between therapy styles. In doing so, I aim to explore, in greater detail, the implicit beliefs emanating from each therapy group.

---

[23]For example, doctors, mainline religions and support groups.

CHAPTER EIGHT

CELL DISTINCTIONS

Throughout the previous chapters I have aimed to draw out the major distinctions between therapists' and clients' beliefs and practices. A further distinction, however, arises throughout this research: the divisions between therapy cell groups. The following exploration of complementary health will emphasise the differences between therapy groups and highlight the belief differences between therapy styles. Thus I hope to explore whether beliefs are substantially different between cell groups according to the themes raised throughout the present thesis. By drawing out the features of each cell group, we are then more able to see whether beliefs held by health adherents are relative to individuals according to their client or therapist status, and whether these beliefs are dependent on cell group. This chapter, therefore, aims to highlight the major distinctions between therapy cell groups. The defining cell groups, as previously discussed, are Integral, Psychological/Spiritual and Physical. Explanations will be offered throughout the chapter, as to the particular reasons for belief differentiations between cell groups.

This chapter begins, nonetheless, by proposing several hypotheses as to the major differences between cell groups. These hypotheses are initially based on the specific characteristics of each cell groups. These are: Integral (Cell A), Psychological/ Spiritual (Cell B) and Physical (Cell C).

Table 1 Matrix of Complementary Health and Healing Styles

		Physical	
		Positive	**Negative**
Psychological/ Spiritual	**Positive**	**Cell A**	**Cell B**
	Negative	**Cell C**	**N/A**

The main concern of this analysis is whether certain cell group(s) illustrate more obvious features of spiritual health beliefs than other cell group(s). As we have previously discussed in Chapter Two[1], complementary health and healing practices can

[1]See Chapter Two for definitions of spirituality and religiosity.

resemble features of conventional religious beliefs. However, although we have argued that complementary health practices can illustrate implicit features of a religious belief system several core notions emerge (for example, structure of beliefs, relationship with divine forces and one's intimate and relative identification with divine forces) which question the appropriateness of regarding complementary health practices as a religious belief system. By distinguishing the differences between cell groups, therefore, it could be possible to examine, more closely, the specific features of treatment styles and review any belief differentiations between them which may emerge. Indeed, in order to analyse the specific characteristics of each cell group it becomes necessary to review all the major chapter themes and explore whether certain cell group(s) sustain, and promote, greater transcendental beliefs than other therapy group(s). Before such an investigation can be undertaken, however I hypothesise through which particular cell group(s) these prevalent beliefs are expressed. These are:

HYPOTHESIS A: Principally then, as Psychological/ Spiritual therapies (Cell B) and Integral therapies (Cell A) base their practices on spiritual forces, I propose that these therapy groups have a greater level of belief in their treatment than Physical treatments (Cell C). On reflection then, I hypothesise that adherents from Physical treatments (Cell C) have proportionally the lowest levels of belief in their treatments. Thus I hypothesise that the strength of adherents' beliefs in treatments relies on the inclusion of Psychological/ Spiritual practices.

HYPOTHESIS B: As such, I propose secondarily that similarities will emerge concerning Cell groups A and B due to the significant impact of spiritual beliefs within their health practices. Thus, beliefs in complementary health and healing do not rely solely on the presence of *pure* cell categorizations (that is, cell groups which are based on *either* Psychological/ Spiritual (Cell B) or Physical treatments (Cell C)), but rather on the use of divine healing forces, as used on Cells A and B.

A third area of study within this chapter is belief transference. Thus, I wish to examine whether complementary health beliefs are significantly transferred from

therapist to client groups within each cell. In examining belief transference one can initially analyse how beliefs are conveyed between health adherents. A third hypothesis therefore arises.

HYPOTHESIS C: I hypothesise that belief transference does occur within all cell groups, but is proportionally more prevalent in Cell groups A and B, due to the overt use and inclusion of divine forces within these treatment styles. Again, as these treatments are grounded in Psychological/ Spiritual practices these cell groups are hypothesised to illustrate greater features of belief transference.

This analysis will be undertaken using the qualitative computer package WINMAX Pro which enables the researcher to search and retrieve specific fractions of qualitative data. Particular issues were sought by highlighting texts and list of codes (Appendix 3.8) and performing a specific search and retrieval procedure. For example, in undertaking a search regarding 'beliefs in treatments' all coded segments referring to therapists' and clients' beliefs in treatments were retrieved and reviewed. This process enabled recurring and prominent themes to arise, for example hope and seekership. The secondary process to this analysis was the study of therapist and client groups. Throughout the previous chapters I have emphasised the belief differentiation between therapists' and clients' beliefs and practices. Coded segments were therefore retrieved from the WINMAX Pro program according to their practitioner-client status. In discovering data relevant to this chapter it was necessary to arrange interview texts, within WINMAX Pro, according to cell group. As such ethnographic material was sought and retrieved according to the cell group in which it was assigned.[2]

In order to clarify the arguments posed it will be necessary to divide this chapter into six sections. Each section will focus on a different health theme which has been formally raised in previous chapters. Section 8.1 will explore cell distinctions relating to issues of faith and belief which are formed when encountering complementary health

---

[2]An additional remark must be made as to the format of this chapter. As the research does not intend to be quantitative in form, but qualitative, the table numbers act only as indicators of therapy differentiations. In order to substantiate further these cell differentiations additional quantitative research would be necessary.

and healing therapies (see Chapter Four). Section 8.2 will introduce the cell distinctions regarding mistrust between therapy groups and attendance at social events. These issues will be briefly discussed as they contribute to the wider discussion of belief transference. Section 8.3 will look specifically at cell distinctions regarding energy beliefs and inquire into possible differentiations in therapy group interpretations of healing energy (Chapter Five). Section 8.4 will explore similarities and contrasts in body, lifestyle, and world-view perspectives (Chapter Six). Section 8.5 will review concepts of change according to the cell group categorization (Chapter Seven). Finally Section 8.6 will conclude this chapter by drawing together the hypotheses posed, assessing possible differences in treatment beliefs, and finally distinguishing between cell groups regarding belief transference.

To begin this chapter it is first necessary to review briefly the cell groups, by describing their practices, techniques, and individual characteristics. In accordance with Fulder (1988) and West (1992), the research categorizations were: Physical (Cell C), Psychological/ Spiritual (Cell B), and Integral (Cell A).[3]

Cell group C is distinguished by its emphasis on the physical body. Movement, manipulation and touch are all methods which are employed by therapies in this group. Attention is placed on the body's own ability to rejuvenate its healing properties by appropriate physical action. The practices which have been categorized within this cell include:

(a) *Shiatsu* which is a finger pressure technique designed to bring about the movement of healing energy throughout the body;

(b) *Homeopathy*, based on the principle that 'like cures like', that is, when small quantities of substances are given to the recipient in order to simulate the body's own healing mechanism;

(c) *Bowen Technique* which consists of a very precise sequence of moves at specific points of the body in which the therapist 'gently manoeuvres the muscles or tendons resulting in a general feeling of well-being' (Bowen Technique leaflet 1994 distributed by therapist 16/11/95);

(d) *Reflexology* which, like Shiatsu, involves the gentle manipulation of the body to bring

---

[3]See Chapter Two, Section 2.1 for an explanation of these cell groups.

about the body's own healing properties. Reflexology, however, is concerned specifically with the feet, since it is believed that the feet mirror the various systems and organs of the entire body; and finally,

(e) *Natural Healing* which is a combination of *Homeopathy* and *Aromatherapy.* This practice relies on the use of various essential oils which are claimed to contain specific healing qualities. These oils can be based on flowers, herbs, spices, plants or trees. There are several methods by which these oils are used, for example in baths, skin preparations, massage or inhalation. By far the most frequent use of these oils is by massage. By massaging these essential oils onto the skin it is believed that it can provoke various systems of the body (lymphatic, endocrine, circulation) to be stimulated to bring about body relaxation and physical well-being.

Hence, by the assistance of touch, Cell C therapies place an emphasis on the body's own healing ability. In addition, Cell C therapies are more orientated towards self-perpetuated change, self-motivation and problem solving to combat declining self-perception. This group of therapies can therefore be seen to place importance on body self correction.

Cell B therapies place an emphasis on Psychological/Spiritual techniques. These treatments are in contrast to Cell C in that practices place greater attention on the exterior, transcendental forces of healing to bring about good health. Cell B treatments therefore place a strong emphasis on transcendental forces. Indeed these forces are the central focus of therapies from Cell B. These types of therapies also advocate positive thinking and visualization techniques. As such, these treatments advocate the benefits of healing through the utilization of celestial forces on the body. These treatments include:

(a) *NFSH Healing* which commonly refers to the invocation of divine forces, and the laying on of hands to the individual. Such actions are believed to encourage the cleansing of negative energy throughout the body, which consequently leads to good health;

(b) *Reiki* which similarly involves healing by catalyzing external healing forces, and drawing them to the physical form; and finally,

(c) *Creating Prosperity* which involves an examination of 'your beliefs around prosperity - money, relationships, life goals, successful careers, health - and to find dynamic ways

of moving from out-dated patterns and into new pathways of success' (Creating Prosperity leaflet 1996). The techniques employed involved the reformulation of one's aims, goals and beliefs, and to advocate an alternative perspective to knowledge and behaviour.

Finally, **Cell A** therapies are Integral in that they combine the characteristics of both physical and psychological/ Spiritual treatments. These treatments include:

(a) *Colour Healing* can be seen to incorporate into its practice not only physical characteristics, as outlined previously, but also Psychological/Spiritual notions relating to the body's ability to be influenced by colour and visualization techniques. Hence, Colour Healing, 'reactivates our understanding of the meaning of colour, and, through that new found awareness, enables us to reconnect with our "real selves"'(Colour Healing leaflet, produced and distributed by interviewee 1/8/96). Colour healing occasionally involves the invocation of transcendental forces in order to interpret, purify and assist in the health sessions;

(b) Similarly, within *Crystal Healing* there is a balance of techniques used. Therapists believe in each crystal's quality. By placing these crystals onto the physical body the stones are believed to absorb clients' ailments. Invocation of spiritual guides also occurs inasmuch as they guide the Crystal Healer to select the appropriate crystal for the illness symptom. Spiritual guides can also assist the healer by locating the specific injury;

(c) *Rebirthing* is the final therapy located in Cell A. Rebirthing can be described literally as a specific breathing technique which incorporates both a form of counselling and psychotherapy. The breathing technique is believed to enable the individual to 'bridge their conscious and subconscious mind' (Rebirthing Practitioner Anthony, 1997:29). Rebirthing then, 'opens up the subconscious mind and allows the individual to begin to access any conditioning as it is expressed in unexpressed emotional or mental patterning' (Rebirthing Practitioner Anthony 1997:30-31). The process of Rebirthing can become very physical resulting in various forms of erratic body movements. Hence, this treatment is performed in a sparse and often cushioned room.

8.1 Beliefs and Healing Experiences

We have indicated in Appendix 7.1 that there were four significant avenues through which individuals turn to complementary health and healing techniques. Briefly, these are: previous interest in health and spiritual issues (twenty seven percent), an individual's recognition of their own healing abilities (fifteen percent), personal problems and family crises, for example divorce/ redundancy (fifteen percent), and finally illness, (forty three percent).[4] A duplication of Appendix 7.1 is shown below.

Duplication of Appendix 7.1 Movement to Complementary Health and Healing by Therapy Style

	Clients				Therapists				
	A	**B**	**C**	**Client Total**	**A**	**B**	**C**	**Therapist Total**	**Total**
Physical	+	-	+	+ -	+	-	+	+ -	+ -
Psychological/ Spiritual	+	+	-	+ -	+	+	-	+ -	+ -
Interest in Health and Spiritual Issues	1	2	1	4	1	4	2	7	11
Healing Gifts	-	1	-	1	1	3	1	5	6
Personal Problems & Family Crises	-	-	2	2	2	-	2	4	6
Illness	4	6	3	13	2	1	2	5	18
Cell Total	5	9	6	20	6	8	7	21	41

The most suggestive of these figures is of course the high level of illness experience. In viewing Appendix 7.1 we can see that clients predominantly sought

---

[4]All clients had previously tried conventional medicine before approaching a complementary health practitioner. These clients either had a bad experience with a doctor, had been told that their condition needed treatment, but had opted instead for a natural method of treatment, felt that there was something lacking in conventional medicine which would hinder their own development, or found that conventional medicine could not diagnose their symptoms.

complementary health, for health reasons.[5] In contrast to this, however, therapists were more diverse in their movement to complementary health. Perhaps not surprisingly therapists from Cell B were found to gravitate towards complementary health, not so much out of a desire to alleviate any illnesses, but rather to satisfy their interest in health and spiritual issues and to use their perceived healing gifts. Even cell groups A and C can be seen to have a significantly small number of therapists, originally seeking complementary health, for health reasons. Both therapist A and C groups then, had a diverse range of reasons for their movement into complementary health practices, but were significantly less interested in spiritual issues. Clients, on the other hand, were found to attend health sessions predominately out of a need to alleviate health problems. The only marginal difference is between client groups B and C. That is, a small proportion of Cell B clients were interested originally in health and spiritual issues, causing them to attend health sessions. These clients were then curious as to the practices of complementary health. In contrast, Cell C clients (n=2) encountered personal crises which initiated their health interest. In order to overcome these personal crises clients from Cell C required dialogue, time, space, and most importantly to Cell C treatments, the underestimated aspect of physical touch.[6]

While studying adherents' journeys to health treatments no distinctions occurred between cell groups. The study does, however, signify the variety of reasons why people attend complementary health sessions.

Illness, personal and family crises are all aspects which are linked to the notion of hope, for hope in these circumstances enables the individual to feel fairly confident that some form of change will take place. Hence, the concept of hope becomes particularly noticeable while initially discussing complementary health with adherents. As previously discussed in Chapter Four, hope formed the foundation to complementary health through its ability to install a sense of meaning to the adherents' ailments, and purpose as to the course of action needed to alleviate these maladies. Hence, the

---

[5]In addition see Appendix 7.2 and Appendix 7.3 for details of therapist and client illnesses.

[6]See Appendix 3.5 for interviewee descriptions. See particularly Cell C clients Janine and Jane.

individual's circumstances can be analysed in order to seek specific solutions to daily events.

Table 8.1 illustrates all health participants who mentioned the notion of hope while discussing their participation in complementary health. In analysing these findings, by cell group, we discover that the main exponents of hope are those therapists found in Cell A and clients located in Cell C.[7]

We can see then that clients from Cell B and C have proportionally greater concepts of hope than Cell A. This can be explained by Cell B and C clients' recognition of their practices pure health styles. To explain , Cell B and C therapies are grounded on a strong faith in the treatment style as these practices rely on the sole use of Physical or Psychological/ Spiritual techniques. Hence, adherents are more willing to hope in the benefits of their treatments if the practices are grounded in a single health style. For example a Bowen client is more willing to believe in the benefits of their treatment technique because of the treatment's foundation on the anatomy, and hence, is believed to offer a scientific explanation for illnesses. Treatments such as Reiki rely predominantly on the intervention of divine forces and concepts of spirituality to initiate a sense of well-being. It can be argued, therefore, that adherents are unable to combine the explanation of both science and belief within one treatment style (as represented in Cell A treatments).

---

[7]Indeed, in order to clarify the coding process several distinctions must be made regarding Table 8.1. Hope, as explained in Chapter Four, represents health adherents' expectations of change while trust relates to the trust formed in the therapist-client relationship. Adherents' also mention trust while discussing the treatments ability to alleviate illness symptoms. Finally, faith indicates health advocates beliefs in treatments.

Table 8.1 Beliefs in Treatments by Therapy Style

	Cell A		Cell B		Cell C	
Psychological /Spiritual	+		+		-	
Physical	+		-		+	
	Therapists	Clients	Therapists	Clients	Therapists	Clients
Hope	5 (83)	2 (40)	5 (63)	5 (56)	4 (57)	4 (67)
Trust	4 (67)	1 (20)	3 (38)	4 (44)	2 (29)	4 (67)
Self-understanding	6 (100)	1 (20)	4 (50)	6 (67)	5 (71)	3 (50)
Faith	6 (100)	3 (60)	5 (63)	5 (56)	4 (57)	5 (83)
N=100%	6 (100)	5 (100)	8 (100)	9 (100)	7 (100)	6 (100)

Relating to the notion of hope is the concept of trust. Hope only prevails, when there is an underlying trust in both the treatment and practitioner. Table 8.1 illustrates the number of participants who remarked on trust in health sessions. For clients, trust in both their practitioners' ability to facilitate healing, and the treatment's method becomes an important issue in taking part in health sessions. However, for therapists, trust emerges in their own ability to facilitate the healing process, by means of catalyzing the flow of healing energy. Practitioners' self-trust (in their own abilities), and their beliefs in the presence of healing power, all contribute to the therapists' beliefs in complementary health and healing. Table 8.1 illustrates the number of health adherents who mentioned trust while discussing their health sessions. Although all cell groups mention trust, a dissimilar pattern emerges between cell groups. The most noticeable feature of trust emerged between therapists and clients within Cell A. That is, although therapists illustrate a high level of trust and hope their clients represent only a small proportion of these issues. Hence, as illustrated in Table 8.1, Cell A clients were proportionally less likely to mention hope and trust than the other cell groups. Belief transference can therefore be seen to be minimal within Cell group A. The low level of belief transference between adherents of Cell A can be explained as Cell A's therapists' inability to promote both the transcendental and scientific explanations of their therapy. An example of this inability can be seen in Crystal Healing. Crystal Healing emphasises the natural healing abilities of crystals. In order to catalyze these healing properties,

practitioners use several methods to draw out the crystals' healing properties. Silent prayer and meditation are the most frequent methods used. However, although the client is often aware of these methods they are often only privy to what is observable in the therapy session. Clients therefore observe a mixture of techniques. Therapists in Cell A are also more reluctant to share their faith in their treatments with their clients, and therefore are less likely overtly to influence their clients with their beliefs. Practitioners therefore state that their own faith is a prerequisite to performing treatments but it is unnecessary for their clients to believe in their practices. As such practitioners may be less likely to discuss issues of faith with their clients. The contrast between Cell A's practitioners' and clients' concepts of faith is observable from Table 8.1. In contrast to this, a high proportion of clients from Cell C mentioned trust within their health session. Trust, for Cell C clients, mainly took form of trust built up through their experiences of physical manipulation by the therapist. A degree of trust must be created in these types of health sessions due to the relatively high level of physical intimacy which takes place. It would be highly unlikely, therefore, for an Aromatherapy session to take place if the client did not have a high degree of trust in the integrity and sensitivity of the practitioner.

Hope and trust are therefore factors which are created within the milieu of the therapy room. The therapy experience itself, then, seems to be an essential factor in initiating belief in the effectiveness of health treatments.

Healing sensations, as noted in Appendix 4.1, were previously argued to have formed the foundations to adherents' beliefs in complementary health practices. By viewing these experiences by cell group we once again encounter a pattern of responses from each cell group. The duplication of Appendix 4.1 is shown below.

Duplication of Appendix 4.1 Clients' Healing Experiences by Therapy Style

	Cell A	Cell B	Cell C	Total
Physical	+	-	+	+ -
Psychological/Spiritual	+	+	-	+ -
Absent Healing	1	1	-	2
Energy Experiences	1	5	4	10
Laylines/ Home Healing	-	2	-	2
Out-of-Body Experiences	-	-	2	2
Past Life	-	1	-	1
Visions/ Dreams	1	4	1	6
Communicative Experiences	1	-	-	1
Levitation Experiences	-	1	-	1
Total Experiences	4	14	7	25
Cell Total	5	9	6	20

Cell B adherents had proportionally a wider range of experiences, and a greater frequency of health experiences than other cell groups. Surprisingly, there was a wide range of experiences encountered by each client group. The most noticeable of these experiences were sensations associated with energy (n=10). In viewing this figure by cell group we find that clients from Cells B and C claim to have the most frequent number of energy experiences. Visions and dreams, in health sessions, were found to be the second most frequent health experience. These types of experiences were prevalently found to be from Cell B clients. One noteworthy comment however is needed regarding Cell C clients. Although Cell C clients had a limited range of healing experiences, some of these did have out-of-body experiences which other groups did not encounter. This discovery was particularly unexpected considering Cell C's emphasis on physical manipulation and movement.

The clients found in integral cell group A, on the other hand, had a small, but diffused range of experiences. Substantial differentiation between the proportion and range of healing experiences, encountered by Cells B and A clients can be argued to be grounded on the cell groups opposing positions on the origins and primary source of

health care. Simply, while Cell B treatments are concerned principally with healing initiated from external forces, Cell A therapies are primarily concerned with beliefs in one's own power to provoke self-healing. Hence, we are able to identify a contrast between client experiences in Cell groups A and B in as much as Cell B clients' believe that their healing experiences largely originate from external and divine sources while clients from Cell group A predominantly believe that their healing experiences are grounded in their beliefs of self-change. Hence, clients located in cell group A do not demonstrate many overt forms of healing experiences. (See Appendix 4.1).

Nonetheless health sessions for all clients enabled time and space for self-reflection. While reflecting on the data collated one was able to note clients' pragmatic approach to healing. Clients then, use the health session as a cognitive experience whereby they are able to identify and assess themselves and their circumstances. The therapist's role is thereby facilitator in this process, thus enabling clients to interpret, question and assess their own health needs. To enable such self-reflection to take place, practitioners and clients were seen to develop a process of dialogue. Such frequent, and often intimate, exchanges can be argued to bring about a deeper understanding of oneself. The ability of health sessions to encourage introspective analysis is especially prevalent when one is asked to communicate one's present needs and one's future expectations. As such, these discussions enable participants to develop a heightened sense of self-identity.

Table 8.1 again highlights the number of adherents who specifically remarked on their self-understanding as a consequence of health sessions.[8] Similarly to the previous patterns there was a strong relationship between practitioner and client notions of self-understanding in Cell groups B and C. Again, Cell A adherents illustrated the lowest level of belief transference. In order to build self-understanding adherents emphasised the role of dialogue. Dialogue, therefore, became an essential factor in the process of discovering one's health needs, as well as initiating a process of self-

---

[8]An additional relationship can also be seen regarding the construction of self-identity. If we are to study practitioners' ambitions for their clients, we can see specifically (in Appendix 7.4), that a high proportion of therapists hope to convey a sense of empowerment and education to their clients. It is by means of these aims that clients claim to develop a cognitive sense of self.

discovery. In inquiring into the importance of therapy discussions we discover that all but one therapist (Cell B) thought that in-depth discussions were critical to the functioning of the health session. Similarly, clients also remarked on the essential role of dialogue. Only two clients (one from each of Cells A and B), did not remark on the role of communication. Dialogue, therefore, and often reflective dialogue, was perceived by therapists and clients alike to be the foundation for promoting self-understanding and trust between therapy participants.

The issue of faith can also be seen to be an important underlying issue while discussing health experiences. Faith in one's treatment, therapist and the forces of healing, was previously argued to have originated from a variety of health experiences. Beliefs then, for the majority of clients, were gained experientially as they often sought external sources of meaning, while others were accidental recruits as they gradually became interested in the practices of complementary health.[9] Beliefs for clients are additionally grounded in their faith in the treatment itself and on the treatment's ability to alleviate ill-health symptoms. While therapists also gain faith by encountering health sensations, they also claim to ground their faith in their own ability to perform treatments, and in their own healing abilities. As expected, then, the majority of therapists were found to have a greater belief in the treatments that they practise. The exception can be seen, surprisingly, from Cell C. Table 8.1 illustrates the finding that Cell C clients have a higher level of faith than the Cell C practitioners. A possible explanation for this imbalance can be that practitioners are more prominent in their beliefs in energy (see Table 8.5) and are therefore more likely to advocate the benefits of faith in the treatment, and treatment method, to their clients.

In studying clients' notions of belief and faith in treatments, by cell group, we discover that all client groups frequently mentioned faith in their treatment. More specifically, however, Cell groups A and B held similar views regarding faith in complementary health. Regardless of the total response rate for these two cells, it still becomes clear that these client groups recognise their feelings of faith towards their treatments. The following interview extract illustrates how health adherents' become interested and come to believe in treatments. Felicity, a NFSH client (Cell B), notes an

---

[9]See Chapters Four.

experience which subsequently led her to take therapy sessions. She observes:

> I went to The Healing Centre one day and there was a demonstration going on, and I thought 'that will do me'... it was quite funny because she was putting her hands on me like this [demonstrating therapist's hand movements over her torso] and I was laying with my eyes shut and I remember saying to her, 'gosh it is ever so cold where your hands are now', and she said, 'open your eyes... My hands are not there now'. I looked and she was way down here somewhere [indicating legs], but this bit of me [the torso] was frozen. It was actually cold to touch. It was most odd. (1997:178-191).

Throughout this chapter, so far, we have seen that there have been a remarkable similarity between client groups B and C regarding movement to complementary health practices, hope, trust and self-understanding. This finding does not correspond to the first hypothesis posed. I had hypothesised that Cell groups A and B would be most similar because of the presence of spiritual forces in their practices. We discover, however, that *pure* cell categorizations, cell groups B and C, are most alike concerning notions of hope, trust and self-understanding. What this analysis has discovered, however, is the similarities of beliefs in treatments throughout all cell groups. Indeed, more specifically, clients from Cell B were found to be the least likely to remark on faith in complementary health while, in contrast, clients from Cell C were the most likely to discuss faith in their treatment session.

The remarkable factor which emerges from Table 8.1 is the minimal transference of ideas from therapists to clients in Cell A. As we have previously seen throughout this chapter, a pattern arises between Cell A therapists and clients regarding the minimal transference of ideas relating to hope, trust and self-understanding. This perhaps offers an initial observation as to the transference of beliefs from therapist to client. That is, Cell group A therapists are aware of beliefs and practices associated with their treatments, but are less likely to transfer their ideas onto their client. Two simple explanations can be offered as to this finding. Speculatively then, a combination of Psychological/ Spiritual and Physical beliefs may

imply less commitment or conviction than either Psychological/ Spiritual or Physical beliefs considered separately. Secondly, it seems that health adherents were unable to believe in the presence of both Psychological/ Spiritual treatment styles (based on belief) and those treatment styles which are claimed to be based on science (for example a knowledge of anatomy). The incompatibility of these ideas could have resulted in adherents' reluctance to believe in both the presence of divine healing and scientific explanations for treatment techniques.

The relationship between therapist and client, therefore, entails many different concerns. The building of hope, trust, dialogue, and faith are all features which continuously evolve throughout their association. It is by no means surprising then, that there were few differences between cell groups regarding the construction of ties between health participants. It was observed that all practitioners were thought to provide the same qualities (compassion etc) and opportunities as those from other cell groups.

Several additional observations can be made concerning the often intimate relationship between practitioner and client. The first observation relates to Cell B clients. In enquiring as to the treatments previously taken by them, before discovering treatments located in Cell B, it was found that many clients had initially experienced Cell C treatments. Clients from Cell B were the only client group through which such an observation could be made.[10] Hence, clients from Cell B were more explicit in their search for meaning and good health.

Secondly, the average length of association between therapist and client was discovered to be approximately two/three years. However, a few Cell B clients had been attending their therapist for approximately seven/eight years. It is throughout this time of prolonged contact that a degree of closeness emerges between practitioner and client. Due to the health sessions' nature of continuous dialogue a level of intimacy occurs. Such intimacy can be argued to be relatively unique to this type of health care, for complementary health aims to promote a feeling of equality between client and

---

[10]The previous therapies taken by Cell B clients could also be argued to indicate the notion of seekership, as outlined in Chapter Seven. In addition, the progressive movement of adherents from Cell C to Cell B could also indicate the pathway of therapy recruitment.

practitioner. Intimacy cannot occur if a degree of identification and commonality, between therapist and client, is absent. The relationship between the practitioner and client was observed by Claire, a Bowen Therapist (Cell C), while discussing clients' notions of equality. She notes:

> It is not a matter that they feel equal to the therapist. It's that they feel more equal than they would do to a doctor who is way up there in terms of their approach, and presentation, and perception in the social scale. So I tend to enter into partnership with clients over time, and I have clients that I have had for nine to ten years. There has to be in terms of ethics, a separation. And so I am extremely lucky that I have a very good friendship with my clients and they treat me as a friend but there is always that little dividing line between the sorts of friends they have got, who are real friends, and the friend therapist that I am to them. So there is a demarcation and there is a closeness with me, but I think that that is quite unusual (1996: 372-380).

The equality which complementary health practitioners aim to achieve, nonetheless can be argued to be purely cosmetic. As the quote above implies, there is a differentiation between what comprises social support, and what constitutes personal friendship. In addition, regardless of the closeness which is formed between participants, there is automatically a distinction between parties in terms of technical skills (therapist's healing ability, and their strategies for invoking healing forces), which still separates and gives power to the practitioner. Irrespective of therapists' claims that clients are able to embrace these skills themselves, the therapist is perceived as the custodian of these forces. Practitioners are, therefore, structurally distinguished from their clients. Hence, what emerges is only a perceived equality between practitioners and their clients. A secondary argument for continued inequality between participants can be seen in the differences between adherents concerning purification issues (therapists' energy/aura balance), the custodians of sacred symbols and rituals, and the gradual professionalization of health and healing treatments by regulatory associations (which monitor and control these treatment areas). Finally, as

we have argued throughout this thesis, therapists become interpreters of their clients' illnesses and circumstances, which may indicate a further underlying authority and control. Regardless of cell group, therefore, these issues still distance the therapists from their clients.

8.2 Mistrust & Social Events

While viewing health adherents' movement to complementary health practices it was found that the majority of therapists took an active interest and role in communal events such as festivals and exhibitions. Ninety five percent of practitioners were seen to participate in health related social events. Perhaps not surprisingly only fifty five percent of clients actively chose to attend such events. A further twenty percent of clients were found to be interested in communal events, but had not yet visited any assembly. The remaining twenty five percent of clients did not intend to attend any communal health related event. The brief study of attendees and non-attendees at social events was initially interesting for it was found that almost one-third of adherents sought complementary health practices out of an interest in health and spiritual issues. By enquiring into social events, therefore, I aimed to explore whether these types of events contributed to adherents' beliefs in treatments and enquire as to whether these events provided an additional means through which beliefs were conveyed between practitioner and client. The unexpected issue of mistrust also arose from this enquiry.

The following table illustrates the attendees and non-attendees of health and healing events. The table is categorized by cell group in order to view each group's participation in social events.

Table 8.2 Attendance at Social Events by Therapy Style

	Cell A		**Cell B**		**Cell C**	
Psychological/ Spiritual	+		+		-	
Physical	+		-		+	
	Therapists	Clients	Therapists	Clients	Therapists	Clients
Attendees at Social Events	6 (100)	4 (80)	8 (100)	3 (33)	6 (86)	4 (67)
Non-attendees at Social Events	-	1 (20)	-	6 (67)	1 (14)	2 (33)
Mistrust of Social Events	2 (33)	4 (80)	5 (63)	5 (56)	5 (71)	3 (50)
N=100%	6 (100)	5 (100)	8 (100)	9 (100)	7 (100)	6 (100)

As we can see from Table 8.2, therapists across all cell groups participate in social events. Only one therapist did not attend events, due to time restrictions. The most noticeable figure within this table is the high proportion of clients located in Cell B who did not attend social events. The principal reason for this was due to the high proportion of Cell B therapists who explicitly commented on their mistrust and overt scepticism of other forms of practice, which dealt centrally with transcendental forces. We can see, then, that although Cell B therapists themselves attended communal events, they actively discouraged their clients from doing so. The main concern for Cell B therapists are events which promoted divinatory beliefs and practices (tarot, palmistry), for these therapists believe that divinatory practices do not address the individual problem encountered by the client, but rather offer solutions by relying on fate and predictive skills. Health practitioners, on the other hand, believe that they are better able to assist individuals by addressing specific problems and constructing practical solutions to change their clients' circumstances. A secondary distinction is highlighted by Cell B therapists while discussing their scepticism of divinatory practices. The second distinction refers to the use of transcendental powers within both complementary health and divinatory practices. That is, although practices such as Reiki incorporate transcendental powers into their own practice, therapists emphasised

the differences between positive divine powers, which were catalyzed in health and healing practices, and the possible access to negative, malignant forces which divinatory practices may, inadvertently, invoke (and promote). Hence, the scepticism of therapists was grounded in the predictive skills of these practices rather then their spiritual beliefs. Unfortunately, it was not possible to explore divinatory practices in this present research. However, for future research purposes it would be beneficial to redefine the Complementary Health and Healing Matrix (as illustrated in Chapter Three), to allow a division within Cell B (Psychological/ Spiritual). This division would provide a further focus to study the specific characteristics of treatment styles. Mistrust then, highlights the possible split within Cell B between the use of predictive skills in divinatory practices and health spiritual beliefs.

To varying degrees mistrust can then be seen to permeate all cell and therapist-client groups. Table 8.2 illustrates the number of participants who mention mistrust of social events by therapist and client groups. We can identify then that the most prominent sceptics of alternative social events were clients located in Cell A. Cell A practitioners, on the other hand, were seen to be the least sceptical of alternative health and spiritual events.

Complementary health and healing circles can offer an entire network of social support. Regardless of such scepticism we can still note that seventy six per cent of health adherents attend social events. For therapists, particularly, additional social gatherings such as development groups, and therapist network groups, are essential for the gathering and sharing of information. While discussing the development of her healing skills, April, a Crystal Healer (Cell A), remarks on the role of therapist development groups. She observes:

> I went into what they call a development group, which develops that side of you [Psychic skills]. Some people call it a circle but it sounds too mystical, but basically it's a group of people that are like minded, and you can develop your intuitive side, and you learn to trust that side of you, and then you grow from it. (1997:15-22).

Social events, however, regardless of degrees of mistrust of other practices, act as a catalyst for health participants in their construction of beliefs. Social events additionally offer an environment where an individual's experiences can be reviewed and beliefs can be reinforced. The review of ideas emerges again while discussing the group workshop. April emphasises how social events can make a significant impact on the construction of an individual's beliefs and practices. As such, communal events were believed to influence adherents' thoughts and enable participants to share ideas and experiences. Participation in events is, therefore, 'how people change their lives. ... That is why all these self-help groups are here because it's about what we think' (1997:339-342). Hence, April implies that once changes in thought have occurred, through participation in social events, then one is more likely to acknowledge one's needs and to devise development strategies.

8.3 Energy Beliefs

A significant issue which emerged while studying complementary health beliefs and practices was the presence and use of healing energy. While analysing how practitioners first became aware of energy a number of common issues arose. Surprisingly, one of the most significant discoveries was that twenty nine percent of therapists did not know how they discovered this healing force, which constitutes a central place within their practice. This figure is evenly distributed throughout all cell groups. The most suggestive finding, however was the number of therapists who instinctively knew of these forces (fifty seven percent), through their own healing gifts, and psychic abilities. (See Appendix 7.5 for a list of Therapist Skills by cell group). Indeed, by viewing Table 8.3 it can be noted that the majority of therapists who were instinctively aware of these healing forces were located in Cell groups A and B. Finally, therapists in Cell C were more likely to learn of these healing forces from another therapist, colleague or training course (forty three percent).

The following Table (8.3) indicates how beliefs in healing energy were learnt by therapists and how clients became aware of energy concepts. Clients represented on this table predominantly heard of energy by means of their therapist's comments

throughout their health sessions (fifty five percent). By inquiring into clients' knowledge of energy beliefs it was therefore possible to satisfy an interest as to whether clients absorb certain notions from their therapist. As we can see then, from Table 8.3, clients did absorb information offered to them by their therapist. Although one does not mean to imply that there is a significant conversion technique being employed by the therapist, it does indicate that clients do receive messages from their therapist, which shape their perception of themselves and their surrounding environment. In addition, as we have previously argued, beliefs originate from health experiences. As such clients' preliminary knowledge of these transcendental forces is re-inforced by therapists' interpretations of the clients' healing experiences (See Chapter Four). Only three clients from Cells A and B instinctively knew of these healing forces. Like their therapist, these clients believed that they became aware of these forces by means of their own psychic and/or healing ability.

Table 8.3 Adherents' First Knowledge of Healing Energy by Therapy Style

	Cell A		**Cell B**		**Cell C**	
Psychological/ Spiritual	+		+		-	
Physical	+		-		+	
	Therapists	Clients	Therapists	Clients	Therapists	Clients
From a Therapist	-	3 (60)	-	4 (44)	3 (43)	4 (67)
School	-	-	-	-	-	1 (16)
Instinctively Knew	4 (67)	1 (20)	6 (75)	2 (22)	2 (28)	-
Spiritualist Church	-	-	-	1 (12)	-	-
Don't Know	2 (33)	1 (20)	2 (25)	2 (22)	2 (28)	1 (16)
N=100%	6 (100)	5 (100)	8 (100)	9 (100)	7 (100)	6 (100)

We have already questioned health advocates' perceptions of what constitutes healing energy and found that the most frequent concept was that of images of the divine, (therapists n=7, clients n=6), science, (therapists n=9, clients n=3), and, finally,

the cosmos, (therapists n=5, clients n=1). Ten clients could not describe their concepts of healing energy.

However, in distinguishing these issues by cell group we discover that practitioners in therapy groups A and B predominately identified healing energy as being explained by science. This finding is somewhat surprising considering the level of belief, therapist skills and the treatments' characteristic use of divine healing powers, found in both therapy groups. However, this can be explained by therapists' caution in explaining their beliefs to others. It is possible that my inquiry into this subject area could have aroused a degree of prudence on behalf of some practitioners. Indeed, this is illustrated by Lilly, a Reiki practitioner (Cell B), while discussing the disclosure of therapy methods to clients. She says 'You have to look at yourself and why certain people are coming to you and you have to hide your own feelings from that person' (1996:303-305). Therapists from Cell A also attribute energy concepts to science. In considering these therapists' concepts of belief (as noted in Table 8.4) and their notions of what constitutes energy, we note that Cell A treatments claim to explain their therapy as a balance of notions between science and the divine. Cell C represents a more diverse range of explanations for energy.

Table 8.4 Adherents Concepts of Healing Energy by Therapy Style

	Cell A		**Cell B**		**Cell C**	
Psychological/ Spiritual	+		+		-	
Physical	+		-		+	
	Therapists	Clients	Therapists	Clients	Therapists	Clients
Science	3 (50)	2 (40)	4 (50)	1 (11)	2 (29)	-
Divine	2 (33)	1 (20)	3 (38)	2 (22)	2 (29)	3 (50)
Cosmos	1 (17)	-	1 (12)	1 (11)	3 (42)	-
Don't Know	-	2 (40)	-	5 (56)	-	3 (50)
N= 100 %	6 (100)	5 (100)	8 (100)	9 (100)	7 (100)	6 (100)

Clients had greater difficulty in explaining their concepts of energy. While ten clients did not know, or could not explain healing forces, ten clients were able to

provide preliminary ideas. It seems possible that the remarks made by clients, regarding energy beliefs, may further indicate a basic transference of belief between therapist and client. However, a caution must be noted as commentary regarding this belief transference could take us beyond the present data.[11]

While there were similarities between all cell groups' invocation of healing forces and spiritual guides, for example prayer and visualization, there was often a noticeable differentiation between cell groups' use of healing forces. Cell B therapists principally used prayer to guide them to clients' ailments. Cell A practitioners chiefly invoke energy as a means to attain a heightened state of awareness, in which to guide them to specific energy points on the body. Finally, Cell C therapists used intuition, touch and sensory skills to guide energy to the appropriate points on the body. Nonetheless, the fundamental role of energy in healing was the same throughout all therapy cell groups. Healing forces then, were used as a mechanism for unblocking, and interpreting, stagnant forces throughout the multi-dimensional body.[12] Hence, the alleviation of ill heath, for many practitioners was seen to rely on the use of energy.

The effects of energy were found to be similarly distributed across all cell groups. The majority of therapists (n=15) and clients (n=17) thought that energy provoked a change of perspective which encompassed body, lifestyle and world-view attitudes. Particularly noticeable, however, were the attitudes from Cells B and C clients regarding energy beliefs' wider influence on one's exterior, social, and even global environment. In contrast, adherents located in Cell A principally identified their beliefs in energy to be related specifically to their body perspective. In other words, energy was primarily seen to influence the multi-dimensional body and, hence, to influence recipients' body perspectives for example healing energy's ability to portray specific messages to the individual via the different dimensions and qualities of the body's chakra and aura zones. Thus, for Cell A adherents energy is predominantly used to focus on the specific problems of the body.

While asking practitioners whether they themselves need to believe in energy

---

[11]Further explorations into this matter must be reserved for future research for it is beyond the specific realms of this paper to quantitatively represent this argument.

[12]See Chapter Six.

to perform therapies, seventy one per cent mentioned that belief was necessary. Table 8.5 highlights practitioners' remarks as to their own necessity to believe in energy.

Table 8.5 The Necessity for Practitioners to Believe by Therapy Style

	Cell A	Cell B	Cell C	N=100%
Psychological/ Spiritual	+	+	-	
Physical	+	-	+	
Yes	4 (67)	5 (63)	6 (86)	15 (71)
No	2 (33)	3 (37)	1 (14)	6 (29)
N=100%	6 (100)	8 (100)	7 (100)	21 (100)

Although twenty nine percent of practitioners remarked that no belief was necessary, they did specify that it was necessary to have faith in their own healing abilities in order to perform treatments. In breaking down this figure by cell group we find that Cell C therapists profess greater beliefs in energy concepts. Indeed, a high proportion of both Cell A and Cell B therapists also expressed the central role of energy in their practice. Suzanne, a Reiki practitioner (Cell B), remarks on the necessity of energy beliefs within complementary health practices when she notes, 'You don't do it without some sort of belief' (1996:470). Suzanne continues by commenting on the difficulties of informing clients as to the use of energy in health sessions. The following interview extract highlights the problem encountered by practitioners while discussing energy beliefs with clients. Suzanne relates one of the difficulties of expressing energy beliefs to clients by recounting:

> I've treated atheists. One chap was extremely worried about experiencing something because his central pillar in his life was atheism, and if I was using something that science couldn't measure, or detect, then that would mean this whole belief, that there is no such thing [as energy], would come tumbling down, and that could cause all sorts of problems (1996:47-484).

Suzanne's quote also illustrates why practitioners may be hesitant about relating

the underlying beliefs of their treatment session. As their practice relies on the continual re-visitation of clients then therapists may, to some degree, avoid or disguise particular details of the treatment method.

Surprisingly, however, in asking therapists whether *clients* have to believe in energy forces, in order to receive the therapy, the findings are remarkably similar. Table 8.6 aims to illustrate this similarity.

Table 8.6 Therapists' View of Their Clients' Need to Believe in Healing Energy

	Cell A	Cell B	Cell C	N=100%
Psychological/ Spiritual	+	+	-	
Physical	+	-	+	
Yes	4 (67)	5 (63)	3 (43)	12 (57)
No	1 (16)	3 (37)	3 (43)	7 (33)
Don't Know	1 (16)	-	1 (14)	2 (10)
N=100%	6 (100)	8 (100)	7 (100)	21 (100)

Indeed, while viewing Table 8.6 we can identify a further inconsistency relating to the therapists and clients within Cell group A. Here we can identify the high proportion of Cell A therapists' who thought it was necessary for clients to believe in healing energy (Table 8.6) and the actual level of belief transference which occurs (as indicated in Table 8.1 regarding Cell group A's notions of hope, trust, self-understanding). There arises, then, a differentiation between therapists expectations of clients' belief in energy forces and the actual level of belief which is demonstrated by clients of Cell group A. This indicates that the transference of beliefs, from therapist to client, within Cell group A does not significantly take place. A Rebirthing client expresses his non-beliefs by saying: 'No you don't have to believe in it. That's the beauty. It just works. You don't have to believe in it, you just have to allow it' (Anton 1997:274-276). Here, Anton illustrates one of the attractions of complementary health beliefs and practices, that is, the fluid, and ultimately relative construction of belief. Indeed Anton, while discussing clients' beliefs in healing energy, implies that the treatment can address illness symptoms without the necessity to believe in the

treatment method.

The final significant issue relating to Table 8.6 refers to Cell C therapies. Practitioners within this cell claim to need self-belief in healing forces (Table 8.5) while professing that their clients do not necessarily have to sustain such convictions (Table 8.6). The paradox of practitioners' beliefs, and their clients' non-belief can therefore be seen to co-exist. A therapist remarks on this anomaly when he comments:

> I know that all energy workers believe that it exists. There is no need to believe, it is not even a belief; it's a fact because you experience it on a daily basis. We experience it in our body and it's an awareness. Ultimately for me, saying that the life force is God is an understanding that the Life Force is alive. It's alive and that means that nothing is dead. So when I am looking at something it's like an agnostic interpretation of life. (Anthony 1997:342-365).

Indeed, Anthony's interview extract also hints that this paradoxical relationship occurs in some practitioner groups. Anthony's remarks suggest that all practitioners believe in the presence of healing energy throughout their heath session. However, although these forces exist, and are used, throughout the session he claims that this does not constitute a belief system. Instead faith in energy is grounded in healing experiences and the awareness of exterior forces which could possibly influence one's body and, ultimately, one's life. The contradiction of adherents' beliefs in healing energy (via healing experiences) and their claims of non-belief are therefore seen to emerge. As such Anthony's comments, once again, highlight how complementary health participants do not envisage their practice as constituting a belief system

In asking *clients* whether it was necessary for the client to believe in healing energy, to receive healing, the findings were more diffused. Table 8.7 illustrates clients' notions of belief in healing energy. The cell labelled 'Yes' indicates all respondents who thought beliefs in energy occurred, once they had experienced energy forces. 'No' respondents were those who thought that no belief in healing forces were needed, in order to take part in complementary health sessions. The label 'Don't Know' includes three respondents where no answer was detected.

Table 8.7 Clients' Beliefs in Healing Energy by Therapy Style

	Cell A	Cell B	Cell C	N=100%
Psychological/ Spiritual	+	+	-	
Physical	+	-	+	
Yes	2 (40)	2 (22)	3 (50)	7 (35)
No	2 (40)	1 (11)	1 (17)	4 (20)
Don't Know	1 (20)	6 (67)	2 (33)	9 (45)
N=100%	5 (100)	9 (100)	6 (100)	20 (100)

Not surprisingly, the majority of clients did not know (n=6, thirty percent), or could not remark (n=3, fifteen percent), on whether clients need to hold energy beliefs. However, thirty-five percent professed that beliefs were required and were convinced of healing energy properties. Julie, a NFSH client (Cell B), remarks on the presence, and importance, of energy experiences on her sense of belief when she observes:

> I felt that it [energy] had shifted something within me. That was quite an important experience. Once you have freed yourself from other restrictions, the healing process begins... what I began to experience convinced me really that these energies were there, and that they are real.... it can have such an profound effect on you (1997:82-85).

To summarize this section, therefore, we can see that, although clients claim to require little belief in energy (Table 8.7), many still assert beliefs in their treatments. A possible explanation for this general belief is the additional factors which participants gain by attending health sessions. Such factors include a heightened sense of self-awareness, hope etc., Indeed, therapists themselves retain a high level of belief in energy experiences (Table 8.5) but have conflicting ideas regarding the substance and origins of this healing force (Table 8.4). Such inconsistences contribute to the paradoxical relationship between adherents' faith and experience of health treatments and their sense of disjuncture with conventional ideas of belief and religiosity.

8.4 Body Concepts

While looking at therapists' and clients' body concepts one finds a remarkable symmetry between adherents' perspectives. When enquiring as to whether any changes of body perspective had taken place, almost all clients and therapists believed that they had undergone a process of attitude change. Due to the influence of health experiences, and dialogue, health participants were encouraged to evaluate body messages (ailments), and evaluate their physical, spiritual, and psychological needs at a particular moment in time. These requirements would, naturally, change over time whereupon a new self-assessment would be undertaken, and new developments planned. Luke, NFSH practitioner (Cell B), illustrates the continual process of body assessment and the resulting knowledge which is gained by this body review when he comments:

> And so often they [a client] can have a personal revelation, and it's just that you have to feed a little bit of energy into that area, give a little boost so that they have a little bit of energy to actually confront it and see it... it may be that the healing that you placed into their mental conditioning, or their emotional conditioning, has allowed them to confront the person and to relate it all to the pain (1997:243-249).

This extract therefore highlights how the evaluation of one's body messages can give meaning to an illness experience. As such, one is able to relate illness problems to difficulties which are present in one's daily life. Thus, development strategies can then be devised to address these specific problems. The evaluation of one's body is, therefore, a contributory factor in the self-discovery of an individual's needs and aims. Such assessment provides an additional means to discovering one's self-identity. Daniel, a Natural Healing client (Cell C), again highlights this issue while discussing the recognition of his own body. He explains this discovery by noting his therapist's contribution to this process. He remarks: 'She's really helped with, I guess, with my self-discovery really' (1997:15-16).

Eighty percent of all clients believed that a change in body perspective had therefore taken place. In distinguishing the clients who experienced no change in their body perspective, two clients were found to be located in Cell B (ten per cent), and one client from each of Cells A (five percent) and C (five percent). Similarly, this is mirrored in therapists' responses, as all but one therapist (from Cell B), remarked on their change of view regarding their physical body. This discovery is not surprising considering the nature of complementary health and its desire to bring about a greater body awareness for all its adherents.

As we have previously argued in Chapter Six body perspectives are the foundations to other forms of attitude change. These materialize in the form of lifestyle and world-view perspectives. The most noticeable characteristic when exploring adherents' attitude change is the distinction between lifestyle and world-view perspectives. Without reiterating the arguments presented in Chapter Six, it seems that by focusing on lifestyle and world-view perspectives of health adherents, we are able to identify further a negligible correlation in the transference of ideas, from practitioner to client. To explain, we find that two-thirds of therapists (n=14) advocate that changes in world-view are significantly more likely to take place as a consequence of health sessions, whereas if we look at clients, we find that two-thirds of clients (n= 13) view lifestyle perspectives as the most influential aspect to their health experiences. As such, then, it can be argued that, although a level of transference takes place between practitioner and client groups, the particular manifestation of this transference does not materialize in its expected form. For example, exercise, food habits, posture, relaxation techniques have greater impact on the daily life of clients than adaptations in their world-view perspective. Ann, a Colour Therapist (Cell A), comments on complementary health's ability to influence lifestyle attitudes when she remarks: 'it's a way of life' (1996:764-764). In viewing these issues by cell group we discover that again clients in Cells B and C are similar with regard to lifestyle perspectives. Indeed, as Table 8.8 indicates, one-third of clients claim to experience changes in their world-view perspective as such, then, we can argue that there is a negligible transference of ideas between therapists and clients, across all cell groups. Complementary health notions can therefore be seen to be marginally

conveyed from the practitioner to client. This transference can be illustrated by Julie, a NFSH client (Cell B), while discussing the effects of healing. Julie notes the alteration in her attitudes when she observes: 'Healing has an effect because it does change the conscious slightly ... it is like you have gained something a little bit different... you are happier, or your outlook has changed' (1997:277-296).

Table 8.8 Lifestyle and World-View Perspectives by Therapy Style

	Cell A		**Cell B**		**Cell C**	
Psychological/ Spiritual	+		+		-	
Physical	+		-		+	
	Therapists	Clients	Therapists	Clients	Therapists	Clients
Lifestyle	2 (33)	3 (60)	2 (25)	6 (67)	3 (43)	4 (67)
World-View	4 (67)	2 (40)	6 (75)	3 (33)	4 (57)	2 (33)
N = 100 %	6 (100)	5 (100)	8 (100)	9 (100)	7 (100)	6 (100)

Hence, the general consensus for both therapists and clients was the perception that one's body, lifestyle, and world-view, in everyday life, all contribute to the modification and review of one's self-identity and one's beliefs.

8.5 Concepts of Change

The self-evaluation which is undertaken in complementary health can therefore have differing influences between therapist and client groups. Another noteworthy distinction between these two groups can thus be identified while discussing concepts of change and seekership. Clients view inner peace, serenity, self-knowledge, and the physical body (in recognition of its strengths and weaknesses), as the most influential aspects of change after taking part in health sessions. Therapists, on the other hand, believe that enlightenment, empowerment, and spiritual insights are the most important changes which can take place, both for themselves and their clients. Both of these groups, however, seek these changes primarily by means of external sources of meaning. Clients represent this process by means of evaluating not only their own

physical state, but also by reacting and reflecting messages that are given from their immediate environment (for example from their family). Illness for the client, then, represents lost power, and lost identity through the inability to evaluate themselves and their social surroundings. Similarly, therapists also react and reflect messages portrayed by their environment. However, practitioners search more widely for these meanings. Therefore, instead of simply viewing their own physical state of health, work and family situations, practitioners tend to look at social, national, and even occasionally international issues, in order to contextualize themselves and their beliefs.[13] The recognition of problems is also reliant on the individual's conscious or unconscious state. As discussed in Chapter Seven the client's conscious state is the individual's ability to evaluate one's own needs, acknowledge development areas, and retain a sense of self-identity. The unconscious state is one's ill health status whereby the individual is dislodged from their sense of self by the illness condition. An unconscious state of health is then the adherent's inability to acknowledge fully their health needs, and consequently their inability to enhance their sense of personal identity. Hence the individual is thereby unable to recognise the factors necessary to alleviate their condition or to plan development strategies. Four-fifths of therapists therefore believed that conscious and unconscious senses of self (by such social awareness) are critical for initially recognising forms of personal change. Indeed, the recognition of one's condition is therefore important for practitioners for the majority of therapists believe that their sense of self-awareness (conscious state) impacts on their ability to bring about societal changes.

Table 8.9 illustrates sources of change by cell group. We discover from this final table that there is a consistent level of client belief, across all cell groups, regarding the influence of change. This is particularly noticeable while viewing clients' remarks on change influencing their social group (for example friends and work colleagues). James, a Colour Healing client (Cell A), observes the influence of his treatment particularly on his family when he comments 'My son wasn't living with us at the time, but after six months of treatment it was, "dad had changed completely...

---

[13]Therapists' beliefs can also be reinforced by means of these external, societal and communal events.

what's happened?" So it is not just my subjective opinion, but also those around me. It [the treatment] has made a very very big difference' (1996:224-226).

What is particularly remarkable, though, are the numbers of practitioners who identified self-change with global events (twenty four per cent). One-third of practitioners in Cells A and B claimed a wider influence of self-development by believing that as one's body has links with one's surrounding environment, then even international and global events can be manipulated by certain practices, for example prayer.

Table 8.9 Influences of Change by Therapy Style

	Cell A		**Cell B**		**Cell C**	
Psychological/ Spiritual	+		+		-	
Physical	+		-		+	
	Therapists	Clients	Therapists	Clients	Therapists	Clients
Family/ Spouse	2 (33)	1 (20)	-	4 (45)	. 3 (42)	2 (33)
Society/ Friends	2 (33)	2 (40)	3 (37)	2 (22)	2 (29)	2 (33)
Global/ Universal	2 (33)	-	3 (37)	-	-	-
Don't Know/ No Remark	-	2 (40)	2 (25)	3 (33)	2 (29)	2 (33)
N=100%	6 (100)	5 (100)	8 (100)	9 (100)	7 (100)	6 (100)

Thus practitioners promote personal change through the development and re-assessment of one's original form. Such self-development encompasses notions of time and space, and the 'now and then', inasmuch as one's needs are assessed at a specific moment in time, and in a particular context. In addition, by the continuous cycle of introspective assessment, one is able to compare previous and current needs, and acquire greater self-knowledge. In analysing change, by cell group, it is difficult to assert significant differences. The main difference lies between the therapist and client groups in their expectations of growth. For clients, beliefs in self-change are made via simple lifestyle changes. Hence, lifestyle becomes more important than world-view beliefs. Therapists, on the other hand, believe world-view changes have

a greater significance for the individual, and indeed the wider social system.

8.6 Conclusion

Throughout this chapter I have explored the major distinctions between cell groups. By undertaking such analysis I hoped to distinguish several issues. Firstly, I aimed to discover which cell group encompassed and promoted greater beliefs in treatments than other therapy groups, and hence, had stronger beliefs than other treatment styles. Secondly, I hoped to question whether the presence of pure cell categorizations (that is, cell groups which are based on *either* Psychological/ Spiritual (Cell B) or Physical treatments (Cell C) impacted on the levels of beliefs sustained by cell groups. Finally I hoped to discover if beliefs were transferred from therapist to client, and how these beliefs were conveyed within each cell group. This chapter has shown that there are similarities within cell groups. As such, the beliefs and practices held by adherents are not individually constructed but are, in fact, relative to the therapy group to which they belong. Three principal hypotheses were raised. These were:

(a) That Psychological/ Spiritual therapies (Cell B) and Integral therapies (Cell A) would have a greater level of belief in their treatment than Physical treatments (Cell C). This assertion was base on Cell groups A and B inclusion, and utilization, of spiritual forces. Indeed in discussing the chapter findings one must note, initially, the paradoxical relationship between cell groups. While expecting Cell group A to resemble features similar to Cell B (due to the inclusion of Psychological/Spiritual methods), one found a remarkable differentiation between these cell groups. Irrespective of respondent numbers, Cell group A was distinct due to its remarkable contrast to either cell groups B or C. Cell group B and, surprisingly, Cell group C were similar regarding notions of hope, trust and self-understanding, health experiences, beliefs in energy and finally lifestyle and world-view perspectives. Similarities can be seen, however, between clients located in Cell's A and C regarding beliefs in treatments. I would like to summarize by claiming that Cell groups B and C

represented, overall, the most prevalent features of health spirituality. Due to the strong emphasis on Psychological/ Spiritual features in Cells A and B, one would have expected cell group A to present similar beliefs to Cell B. However, from the examination of cell characteristics, Cell group A gave relatively few signs of proselytizing their beliefs to their clients and hence illustrated a relatively low level of health spirituality. More noticeable, though, is the contradiction which emerges from Cell B therapists and clients regarding beliefs and mistrust. That is, although we find a high degree of transference of beliefs within Cell B, we additionally find a high level of mistrust, and high non-attendance rate of clients at social gatherings (See Table 8.2). This paradox is characteristic of Cell B treatments since they claim to offer beliefs, by experience, but are unwilling to promote other experience options, for example those found in divinatory practices. When viewing therapist skills by cell group (Appendix 7.5), we discover that practitioners from Cell B profess to hold a greater number of skills than those found in Cell groups A or even C. This finding, perhaps, enables us, once again, to claim that Cell B's therapists substantially incorporate greater beliefs into their practice than other treatments. Practitioners themselves argue that they need self-belief in their healing abilities, in order to perform treatments. Treatments such as Reiki and NFSH (both Cell B), therefore, have a greater corresponding relationship between belief, experience and therapist skills than other therapy groups. Remarkably, we can identify from previous Tables (8.1 and 8.9) that the transference of beliefs, from therapist to client, within Cell group A does not take place in the same way as other cell groups. These practitioners claim that they believe in their treatments (Table 8.1), that their clients need to believe in healing energy (Table 8.6), and claim their own need to believe in healing energy (Table 8.5), but once viewing clients' actual level of belief we can see a comparatively small level of belief transference. This can be directly related to the relatively low levels of client healing experiences (Appendix 4.1). That is, as only a fraction of Cell A clients have had direct health sensations they are, therefore, less likely to develop their beliefs by means of these direct experiences. We can infer, then, that clients located in Cell A are not disposed to be directly guided solely by their therapists' beliefs, but rely on their own health experiences. The transference of beliefs from therapist to client can

be seen, marginally, within Cell groups B and surprisingly C, due to their levels of beliefs in the treatments (hope, trust) and health experiences. Indeed, by viewing Table 8.8 we can develop the argument further by suggesting that the transference of belief does not emerge in its expected form. Hence, lifestyle changes are seen to be adopted over those of world-view changes. The emphasis placed on the transference of beliefs, and therapies which encompass greater features of beliefs and spirituality, perhaps hints at health adherents' desire to find significant meaning in their personal circumstances. In reviewing the first hypothesis we can see that although I had predicted the greater presence of health beliefs in Cells A and B (due to the use of Psychological/ Spiritual health techniques), what was found was a high level of health spirituality in Cells B and C. The underlying factor of Psychological/ Spiritual features did not, therefore, mean a higher level of belief would emerge. The explanation as to the cause of this finding is directly linked to the second hypothesis.

(b) The second hypothesis concerned pure cell categorizations. I hypothesised that belief was reliant on cell features which were based on the use of Psychological/ Spiritual practices (Cells A and B) and not on cell group which illustrated pure categorization features, (Cells B and C). To summarize, therefore, the data did not support the hypothesis for it seemed that pure categorization groups (Cells B and C) have stronger belief, and greater transference of beliefs than a combination of therapy styles. As such, health practices which are believed to be grounded on purely scientific explanations (Cell C therapies) or divine explanations (Cell B therapies) are more likely to stimulate belief than a combination of health styles (Cell A therapies). A possible explanation for the reluctance of therapists and clients to believe in the combination of health styles could be the perceived incompatibility of belief in both scientific and spiritual explanations for their treatment.

(c) The final hypothesis concerned belief transference. Indeed, although a level of belief transference was expected between therapists and clients within each cell group I hypothesised that this transference would be greater between practitioners' and clients' of Cell groups A and B. The initial finding to this hypothesis was confirmed

when a level of belief transference was illustrated throughout all practitioner and client cell groups. Indeed, although a level of transference did take place in all cell groups, occasionally the transference of ideas did not materialize in its expected form. That is, clients sometimes constructed alternative explanations from those offered by therapists (See Table 8.8). However, some unexpected findings emerged. Beliefs were seen to be conveyed most prevalently between therapists and clients in Cell groups B and C. In fact, due to the level of health experiences (Appendix 4.1), levels of hope, trust and self-understanding present in Table 8.1 and similarities (in Table 8.8) of lifestyle and world-view perspectives we can identify a greater level of transference between practitioners and clients within each of Cells B and C. As such, ideas were seen to be conveyed more prevalently between adherents in these cell groups. Hence, therapies located in Cells B and C were identified to have a greater level of belief transference. Hence, the final hypothesis was not entirely supported by the ethnographic data.

By revealing the distinctiveness of cell groups, and the principal method of belief proliferation, we can therefore highlight the particular features of the complementary health and healing environment. As such it becomes possible to identify the milieu which assists in the construction and nurturing of a modern self-identity.

The following chapter aims to draw together the principal themes of this thesis by analysing the major findings of each chapter and reviewing the accumulated theory in the light of the original research question. Indeed this chapter also hopes to note the impact of this research and remark on its location within the Sociology of Religion.

CHAPTER NINE

BELIEFS AND SPIRITUALITY IN COMPLEMENTARY HEALTH AND HEALING

The present interest being shown in beliefs and practices of the New Age can be seen to link directly to contemporary society's gradual modernization and desire to have beliefs which are more relevant to individuals lives. It is by studying one fragment of what we consider 'new age' beliefs, namely those of complementary health and healing, that we can then identify the relevant needs of individuals and explore the expression of these beliefs on their health and general well-being. The present research, therefore, evolved out of an initial interest in health and alternative forms of belief. It was grounded in a study of a particular healing centre in North West London. The research was essentially an exploratory study which aimed to contribute to the study of contemporary beliefs regarding the body, health and identity. The study was based specifically within the previous knowledge of the sociology of religion. In performing this task I hoped to draw out the explicit, and increasingly important, role of the body in contemporary meaning systems and draw new attention to the examination of religion and spirituality. This concluding chapter aims to drawn together the successive arguments of each chapter and suggest that the accumulated features of complementary health can represent a specific belief system which, when applied, can have a significant impact on the everyday lives of adherents.

My research problem enquired as to the extent to which complementary health beliefs and practices could be interpreted as 'religious'; how these beliefs impacted on adherents' sense of identity and body awareness; and finally whether the expressions of health beliefs were substantially different between therapy styles. The research aimed to study the re-occurring features present in complementary health practices and explore the common beliefs which ensued. In discovering the underlying themes, namely beliefs in treatments, beliefs in healing energy, body, lifestyle and world-view perspectives, and concepts of change, it was possible to question how these beliefs can resemble features of a conventional belief system and demonstrate the impact of these beliefs on adherents' sense of body-awareness and self-identity. By viewing these beliefs in relation to Bryan

Wilson's 'Probabilistic Inventory' (1990:279), we can now draw together the features of complementary and conventional forms of belief and demonstrate the similarities and differences which emerge. In addition, although I did not set out to amend Wilson's 'Probabilistic Inventory' it became clear, through analysing complementary health beliefs, that several features arose which could contribute to the original inventory.

While exploring *Healing Experiences and Therapist and Client Relationships* specific features arose to ground adherents' beliefs in treatments. Hope, health experiences and trust were all identified as factors which contribute to adherents' belief in treatments, and indeed in symptom alleviation. Faith in treatments was found to be essential not only for practitioners, through their belief in their own healing abilities, but also for clients in their desire to change aspects of their lives. Optimism towards the possibility of change became a prerequisite, for adherents were taught that the success of treatments was reliant on what the individual brings into the health session. Hence, if the adherents brought optimism they were more likely to experience health alleviation. Faith in treatments relied equally on the healing experiences of health adherents. Health experiences were binding elements in the formation of health beliefs inasmuch as they were seen to portray several meanings to the individual. These were: to indicate a necessary change; to alleviate an illness symptom; and finally, to encourage a greater interest in one's health. Throughout health sessions every sensation is interpreted and analysed in order to acquire greater knowledge of the individual adherent. It is by means of this process that self-reflection and reflective dialogue emerged. The exploration of these experiences encouraged greater self-knowledge and consequently the initial building of self-identity. While exploring the significance of health experiences, however, many health advocates mentioned their sense of spirituality. Adherents' sense of spirituality was grounded on their healing experiences and the beliefs that these originated from divine sources. In addition, as these messages were conveyed through the body, adherents believed that healing experiences were directly addressing their personal circumstances. As such, health experiences played an essential role in the construction of health beliefs.

The health sessions were not static for they changed and evolved with every new ailment or health sensation encountered. It is particularly important then that adherents

were able to trust in the treatment and their therapist. This trust was not confined simply to trust in the treatment's ability to facilitate healing; trust was also needed regarding therapist-client confidentiality, and therapists' trust in sharing their beliefs with clients. Similarly, Wilson highlights the presence of a sense of good-will while discussing his 'Probabilistic Inventory' (1990:279). Wilson relates: 'Occasions of worship and exposition of teachings are claimed to encourage a sense of community, goodwill, fellowship, and common identity and reconciliation among devotees' (1990:280 (No.12)). While elements of worship were occasionally identified while invoking healing energy, the relationship between practitioner and client generally presents a sharing of ideas which tends to encourage a sense of common identity and goodwill. While the religious community emphasizes a collective, public gathering in the form of congregations, health adherents perform their acts of worship in private and in individual treatment sessions.[1] These sessions thereby offer private contemplation though reflective dialogue. An open forum for dialogue and self-enquiry also inevitably leads to the building of trust and a sense of personal security for health participants. This sense of trust is constructed through a constant dialogue between the practitioner and client. As such, while discussing therapist and client relationships, we can see a building of trust which is grounded in an intimate and open self-enquiry. By dedicating time, space and dialogue participants can introspect their own needs and are able to plan development strategies. This process was additionally aided by the therapist's role as 'witness' in the treatment process. As such, the therapist was often thought to facilitate this dialogue by means of drawing out, and reflecting on issues, symptoms, and experiences of their client. In acting as a witness, therefore, the therapist provokes new perspectives. The foundation of practitioner-client relationships was seen particularly through dialogue, for participants were then able to trust and construct a milieu for intimate self-reflection.

Wilson highlights several other features in his 'Probabilistic Inventory' (1990:279) which could also be reflected in complementary health practices. He says:

'A class of specialist religious functionaries are licenced as custodians of sacred objects,

---

[1]Indeed, complementary health groups do not, then, demonstrate a collective, coherent community for their aims and methods are diverse. Although there are common themes (energy beliefs, change etc) which are embedded within many health centres and network groups, these are fluid and vary according to the particular focus of the centre.

places, and scriptures; and/or as instructors in doctrine, ritual, and/or as moral exemplars or mentors' (1990:281 (No. 16)). Unlike many religions the presences of chosen spiritual representatives was absent in complementary health for practitioners are often self-appointed through their 'calling' to the profession. Therapists frequently experience this 'calling' through experiences such as visions and dreams. Hence, although both religious and health representatives act as the medium between divine forces and man, complementary health practitioners are not the sole custodians of healing forces. Practitioners espouse equality between themselves and clients for they view all individuals as having the ability to invoke and utilize healing forces.[2]

While viewing the relationship which emerged between health adherents an addition can be made to Wilson's inventory. A parallel can be drawn between religious groups' teaching of doctrines, namely using stories to illustrate moral messages, and complementary practitioners' methods in using stories to demonstrate the underlying message of illness experiences. Stories are therefore used to promote beliefs and potential change in both the religious and health audiences.

Wilson also notes the custodians' methods of payment in religious belief systems. He says: 'Specialist functionaries are paid for their services, whether by tribute, specific rewards, or instituted stipends' (1990:281 (No. 17)). Therapists perform treatments with the understanding that they will receive a fee. If, however, the practitioner is aware of a client's financial crisis then they either ask for a small donation or otherwise a bartering system ensues. Fees are especially prevalent when attending workshops and seminars. As with religious functionaries, then, health practitioners are paid for their services. One final aspect emerges while discussing Wilson's inventory in relation to practitioner and client relationships. This is:

> Adherents accumulate merit or demerit, and a moral economy of reward and punishment operates. (The precise nexus between action and consequence varies: it may posit automatic effects of given causes; judgement and punishment by

---

[2]Indeed, health practitioners were also aware of the numerous methods through which these forces can be invoked. As such, practitioners recognised the practices of the wider new age network.

supernatural agencies; the possibility of demerit being cancelled by self-surrender; ritual acts; vicarious atonement; confession and repentance; or special supernatural intercession) (1990:281 (No. 15)).

Here Wilson notes the presence of rewards and confessions while reviewing conventional religious beliefs. In studying adherents' treatment sessions certain aspects emerged which indicated the existence of rewards and merit. Treatment sessions were seen to offer self-imposed judgements and confessions for there was a constant interpretation of health experiences and illness experiences through intensive dialogue. This introspective assessment is facilitated by the practitioner but emphasis is placed on the individual's ability to discover his/her own development strategies. In discussing these factors then, it is not surprising that the practitioner-client relationship and treatment beliefs constitute the primary stage in the construction of a modern self-identity. In contextualizing all features of one's life, within the health session, one is offered an opportunity to reflect on certain existential and spiritual issues.

Beliefs in Healing Energy can be seen to draw the discussion away from notions of social interaction and focus on beliefs surrounding the individual and divine beliefs. Healing energy was discovered to be the principle means through which healing took place in all therapies under study. Healing energy was described as an energy flow which frequently originated from external and/ or divine sources. Energy was used to facilitate healing through the cleansing of the body's multi-dimensions: chakras and auras. Although the summoning and use of energy varied between therapy styles, all practitioners used energy as a means to cleanse their body's multi-dimensions; to interpret body ailments; and to offer adherents meaning and explanations for illness experiences. Practitioners therefore believed that they were able to facilitate healing by catalyzing these divine forces (God, Angels etc) and provoke healing through direct transcendental contact.

In viewing these beliefs in relation to Wilson's inventory we can see that he defines conventional religious beliefs principally by a 'Belief in an agency (or agencies) that transcends normal sense perception, and which may also include an entire postulated order of being' (1990:279 (No. 1)). By questioning adherents' beliefs in healing energy

we identified a specific transcendental force whose primary aim was to heal the human body and to install a sense of well-being.[3] The majority of adherents believed this healing force to be spiritual in form for they identified this force to originate from divine sources and manifest itself through direct healing experiences. By interpreting events within the healing session, then, adherents were offered an individual interpretation of the divine. In addition, as the body was the receptacle for these divine powers participants were also likely to view these beliefs as being directly relevant to their needs at specific moments in time. Indeed, Wilson's inventory identifies several other features present in conventional religious beliefs which are also seen in complementary health's beliefs in energy. Wilson notes: 'Belief that such an agency not only affects the natural world and the social order, but operates directly upon it, and may have created it', 'The beliefs that at some time (past, present, or future) explicit supernatural intervention in human affairs has occurred, or does or may occur' and, 'Belief that supernatural agencies superintend human history and destiny: when anthropomorphically depicted, these agencies are created with definite purposes' (1990:280 (No. 2, 3, 4)), as contributory factors in defining a religion. By discussing healing energy as a force which affects 'the natural world' (ibid) we can see that participants view these healing forces as being directly influential to those individuals closest to them and indeed to the wider social environment. Healing energy was therefore seen to impact on the interdependent relationship which occurs between self, society and the cosmos. While participants illustrated a prevalent belief in a transcendental force which affects their world there were, however, only limited inferences to creation.[4] While discussing the impact of

---

[3]Indeed, Lash labels this belief 'Entheism: belief that God is infinite intelligence existing in a boundless variety of beings *(ens)* who animate all things from atom to star- that is, all *en*ergies are really *en*tities expressing the infinite life-activity of God' (1990:279-280).

[4]Diane, a Reiki therapist mentions the presence of a creating force when she comments: 'Like I said, Reiki is hands on so that is for people who have been told that they have been connected to an energy above which is God, Jesus or you can call it, Life Source. Whatever name you wish to give it. All the religions give it a name. It is just all there is. It is just an energy which has created us, whether you believe in God or not, something created us' (1997:83-9). Anthony, a Rebirthing practitioner also remarks on the existence of a creative force. He observes: 'I believe that [energy] is what God is. It's the life force... For me that is what God is. It's a matrix upon which all creation is built. It is a universal source of energy. It's not separate from everything' (1997:293-315).

energy beliefs on adherents' sense of connectedness with the external world, energy beliefs were seen to have a specific relevance to adherents regarding the future surges of energy which are supposed to welcome in the 'new age'. This, as previously discussed, is due to take place in 2012. Hence, energy beliefs were seen to intervene 'in human affairs' (1990:280 (No. 3)) for they are believed to directly influence one's individual and social circumstances. The collective use of energy was also seen to impact local, national and even global events as adherents believed that one's environment was affected by these 'supernatural agencies' (1990:280 (No. 4)). An example of a societal change was the collective invocation of energy at a Reiki workshop which was believed to initiate the collapse of the Berlin Wall. There were, however, several ways in which these forces were invoked. Certain instruments can be used throughout health sessions, for examples candles, incense and crystals, in order to call upon healing energy and to naturalize malignant illness forces. Specific rituals, as found in Reiki initiation ceremonies (Appendix 3.7), also included behaviour such as prayer, chanting, meditation, and even glossolalia. Wilson draws attention to acts of supplication and expressions of worship when he says:

> There are placatory or supplicatory procedures by which individuals or groups may seek special assistance from supernatural sources ... Expressions symbolic of obedience, gratitude, obeisance, or devotion are required in particular circumstances, often in the presence of symbolic representations of the supernatural agency (- ies): such manifestations of attitude constitute worship (1990:280 (No. 8, 9)).

Both factors are represented in the use of healing energy. Acts of worship are prevalent while invoking healing energy for prayer and giving thanks to the healing force was frequently seen in health sessions, workshops and training courses. In addition various public events, such as open days and festivals, also represent a degree of interest (clients) and devotion (practitioners) in promoting and learning about complementary health issues. Rituals performed in therapy sessions were also found to be frequently improvised and spontaneous. In accordance with Wilson's inventory then; 'There are

prescribed actions for individual, collective, or representative performances - namely, rituals' (ibid (No. 7)), which are present in contemporary health beliefs. Rituals performed in therapy sessions were not, however, based on a centralized tradition or belief. Although Wilson suggests that 'Beliefs, rituals, and institutions are legitimized by reference to tradition and/or revelation, and innovation is justified as restoration'(1990:281 (No. 19)) treatments were found to have constantly evolved and participants re-shaped their beliefs and practices in accordance with continued communication with these divine forces.[5] Indeed, what emerged while studying adherents' beliefs in healing energy was the notion that health and happiness can be achieved by acknowledging and utilizing healing energy. This feature is also represented in Wilson's inventory when he observes: 'Belief that man's fortune in this life and in afterlife (or lives) depends on relationships established with, or in accordance with, these transcendental agencies' (1990:280 (No. 5)).

Body sacredness can also be identified while discussing beliefs in energy for the body became the principal recipient of sacred forces. Healing experiences and the adherents' ability to view the body as a multi-dimensional organism, capable of healing and changing, enabled adherents to address specific health problems. The consequence to this awareness was a newly established sense of self-identity. The individual's sense of self was, therefore, heightened through a feeling of connectedness with a transcendental power. Indeed, experiences of healing energy were particularly seen to contribute to the effectiveness of the health session inasmuch as these sensations provoked adherents into believing in the presence of healing forces. Beliefs and experiences of healing energy were therefore seen to be the foundation for subsequent forms of body, lifestyle and world-view changes.

The Body, Lifestyle and World-View Perspectives continued from the previous discussion by exploring further health adherents' view of the multi-dimensional body. This examination aimed to demonstrate how the body was inevitably linked to one's sense of identity, and illustrate the importance of the body in contemporary beliefs.

---

[5]While some practitioners compared their beliefs and healing arts to historical and divine figures such as Mother Teresa, Maharishi, Gandhi and Jesus, practitioners made no formal reference to specific spiritual traditions.

Within complementary health the body is seen to have several layers, dimensions and zones. Adherents were taught that one's body dimensions were the media between one's immediate social environment and transcendental forces. By interpreting these body images adherents were able to 'make sense' of their body and assess illness symptoms. Body messages were not, however, restricted to interpretations of an illness experience for it was often believed that the body could additionally communicate messages from the individual's surrounding environment. Hence, adherents believed that the body became the medium through which they could understand and make sense of themselves, their illness, and even their social circumstances. Participants were therefore encouraged to contextualize their body within a wider social and universal framework. The interpretation of body messages enabled adherents to question and explore their own sense of identity for illnesses were seen to represent powerlessness. To re-gain a level of power, then, one had to acquire body awareness.

Giddens's notion of ontological security assisted the analysis of multi-dimensional body perspectives for he illustrates the specific circumstances which assist and threaten one's sense of identity. In discussing Giddens's existential questions (an understanding of existence itself (1991:48), the exterior world and human life (ibid), other persons (1991:50) and self-identity (1991:52)) we could explore the importance of adherents' body perspectives on contemporary health beliefs. The exploration of one's multi-dimensional body, and the interpretations which emerged, were seen to enable adherents to develop a greater sense of self-knowledge. This consequently impacts on one's sense of identity. Thus, beliefs in the multi-dimensional body became the means through which the individual could explore, not only one's own sense of identity, but also enquire about certain, related, ontological issues.

The impact of adherents' new found body awareness was subsequent changes in lifestyle and world-view perspectives. Lifestyle perspectives refer to the routine behaviour and attitudes we have regarding diet, exercise, mobility etc. World-view changes refer to philosophical perspectives such as good mental attitude, setting goals and objectivity, etc. Hence, with the emergence of a new body image, participants became aware of complementary health's ability to offer alternative routes to personal change. Health participants believed that by making simple amendments to lifestyle and

world-view perspectives they could not only enhance their daily lives, but also enhance their sense of self.

While reviewing Wilson's probabilistic inventory (1990:279) we can again see a parallel between conventional and contemporary beliefs. Wilson notes 'Belief that whilst transcendent agencies may arbitrarily dictate an individual's destiny, the individual may have the possibility, by behaving in prescribed ways, to influence his experience either in this life or in future life (lives) or both' (1990:280 (No.6)). Complementary health practices could, therefore, be seen to emphasize the possibilities of change through modifications in lifestyle and world-view perspectives. These changes were thought to impact on adherents' present life and indeed dictate their future quality of life. By recognizing necessary lifestyle and world-view changes then, adherents believed they could fulfil their desire for self-transformation and improve their present circumstances.

The consequence of participating in complementary health practices was seen most prominently in adherents' expectations of self-development and personal change. Chapter Seven continued the discussion of enhancements to the individual's daily life by concentrating especially on *Complementary Health and Concepts of Change*. Health adherents actively sought forms of change by their initial desire to alleviate health problems and/ or to address an interest in spiritual issues. Notions of seekership emerged as adherents were found to actively seek specific forms of change, for example the alleviation of illness symptoms. Practitioners sought to understanding their spiritual selves, regardless of whether the consequences were legal, while clients sought inner peace and aimed to search for reflective experiences to solve specific problems. These problems could be solved by modifying body, lifestyle and world-view perspectives.

The notion of seekership could be an additional feature on Wilson's inventory. Issues of seekership are present in conventional and complementary belief systems for the ultimate goal for many participants is salvation. Religious and health beliefs advocate self-enlightenment as the means to achieving this salvation. However, it is the method in which salvation is achieved which differentiates religious and complementary health practices.

In exploring seekership a commonality emerged which joins practitioners and

clients. This was the desire to gain meaning to events. Throughout Chapter Five, this meaning was often given by means of body interpretations through divine contact. This divine contact also impacted on adherents' concepts of self and societal change. Adherents believed that by making changes to their own lifestyle societal changes could consequently take place. The link between oneself and the surrounding environment was believed to materialize in two specific ways. Firstly, the individual was believed to reflect the positive and negative forces of the world around them, and secondly, the individual was believed to be linked to the cosmos. Both forms of contact were thought to originate from the flow of divine energy. Hence, the individual is representatively linked to both society and the cosmos. The manifestations of these beliefs were again slightly different according to therapist or client group. Clients were concerned principally with the consequences of their self-change on their family, friends and work colleagues. Practitioners on the other hand, were concerned with a wider social change. Therapists' beliefs of self change were therefore associated with a service to society for they believed that the change of the individual led directly to the modification of their environment. Thus, self change was believed to influence the wider social milieu.

A further aspect of Wilson's inventory emerges while discussing concepts of change. He comments: 'The truth-claims of teaching and the efficacy of ritual are accepted as matters of dogma, without empirical test. Goals are ultimately transcendent and faith is demanded both for goals and for the arbitrary means for their attainment' (1990:281 (No. 20)). Complementary health adherents have faith in their treatment through the prospect of achieving personal change. This faith is not based on a central doctrine but rather through the common issues which are specified throughout this thesis. Goals may be transcendent for practitioners as they strive for personal enlightenment. Clients, on the other hand, were seen to desire lifestyle changes. Faith was strengthened by the hope of achieving these goals. While Wilson's comments may be reflected in complementary health's beliefs they differ as to the specific means of substantiating these beliefs. In contrast to Wilson, then, faith is substantiated by divine healing experiences.

One's sense of identity is also addressed in the therapy session. Health sessions enable adherents to assess their needs at one moment in time, by recognizing one's

'original' sense of self, and to set goals and development strategies in order to address these issues. Hence, a continuous pattern of analysis and self-change ensues. It is the process of working towards, and achieving, these goals that the materialization of the 'developed' self emerges. The continual cyclical pattern of new assessments leads to renewed self-identity. Another contribution can be made to Wilson's 'Probabilistic Inventory' (1990:279) inasmuch as religious and health practices emphasize a continuous pattern of introspection and self-change. By contemplating one's actions, lifestyle and the consequence of these on the surrounding environment, both religious and health adherents can illustrate the same method in achieving self-growth, and hence, salvation. Religious and health adherents therefore undergo a process of self-reflection whereby certain existential questions are raised. Such questioning addresses adherents' role and expected goals within this lifetime. Within complementary health, particularly, the recognition of one's needs, together with planned strategies in achieving these goals, are frequently made making the development of the self a continuous and fluid process. Moreover, the notion of present and futuristic expectations also play a critical role in the continually changing pattern of the original and developed sense of self. In studying adherents' concepts of change we can additionally contribute to Giddens's notion of ontological security inasmuch as one's concepts of change, and one's future expectations are both essential factors in the construction of health adherents' self-identity.

Chapter Eight extends the discussion of beliefs, the body and identity by questioning: whether specific cell groups illustrated more obvious features of spiritual health beliefs than other cell groups; whether the strength of adherents' beliefs relied on a particular therapy style; and finally, whether beliefs were significantly transferred from therapist to client within each cell group. This chapter therefore focuses on *Cell Distinctions.*

Therapy styles were distinguished into three cell groups. These were Cell A, which was characterized by a combination of psychological/spiritual and physical health techniques, Cell B treatments which emphasized purely psychological/ spiritual methods and finally Cell C therapies which focused simply on physical styles of health. The chapter was structured to mirror the main chapter themes.

Three research questions were raised regarding particular characteristics of cell

group(s). These were:

1. To test the hypothesis that cell groups A and B illustrated greater features of an implicit religion (due to the inclusion of Psychological/ Spiritual treatment techniques).
2. To test the hypothesis that implicit beliefs were not based primarily on *pure* cell categorizations (for example Cell B (Psychological/ Spiritual) or Cell C (Physical)).
3. To investigate which cell group(s) represented the highest level of belief transference from practitioner to client group.

The first research question was grounded on the expectation that cell groups which encapsulated Psychological/ Spiritual features, within their practice, would generate greater implicit beliefs. Hence, Cell groups A and B were expected to represent more implicit features of religiosity. Due to the inclusion of Psychological/ Spiritual techniques then, Cell groups A and B were also thought likely to illustrate a greater level of belief transference. In reviewing the beliefs of each cell group it was found that beliefs in complementary health did not rely on the use of Psychological/ Spiritual feature within the practice style. Beliefs were discovered to stem predominately from those therapy groups which illustrated pure categorization features. In contrast to the second hypothesis, then, beliefs were more prevalent in cell groups which demonstrated one primary treatment method. Thus, Cell groups B and C were discovered to produce the highest levels of belief for both therapists and clients. Likewise, in Cells B and C therapy groups, there were higher levels of belief transference than in Cell A. Belief transference was therefore found in Cell groups B and C regarding beliefs in treatments (represented in notions such as hope, trust, self understanding and faith), attendance at social events (including notions of mistrust), and beliefs in healing energy. To summarize then, the expectations of the first and hypotheses were not met. It seems that an explanation for such findings is to be found in the incompatibility of adherents' beliefs in *both* the Psychological/ Spiritual benefits of certain health treatments, *and* the Physical health benefits of some treatment styles. Thus, health participants were more likely to believe treatment which emphasized one pure treatment style.

The discussion of cell groups demonstrated the particular differences of health

beliefs within the same healing environment. Although there are specific ideas which ground all forms of therapies, some techniques were seen to offer more prevalent beliefs. Indeed, by studying these specific features we could perhaps indicate how adherents become attracted to modern beliefs, how these beliefs impacted on adherents' daily lives, and how these beliefs are sustained. The study of complementary health beliefs can then have implications for the development and future shape of contemporary beliefs. Moreover, this cell analysis also illustrates the relevance of complementary beliefs for it illustrates the variety of ways in which modern beliefs are constructed, transferred and applied to life events.

Having addressed the resemblances of complementary health and conventional religious beliefs we must now highlight the major differences between these forms of belief. The foremost difference was represented by the expression of the sacred in health practices and the individual's relationship with healing forces. The expression of the divine within complementary health is principally interpreted through the body and the individual rather than the collective experience of conventional religions. Emphasis is therefore placed on the individual, supported by network groups, rather than a congregational whole. The relationship built up between therapist and client further distinguishes between belief systems, for the conversations which arise in the health environment were specific to the individual adherent and were the direct means through which divine communications were interpreted.

Another feature which differentiates religious and health beliefs is their organizational structure. While health practices are grounded in a fluid, constantly changing and self-interpreting belief system, conventional beliefs are grounded in an established hierarchical and centralized organizational structure (specific structure, role and boundaries). Although Wilson mentions the 'authorized functionaries' present in religious institutions[6] complementary health treatments are largely non-institutionalized. There are, however, some preliminary regulatory bodies for specific therapies but these are specific to each treatment. As such, there is no centralized or regulatory agency

---

[6]"Required beliefs and actions, systematized and legitimized by authorized functionaries, are claimed to provide all necessary knowledge to explain the origin, operation, meaning, and purpose of life and the world; and as means to evoke and assuage emotions' (1990:281 (No.18)).

which monitors specific therapy styles. Each association, therefore, has differing styles of practice which are not governed by one authoritative figure. Moreover, the complementary health milieu can be seen to constitute a fluid social network for different therapies. Associations and centres have specific aims and adopt different methods in order to address these issues. These networks are, however, joined through a common identity and shared underlying beliefs. Indeed, the relationship between practitioner and client is also believed to be grounded in a common identity and egalitarianism for there are no 'custodians of sacred objects' (1990:281 (No. 16)). Therapists are self-appointed and espouse the belief that everyone has the capacity to communicate with divine forces. As such, faith is substantiated by healing experiences and not, as Wilson highlights, by 'truth-claims of teaching' (1990:281 (No. 20)). Faith in complementary health is therefore continually re-created via experiences and one's self-assessment rather than by reference to doctrine and liturgy.

In addition, there are several features of Wilson's 'Probabilistic Inventory' (1990:279) which are not represented in complementary health beliefs and practices. These are: 'Solemnity, seriousness of purpose, sustained commitment, and lifelong devotion are normative requirements' (1990:281 (No. 14)), 'There are specified occasions of celebration and mortification (fasting, penance) and pilgrimage, and re-enactments or commemorations of episodes in the earthly life of deities, prophets, or great teachers', 'Language, objects, places, edifices, and seasons are designated as particularly identified with the supernatural, and may themselves become objects of reverence' (1990:280 (No. 11,10)), and finally,'Moral rules are enjoined upon believers. The area of their concern varies: they may be couched in legalistic and ritualistic terms, or canvassed as being in conformity with the spirit of a less specific, higher ethic'(1990:280-281 (No. 13)).[7]

Although complementary health practices do fulfil some of the characteristics proposed by Wilson in his 'Probabilistic Inventory' (1990:279), health beliefs cannot be

---

[7]Only a few healing associations have structured ethical guidelines for their practitioners, for example the National Federation of Spiritual Healers. These rules are, however, largely defined by the individual practitioner. Clients, however, do not have such rules, but the emphasis lies on one's own self-defined boundaries and the creation of one's own ethical guidelines.

defined as a religion. One's relationship with the sacred, the organization structure, the method of belief construction through healing experiences and reflective dialogue, the egalitarian relationship which practitioners espouse, and finally the personalization of beliefs are all major factors which distinguish contemporary health practices from conventional religiosity. Moreover, while viewing adherents' own interpretation of their beliefs we can additionally find that they themselves did not identify themselves as belonging to a structured or hierarchical religious belief system for they saw their beliefs as constantly evolving with the development of their own body and personal circumstances.

While the research has identified several factors which prevent complementary health being labelled a religious belief system we can, however, argue that health beliefs constitute a form of health spirituality. To reiterate, spirituality refers to *the essence of the individual, one's inner thoughts, beliefs and practices. Spirituality is constructed by identifying with all aspects of oneself, one's surroundings and ultimately the cosmos. Such identification encourages the development of a world-view through which social reality is interpreted. Spirituality practices can be performed in isolation or collectively in network groups. Participants often base their beliefs on divine beings or forms of contact with transcendental powers. The images of the divine do not necessarily have to be personified but these divine forces can, on occasion, be seen as either one's higher, pure self, or a belief in healing angels, guides, or more conventionally, God. Additionally, adherents believe that they have direct access to these divine forces. As such, these higher forces can be individually invoked. Spirituality for health participants, then, is individually constructed. Spirituality provides structure and clarity for an individual's sense of purpose, while often contributing to an individual's beliefs in potential development.* Health spirituality is, therefore, the process through which health practices can promote these senses of connectedness and self-knowledge.

To address the research question proposed at the outset, then, complementary health cannot be seen to constitute a religious belief system. By studying the notions of reflective dialogue, healing experiences, energy beliefs, body, lifestyle and world-view perspectives and finally, beliefs in personal change, we can see how various complementary health beliefs and practices can represent a health spirituality. Moreover,

in studying these aspects in relation to Wilson's 'Probabilistic Inventory' (1990:279-281) and Giddens's notions of 'Ontological security' (1991:243) we could identify the formation of a modern and relative belief system, and its influence on the creation of self-identity. In addition, by exploring complementary health beliefs I hope to have built on Wilson's inventory by highlighting several new features which are present in contemporary beliefs, for example concepts of seekership and practitioner and client dialogue.[8] I further aimed to extend Giddens's work on ontological security by exploring the impact of the body on one's sense of identity and by drawing attention to a possible fifth existential issue, namely one's sense of change and future expectation.

Indeed, identity played a critical binding role throughout the entire thesis. The thesis aimed to highlight the significant aspect of the body in the construction of modern beliefs and the impact of body images on one's sense of identity. In studying the beliefs which emerge from health practices we explored how self-identity was constructed through participants' continual introspection of health and lifestyle issues. It is by means of such awareness that adherents were argued to consider wider ontological and existential issues surrounding their own sense of self. I further suggested that there has been a movement from a collective expression of the sacred to personal, and individual modes of sacred expression. This movement has predominantly taken place through adherents' beliefs in the sacralization of the body.[9] The sacralization of the body considered the role of the body in the search for contemporary meaning. I argued, that due to the construction of adherents' own modern, and relative, concept of the divine, the individual conceptualizes their own body and sense of self according to their experiences and self-knowledge. Hence, as the body is the medium through which health adherents believe they can communicate with transcendental forces, the body can be argued to have become sacralized. Undoubtedly then, even adherents' expression of their relationship with the divine relies on the use and interpretative medium of the body. The sacralization of the body was therefore seen as the *extent to which one interprets health,*

---

[8]This dialogue represents the construction of intimacy, trust and hope including the interpretive process of healing experiences and storytelling.

[9]It is this notion which further distinguishes religion from complementary health practices for identity is irrevocably bound to the continual interpretation of one's own body.

lifestyle and, most importantly, spiritual needs by means of one's body ailments. The sacralization of the body can therefore be seen to depart from previous sociological literature for it places new emphasis on the role of the body in the construction of modern beliefs.

Although Wilson warns of a contemporary move 'towards more secularized forms of religion' (1990:268), what is representative in complementary health practices is the belief that the body maintains a status of unique sacredness inasmuch as the body can provide the opportunity for divine communication. Indeed, while the secularization debate continues today, specific health beliefs perhaps offer an initial insight into the future shape of modern beliefs. The implications of this research are that the body can play a significant role in the construction and maintenance of contemporary beliefs. The body is seen to provide adherents with a means to communicate directly with sacred forces while also being the means through which, through simple lifestyle modifications, adherents can achieve a happier daily existence. The belief that everyone has the ability to communicate with the divine and the specific relevance that these communications have on adherents' lives are significant factors to adherents' sense of well-being. Only by exploring fully the beliefs which arise in contemporary society can we recognise factors which are important to people's daily lives and perhaps indicate the future development of modern belief systems.

In studying complementary health beliefs certain reflections arise as to this research's contribution to the sociology of religion and the study of healing. By exploring the particular features of complementary health beliefs we can perhaps indicate the significance and particular expression of modern beliefs. By addressing issues such as healing experiences, the relationship which occurs between therapist and client and concepts of change we can understand how adherents become attracted to modern beliefs and how these beliefs impact on adherents' sense of spiritual belief, body-awareness and self-identity. This study, therefore, demonstrates how one set of modern beliefs are shaped and sustained daily and how beliefs are applied to everyday life events. Moreover, by exploring health beliefs we can also indicate a particular mode of belief transference. The study of adherents' lifestyle perspectives, illnesses, development strategies in coping with painful and traumatic events could also hint at changes in

contemporary meaning systems for it is possible to illustrate how beliefs need directly to address relevant issues present in adherents' lives. By undertaking an empirical study of health beliefs I therefore address a neglected field of enquiry within the sociology of religion concerned with the body, beliefs and identity.

Before bringing this thesis to a close certain reflections arise concerning particular circumstances that I would have liked to have changed or enhanced relating to the research design. In retrospect, several enhancements could have be made, the first of these being the level of participant observation work. The benefits of gaining access to a large number of client groups in workshop and seminar environments, on reflection, could have contributed substantially to the number of client interviews held, as well as perhaps making client access slightly easier to achieve. In the event, however, due to the constraints of resources this methodology could not be employed.

The second reflection takes the form of a particular regret for not forming the habit of transcribing all interviews immediately after each meeting. Indeed, in spite of writing up extensive field notes after each interview, it was difficult to manage all the transcription during the data collection stage of this research. Regardless of the benefits of immersing myself intensively in the raw interview data and perhaps being able to identify preliminary links and themes, at one moment in time, I particularly recall the difficulty of motivating myself to manage the data transcription. In order to avoid these difficulties I will in future stagger all interview transcription.

It can be argued that even after the completion of this thesis there will still be gaps in existing sociological knowledge concerning health, the body and beliefs. For although this thesis explored a relatively new field of enquiry within the sociology of religion, and indeed contributed to the growing knowledge of contemporary beliefs within the new age, there are still several very interesting areas of study which could possibly give great insight into contemporary forms of spiritual expression. Hence, it is inconceivable that sociological research would neglect such a fruitful and interesting meaning system as currently proliferating within the new age milieu. This research also hoped to lay the foundations to further research concerned with beliefs and the body. Further questions can perhaps be raised as to their relationship. Thus, various questions can be asked concerning the expressions of contemporary beliefs. These can range from

questioning whether healing experiences are comparable to religious experiences, and if so, are there parallels between the messages that they aim to convey; routes of seekership and movement to therapies; notions of mistrust between therapy styles and the particular formation of network groups and therapy boundaries; and finally, the study of the relationship which evolves between the practitioner and client in comparison with the bonds that are formed between clergy and lay people. Do such intimate and supporting relationships proliferate and evolve in similar ways or do such bonds have differing boundaries and content?

To close, therefore, one must emphasize the continuing importance of studying new age beliefs. New age studies, then, address the contemporary need for knowledge concerning new forms of belief systems. As Hanegraaff suggests:

> New Age exemplifies a new phenomenon which may be defined as 'secular religion' based on 'private symbolism'. As such, it presents a challenge to sociologists as well as to historians of religion. The challenge consists in trying to understand what the New Age phenomenon can teach us about the processes of modernization and secularization, and their significance with respect to the systematic study of religions (1999:146).

BIBLIOGRAPHY

Aakster, C.W. (1986), 'Concepts in Alternative Medicine', Social and Scientific Medicine, Vol. 22, 2:265-273.

Abrams, P. & McCulloch, A. (1976), 'Communes and Sociology - Alternative Realities?', In Communes, Sociology and Society, Cambridge: Cambridge University Press, 1-23.

Ahern, Geoffrey. (1988), 'Spiritual/Religious Experiences in Modern Society', Religion Today, (Now entitled Journal of Contemporary Religion), Vol. 6, 4-6.

Albanese, Catherine. (1992), 'The Magical Staff: Quantum Healing in the New Age', In Lewis, J.R. & Melton, J.G. (Eds.), Perspectives on the New Age, State University of New York Press, 68-84.

Albery, N. (1987), 'How to Rate a Guru?', Self and Society, European Journal of Humanistic Psychology, Vol. XV, 5:233-234.

Albrecht, S. & Cornwall, M. (1989), 'Life Events and Religious Change', Review of Religious Research, Vol. 31, 1:23-38.

Allsop, J. & Mulcahy, L. (1998), 'Maintaining Professional Identity: Doctors' responses to complaints', Sociology of Health and Illness, Vol. 20, 6:802-824.

Anson. O, Levenson. A, Maoz. B. & Bonneh, D. (1991), 'Religious Community, Individual Religiosity, And Health: A Tale of Two Kibbutzim', Sociology, Vol. 25, 1:119-132.

Arber, Sara. (1993), 'The Research Process', In Gilbert, N. (Ed.), Researching Social Life, London: Sage Publications, 32-50.

Armstrong , David. (1984), 'The Patients' View', Social Science and Medicine, Vol. 18, 9: 737-744.

Armstrong, David. (1986), 'The Problem of the Whole-Person in Holistic Medicine',

Holistic Medicine, Vol. 1, 27-36.

Armstrong, David. (1993), 'Public Health Spaces and the Fabrication of Identity', Sociology, Vol. 27, 3:393-410.

Bailey, Edward. (1983), 'The Implicit Religion of Contemporary Society: An Orientation and Plea for its Study', Religion, Vol. 13, 69-83.

Bailey, Edward. (1990a), 'The Implicit Religion of Contemporary Society: Some Studies and Reflections', Social Compass, Vol. 37, 4:483-497.

Bailey, Edward. (1990b), 'Implicit Religion: A Bibliographical Introduction', Social Compass, Vol. 37, 4:499-509.

Barker, Eileen. (1982), New Religious Movements. A Perspective for Understanding Society, Studies in Religion and Society, Vol. 3, New York & Toronto: Edwin Mellen Press.

Barker, Eileen. (1985), 'New Religious Movements: Yet Another Great Awakening', In Hammond, P. (Ed.), The Sacred in a Secular Age, Berkeley & London: University of California Press, 35-57.

Barker, Eileen. (1992), New Religious Movements. A Practical Introduction Approach, London HMSO.

Barker, Eileen. (1995), 'The Scientific Study of Religion? You Must Be Joking!', Journal for the Scientific Study of Religion, Vol. 34, 3:287-310.

Beckford, James. (1983), 'The Public Response to New Religious Movements in Britain', Social Compass, Vol. XXX, 1:49-62.

Beckford, James. (1984), 'Holistic Imagery and Ethics in New Religious and Healing Movements', Social Compass, Vol. XXXI, 2-3:259-272.

Beckford, James. (1985a), 'The World Images of New Religious and Healing Movements', In Jones, K. (Ed.), Sickness and Sectarianism, Aldershot: Gower, 72-93.

Beckford, James. (1985b), Cult Controversies. The Societal Responses to the New Religious Movements, London:Travistock Publications.

Beckford, J. & Richardson, J. (1983), 'A Bibliography of Social Scientific Studies of New Religious Movements', Social Compass, Vol. 30, 111-135.

Beckford, J. & Suzara, A. (1994), 'A New Religious and Healing Movement in the Philippines', Religion, 24:117-141.

Bell, Catherine. (1996), 'Modernism and Postmodernism in the Study of Religion', Religious Studies Review, Vol. 22, 3:179-190.

Bell, Daniel. (1977), 'The Return of the Sacred. The Argument on the Future of Religion?', British Journal of Sociology, Vol. 28, 4:419-443.

Bellah, R. H. (1970), Beyond Belief, New York: Harper and Row.

Benoist, J. & Cathabras, P. (1993), 'The Body: From an Immateriality to Another'. Social Science and Medicine, Vol. 36, 7:857-865.

Berger, Peter L. (1963), Invitation to Sociology: A Humanistic Perspective, Harmondsworth, Middx: Penguin Books Limited.

Berger, Peter L. (1974), 'Some Second Thoughts on Substantive versus Functional Definitions of Religion', Journal for the Scientific Study of Research, Vol. 13, 125-133.

Berger, P. & Luckmann, T. (1963), 'Sociology of Religion and Sociology of Knowledge', Sociology and Social Research, Vol. 47, 4:417-427.

Berliner, H.S. & Salman, J.W. (1979), 'The Holistic Health Movement & Scientific Medicine: The Naked & The Dead', Socialist Review, Vol. 43, 31-52.

Bibby, W.R. (1983), 'Searching for Invisible Thread: Meaning Systems in Contemporary Canada, Journal for the Scientific Study of Religion, Vol. 22,2:101-119.

Bird, F. (1979), 'The Pursuit of Innocence: New Religious Movements and Moral Accountability', Sociological Analysis, Vol. 40, 4:335-346.

Bloch, Jon. (1998a), 'Individualism and Community in Alternative Spiritual "Magic"'. Journal For The Scientific Study of Religion, Vol. 37, 2:286-302.

Bloch, Jon. (1998b), 'Alternative Spirituality and Environmentalism', Review of Religious Research, Vol. 40, 1:55-73.

Bloom, Joan. (1990), 'The Relationship of Social Support and Health', Social Science and Medicine, Vol. 30, 5:635-637.

Boutin. P, Buchwald. D, Robinson. L, & Collier. A. (2000) 'Use of and Attitudes About Alternative and Complementary Therapies Among Outpatients and Physicians at a Municipal Hospital', The Journal of Alternative and Complementary Medicine, Vol.6, 4:335-343.

Bowman, Marion. (1984), 'Dyspepsia in the Promised Land: Religion and Diet in 19th Century America', Paper prepared for the British Sociological Association's Sociology of Religion Study Group Day Conference on Religion, Diet and Society, Reading University, 12 November 1994.

Bowman, Marion. (1993), 'Reinventing the Celts', Religion, Vol. 23, 2:147-156.

Bowman, Marion. (1995), 'The Noble Savage and the Global Village: Cultural Evolution in the New Age and New-Pagan Thought', Journal of Contemporary Religion, Vol. 10, 2:139-149.

Bowman, Marion. (1995), Private Correspondence, Bath College of Higher Education.

Bowman, Marion. (1999), 'Healing in the Spiritual Marketplace: Consumers, Courses and Credentialism', Social Compass, Vol. 46, 2:181-189.

Bowman, Marion. (2000), 'More of the Same? Christianity, Vernacular Religion & Alternative Spirituality in Glastonbury', In Sutcliffe, S. & Bowman, M. (Ed.), Beyond New Age: Exploring Alternative Spirituality, Edinburgh University Press, 83-104.

British Medical Association. (1993), Complementary Medicine: New Approaches to Good Practice, Oxford: Oxford University Press.

Brody, Howard. (1992), 'The Physician-Patient Relationship', In Brody, H. The Healers' Power, New Haven: Yale University Press, 44-65.

Bruce, Steve. (1996), Religion in the Modern World: From Cathedrals to Cults, Oxford: Oxford University Press.

Bruce, Steve. (1998), 'Good Intentions and Bad Sociology: New Age Authenticity and Social Roles', Journal of Contemporary Religion, Vol. 13, 1:23-35.

Budd, S. & Sharma, U. (Ed). (1994), The Healing Bond, London: Routledge.

Bull, Malcolm. (1990), 'Secularization and Medicalizatiom', British Journal of Sociology, Vol. 41, 2:245-261.

Bulmer, Martin. (1979), 'Concepts in the Analysis of Qualitative Data', Sociological Review, Vol. 27, 4:651-677.

Bury, Michael. (1982), 'Chronic Illness as Biographical Disruption', Sociology of Health and Illness, Vol. 4, 2:167-182.

Cameron, Bruce. (1966), Modern Social Movements, UK: Random House Incorporated.

Campbell, Colin. (1972), 'The Cult, the Cultic Milieu and Secularization', A Sociological Yearbook of Religion in Britain, Vol. 5, 119-136.

Campbell, Colin. (1978), 'The Secret Religion of the Educated Classes', Sociological Analysis, Vol. 39, 2:146-156.

Carter, Lewis. (1987), 'The New Renunciates of the Bhagwan Shree Rajneesh: Observations and Identification of the Problem of Interpreting New Religious Movements', Journal for the Scientific Study of Religion, Vol. 26, 2:148-172.

Cassell, Eric. (1982), 'The Nature of Suffering and the Goal of Medicine', The New England Journal of Medicine, Vol. 306, 11:639-645.

Charmaz, Kathy. (1983), 'Loss of Self: a Fundamental Form of Suffering in the Chronically ill', Sociology of Health and Illness, Vol. 5, 2:168-195.

Charmaz, Kathy. (1987), 'Struggling For a Self: Identify Levels of the Chronically Ill', Research in the Sociology of Health Care, Vol. 6, 283-321.

Chunn, Louise. (1995), 'Mary Butler is a Computer Programmer From Bradford Who Seeks Enlightenment. She is Not Alone', The Observer Newspaper Supplement, Observer Life, 16th July.

Clark, Victoria. (1995), 'If You Want a Witch Look no Further Than the Freelance Healers Such as Cat Worshippers Who are Replacing Orthodox Religion and Medicine in the New Russia', The Observer Newspaper Supplement, Observer Life, 14th May.

Clark, Peter. (1984), 'New Paths to Salvation', Religion Today: A Journal of Contemporary Religions, Vol. 1, 1:1-3

Clarkson, Petruska. (1994), 'Becoming Whole', Self and Society: A Journal of Humanistic Psychology, Vol. 21, 6: 4-10.

Claxton, Guy. (1987), 'The Lure of the Godless. The Appeal of Eastern Spiritual Atheism to the West', Self and Society. European Journal of Humanistic Psychology, Vol. XV, Sept/Oct, 5:217-220.

Cobb, M. & Robshaw, V. (1998), The Spiritual Challenge of Health Care, London: Churchill Livingstone.

Cole, Michael et al. (1993), What is the New Age?, London: Hodder and Stoughton.

Collee, John. (1995), 'Bad Enough to Believe Your Delusions But Same Enough to Influence Others, Use Some "Coercive Persuasion", How to be a Modern Messiah', The Observer Newspaper Supplement, Observer Life, 14th May.

Collins, H.M. & Pinch, T.J. (1982), Frames of Meaning: The Social Construction of Extraordinary Science, London: Routledge & Kegan Paul Ltd.

Connelly, F, M. & Clandinin, J.D. (1990), 'Stories of Experience and Narrative Inquiry', Educational Researcher, Vol. 19, 4:2-14.

Coward, Rosalind. (1989), The Whole Truth, The Myth of Alternative Health, London: Faber and Faber Publishing.

Coward, Rosalind. (1995), 'In Sickness There is no Alternative', The Guardian Newspaper, Comments and Analysis, 21st August.

Conrad, P. & Schneider, J.W. (1980), Deviance and Medicalization: From Badness to Sickness, St. Louis, MO: Mosby.

Crawford, Robert. (1980), 'Healthism and the Medicalization of Everyday Life', International Journal of Health Services, Vol. 10, 3:365-388.

Davie, Grace. (2000), 'Religion in Modern Britain: Changing Sociological Assumptions', Sociology, Vol. 34, 1:113-128.

Davis, Douglas. (1999), 'Implicit Religion and Inter-Faith Dialogue in Human Perspective', Implicit Religion, Vol. 2, 1:17-24.

Denzin, N. K. (1970), The Research Act, New Jersey: Prentice-Hall.

Diesel, Alleyn. (1998), 'The Empowering Image of the Divine Mother: A South African Hindu Woman Worshipping the Goddess', Journal of Contemporary Religion, Vol. 13, 1:73-90.

Doktor, Tadeusz. (1999), 'The "New Age" Worldview of Polish Students', Social Compass, Vol. 46, 2:215-224.

Doreian, P. & Woodard, K. (1994), 'Defining and Locating Cores and Boundaries of Social Networks', Social Networks, Vol. 16, 267-293.

Douglas, Mary. (1994), 'The Construction of the Physician', In Budd, S. & Sharma, U. (Ed.), The Healing Bond, London:Routledge.

Duckro, P. & Magaletta, P.R. (1994), 'The Effect of Prayer on Physical Health: Experimental Evidence', Journal of Religion and Health, Vol. 33, 3:211-219.

Durkheim, Emile. (1976), The Elementary Forms of the Religious Life, London: George Allen and Unwin Ltd.

Ellison, Christopher. (1991), 'Religious Involvement and Subjective Well-being', Journal of Health and Social Behaviour, Vol. 32, March:80-99.

Farraro, Kenneth. (1998), 'Firm Believers? Religion, Body Weight, and Well-Being', Review of Religious Research, Vol.39, 3:224-244.

Ferguson, Marilyn. (1980), The Aquarian Conspiracy: Personal and Social Transformation in our Times, London: Paladin Press/Harper Collins.

Fielding, Nigel. (1990), 'Mediating the Message: Affinity and Hostility in Research on Sensitive Topics', American Behavioural Scientist, Vol. 33, 5:608-620.

Fielding, Nigel. (1993a), 'Qualitative Interviewing', In Gilbert , N. (Ed.), Researching Social Life, London: Sage Publications, 135-153.

Fielding, Nigel. (1993b), 'Ethnography', In Gilbert, N. (Ed.), Researching Social Life, London: Sage Publications, 154-171.

Fielding, Jane. (1993), 'Coding and Managing Data', In Gilbert, N. (Ed.), Researching Social Life, London: Sage Publications, 218-238.

Fielding, N. & Lee, R. (1991), 'Computing for Qualitative Research: Options, Problems and Potential', In Fielding, N. & Lee, R. Using Computers in Qualitative Research, London: Sage Publications, 1-37.

Fischler, Claude. (1988), 'Food, Self and Identity' , Social Science Information, Vol. 27, 2:275-92.

Foltz, Tanice. (1987), 'The Social Construction of Reality in a Para-Religious Healing Group', Social Compass, Vol.34, 4:397-413.

Frank, Arthur W. (1997). 'Illness as Moral Occasion: Restoring Agency to Ill People', Health, Vol. 1, 2: 131-148.

Fraser, John. (1987), 'Community, The Private and the Individual', Sociological Review, Vol. 35, 4:795-818.

Freund, P. & McGuire, M. (1991), Health, Illness & The Social Body, New Jersey: Prentice Hall International.

Freund, Peter. (1988), 'Bringing Society into the Body', Theory and Society, Vol. 17, 839-864.

Frey, R.G. (1983), Rights, Killing and Suffering: Moral Vegetarianism and Applied Ethics, London: Basil Blackwell, 2-24.

Fulder, Stephen. (1985), 'Complementary Medicine in the United Kingdom: Patients, Practitioners, and Consultations', The Lancet, Vol. II, September 7:542-545.

Fulder, Stephen. (1988), The Handbook of Complementary Medicine, Oxford: Oxford University Press.

Furlong, David. (1995), The Complete Healer, London: Piatkus Books.

Geertz, Clifford. (1973), The Interpretation of Cultures, New York: Basic Books Inc.

Giddens, Anthony. (1990), The Consequences of Modernity, Cambridge: Polity Press.

Giddens, Anthony. (1991), Modernity and Self-Identity, Cambridge: Polity Press.

Giddens, Anthony. (1992), The Transformation of Intimacy, Cambridge: Polity Press.

Gilbert, Nigel (Ed.) et al. (1993), Researching Social Life, London: Sage Publications.

Glaser, B. & Strauss, A.L. (1967), The Discovery of Grounded Theory: Strategies for Qualitative Research, London: Weidenfeld & Nicolson.

Glassner, Barry. (1989), 'Fitness and the Postmodern Self', Journal of Health and Social Behaviour, Vol. 30, June:180-191.

Glik, Deborah. (1986), 'Psychological Wellness Among Spiritual Healing Participants', Social Science and Medicine, Vol. 22, 5:579-586.

Glik, Deborah. (1988), 'Symbolic Ritual and Social Dynamics of Spiritual Healing'. Social Science and Medicine, Vol. 27, 11:1197-1206.

Glik, Deborah. (1990a), 'The Redefinition of The Situation: The Social Construction of Spiritual Healing Experiences', Sociology of Health and Illness, Vol. 12, 2:151-168.

Glik, Deborah. (1990b), 'Participation in Spiritual Healing, Religiosity, and Mental Health', Sociological Inquiry, Vol. 60, 2:158-176.

Glock, C. & Stark, R. (1965), Religious and Society in Tension, Chicago: Rand McNally and Company.

Goffman, Erving. (1959), The Presentation of Self in Everyday Life, Harmondsworth: Penguin Books Ltd.

Glock, C. & Bellah, R.N. (1976), The New Religious Consciousness, Berkeley & London: University of California Press.

Gray, Ross. (1998), 'Four Perspectives on Unconventional Therapies'. Health, Vol. 2, 1:55-74.

Gray, J. & Buttriss, J. (1990), Nutrition and Vegetarianism, Serial Fact File Number 6, London: National Dairy Council, Nutrition Service.

Greer, Paul. (1995), 'The Aquarian Confusion: Conflicting Theologies of the New Age', Journal of Contemporary Religion, Vol. 10, 2:151:166.

Gyatso, Geshe Kelsang. (1992), Introduction to Buddhism, London: Tharpa Publications.

Hamilton, Malcolm. (1994), 'Feeding the Spirit: Food, Diet and "Spirituality"', Paper Presented at the XVII Denton Conference, Ilkley, May 6-8.

Hamilton, M., Waddington, P.A.J., Gregory, S., and Walker, A. (1995), 'Eat, Drink and Be Saved: The Spiritual Significance of Alternative Diets', Social Compass, Vol. 42, 4: 497-511.

Hamilton, Malcolm. (1998a), 'Festivals of Mind, Celebrations of Body, Evocation of Spirits: The Mind-Body-Spirit Festivals', Paper Presented at the Annual Conference of the British Sociological Association, Edinburgh, 1-9 April.

Hamilton, Malcolm. (1998b), 'Secularisation. Now you see it, now you don't', Sociological Review, Vol. 7, 4:27-31.

Hammersley, M. & Atkinson, P. (1995), Ethnography: Principles in Practice, London: Routledge.

Hanegraaff, W.J. (1999), 'New Age Spiritualities as Secular Religion: a Historian's Perspective', Social Compass, Vol. 46, 2:145-160.

Hank, J. (1980), 'The Marketed Social Movement', Pacific Sociological Review, Vol. 23, 3:333-354.

Hannigen, J.A. (1990), 'Apples & Oranges or Varieties of the Same Fruit? The New Religious Movement & The New Social Movements Compared', Review of Religious Research, Vol. 31, 3:246-258.

Hargrove, Barbara. (1978), 'Integrative and Transformative Religions', In Needleman, J. (Ed.), Understanding The New Religions, New York: Seabury Press, 257-266.

Hay, D. & Morisy, A. (1985), 'Secular Society, Religious Meanings: A Contemporary

Paradox', Review of Religious Research, Vol. 26, 3:213-227.

Hayes-Bautista, D. & Harveston, D. (1977), 'Holistic Health Care', Social Policy, Vol. 7, 7-13.

Heath, C. & Luff, P. (1993), 'Explicating Face-to-Face Interaction', In Gilbert, N. (Ed.), Researching Social Life, London: Sage Publications, 306-326.

Hedges, E. & Beckford, J.A. (2000), 'Holism, Healing and the New Age', In Sutcliffe, S. & Bowman, M. (Eds.), Beyond New Age: Exploring Alternative Spirituality, Edinburgh University Press, 169-187.

Heelas, Paul. (1982), 'Californian Self-Religions and Socializing the Subjective', In Barker, E. (Ed.), New Religious Movements: A Perspective for Understanding Society, London: Edwin Mellen Press, 69-85.

Heelas, Paul. (1993), 'The New Age in Cultural Context: The Premodern, the Modern & the PostModern', Religion, Vol. 23, 2:103-116.

Heelas, Paul. (1994), 'The Limits of Consumption and the Post-Modern "Religion" of the New Age', In Keat, R. (Ed.), The Authority of the Consumer, London: Routledge, 102-115.

Heelas, Paul. (1996), The New Age Movement, Oxford: Blackwell Publishers.

Heelas, Paul. (1998), 'New Age Authenticity & Social Roles: A Response to Steve Bruce', Journal of Contemporary Religion, Vol. 13, 2:257-264.

Herbert, David, 'Christian Ethics, Community and Modernity', Modern Believing, Vol. 39, 3:44-51.

Heron, John. (1986), 'Critique of Conventional Research Methodology', Complementary Medical Research, Vol. 1, 1:12-22.

Holloman, Regina. (1974), 'Ritual Opening and Individual Transformation: Rites of Passage at Esalen', American Anthropologist, Vol. 76, 265-280.

Hood, R.W, Morris, R.J. & Watson, P.J. (1989), 'Prayer Experience and Religious Orientation', Review of Religious Research, Vol. 31, 1:39-45.

Hooft, Stan van. (1997), 'Health and Subjectivity', Health, Vol. 1, 1:23-36.

Hopkins Tanne, J. (1998), 'News. Therapeutic touch fails test', eBritish Medical Journal, Vol. 316:1037.

Hornsby-Smith, M., Lee, R.M. & Reilly, P.A. (1985), 'Common Religion and Customary Religion: A critique and A Proposal', Review of Religious Research, Vol. 26, 3:244-252.

Hornsby-Smith, Michael. (1989), 'The Quest for Community' In Hornsby-Smith, M. The Changing Parish. A Study of Parishes, Priest, and Parishioners After Vatican II, London: Routledge.

Hornsby-Smith, Michael. (1993), 'Gaining Access', In Gilbert, N. (Ed.), Researching Social Life, London: Sage Publications, 52-67.

Hornsby-Smith, Michael et al. (1995), The Politics of Spirituality, Oxford: Oxford University Press.

Hornsby-Smith, Michael. (1998), 'Religious Experience: A Sociological Experience', Heythrop Review, Vol. 39, 413-433.

Idler, Ellen. (1995), 'Religion, Health, and Nonphysical Sense of Self', Social Forces, Vol. 74,4:683-704.

Illich, Ivan. (1986), 'The Roots of Medicine: Body History', The Lancet, Vol. II, December 6:1325-1327.

Illman, John. (1995), 'Hands That Heal', The Guardian Supplement, 20 May, 2-3.

Ingram, Larry. (1996), 'The Significance of Personal Change for Operative Goals: A Structuralist Approach to Theoretical Self-Identification & Attitudes Towards Academic

Policy in Southern Baptist Colleges', Review of Religious Research, Vol. 38, 1:61-78.

Iphofen, Ron. (1998), 'Strong Words, Strong Minds, Strong Bodies: an Analysis of the Narrative Structure of Affirmatory Metaphors in Personal Development Programs', Paper Presented at the British Sociological Association Annual Conference 'Making Sense of the Body', University of Edinburgh, 6-9th April.

Jacobs, Evelyn. (1987), 'Qualitative Research Traditions: A Review', Review of Educational Reserch, Vol. 57, 1:1-50.

Jamieson, Lynn. (1999), 'Intimacy Transformed? A Critical Look at the "Pure Relationship"', Sociology, Vol. 33, 3:477-494.

Johnson, Daniel et al. (1986), 'Religion, Health and Healing: Findings from a Southern City', Sociological Analysis, Vol. 47, 1:66-73.

Jones, David. (1987), 'Bagwan and the Human Potential Movement', Self and Society, European Journal of Humanistic Psychology, Vol. XV. Sept/Oct, 5:202-208.

Jones, R.K. (Ed.), (1985), 'The Development of Medical Sects', In Jones, R.K. (Ed.), Sickness and Sectarianism, Aldershot: Gower, 1-23.

Kass, J.A et al. (1991), 'Health Outcomes and a New Index of Spiritual Experiences', Journal for the Scientific Study of Religion, Vol. 30, 2:203-211.

Kelsey, Morton. (1979), 'Faith: Its Function in the Wholistic Healing Process', In Otto, H. & Knight, J. (Ed.), Dimensions in Wholistic Healing: New Frontiers in the Treatment of the Whole Person, Chicago: USA, Nelson-Hall, 213-225.

Kilbourne, B. & Richardson, J. (1988), 'Paradigm Conflicts, Types of Conversion, and Conversion Theories', Sociological Analysis, Vol. 50, 1:1-21.

King, D.E. & Bushwick, B. (1994), 'Beliefs and Attitudes of Hospital Inpatients About Faith Healing and Prayer', The Journal of Family Practice, Vol. 39, 4:349-352.

Knott, Kim. (1998), Hinduism. A Very Short Introduction, Oxford:Oxford University

Press.

Kopelman, L. & Moskop, J. (1981), 'The Holistic Health Movement: A Survey and Critique', Journal of Medicine and Philosophy, Vol. 6, 2:209-235.

Kuckartz, Uno. (1996), WINMAX Pro '96 Scientific Text Analysis: User's Guide & Reference, Berlin: Verein zur Förderung der Ökologie im Buldungswesen e.V.

Lachmund, Jens. (1998), 'Between Scrutiny and Treatment: Physical Diagnosis and the Restructuring of 19th Century Medical Practice', Sociology of Health and Illness, Vol. 20, 6:779-801.

Lash, John. (1990), The Seeker's Handbook, New York: Harmony Books.

Lee, R. & Renzetti, C. (1990), 'The Problems of Researching Sensitive Topics', American Behavioral Scientist, Vol. 33, 5:510-528.

Lenski, G. (1963), The Religious Factor, A Sociological Enquiry, New York: A Doubleday Anchor Book, Revised Edition, 22-31.

Levin, J.S. (1986), '"New Age" Healing in the US', Social Science and Medicine, Vol. 23, 9:889-897.

Levin, J.S. & Vanderpool, H.Y. (1987), 'Is Frequent Religious Attendance Really Conducive to Better Health? Towards an Epidemiology of Religion', Social Science and Medicine, Vol. 24, 7:589-600.

Lewis, J. & Melton, G.J. (1992), 'The New Age', Syzygy: Journal of Alternative Religion and Culture, Vol. 1, 3:247-258.

Linnell, Maxine. (1994), 'Relating through the Chakras', Self and Society, A Journal of Humanistic Psychology, Vol. 21, 6:24-29.

Lofland, J. & Lofland, L.H. (1995), Analysing Social Settings, Belmont, California: Wadsworth Publishing Company.

Lofland, J. & Richardson, J. (1984), 'Religious Movement Organisations, Elemental Forms and Dynamics', Research in Social Movements, Conflict and Change, Vol. 7: 29-51.

Long, Theodore. (1979), 'Cult, Culture Cultivation: Three Different Tillings of a Common Plot', Journal of Scientific Study of Religion, Vol. 18:419-23.

Luckmann, Thomas. (1967), The Invisible Religion, New York: Macmillan Publishing.

Luckmann, Thomas. (1990), 'Shrinking Transcendence, Expanding Religion?', Sociological Analysis, Vol. 50, 2:127-138.

Lyon, David. (1993), 'A Bit of a Circus: Notes on Postmodernity and New Age'. Religion, Vol. 23, 2:117-126.

Mattson, P. (1982), Holistic Health In Perspective, Palo Alto, California: Mayfield Publishing Company.

Maxwell, J. (1992), 'Understanding and Validity in Qualitative Research', Harvard Educational Review, Vol. 62, 3:279-300.

McCutcheon, Russell. (1997), 'My Theory of the Brontosaurus: Postmodernism and "Theory" of Religion', Studies in Religion, Vol. 26, 1:3-23.

McKee, D.D. & Chappell, J.N. (1992), 'Spirituality and Medical Practice', The Journal of Family Practice, Vol. 35, 2:201-208.

Mellor, P. & Shilling, C. (1993), 'Modernity, Self-Identity and the Sequestration of Death', Sociology, Vol.27, 3:411-431.

Mellor, P. & Shilling, C. (1997), Re-forming the Body: Religion, Community and Modernity, London: Sage Publications.

Melton, Gordon. (1986), Encyclopaedic Handbook of Cults in America, New York: Garland Publishing Inc, 107-121.

Merton, R.K. & Kendall, P.L. (1946), 'The Focused Interview', American Journal of Sociology, Vol. 51, May:541-557.

McGuire, M.B. (1981), 'The Sociological Perspective on Religion', In Religion: The Social Context, Belmont, California: Wadsworth Publishing Company, 1-19.

McGuire, M.B. (1983), 'Words of Power: Personal Empowerment and Healing'. Culture, Medicine and Psychiatry, Vol. 7, 221-240.

McGuire, M.B. (1990), 'Religion and the Body: Rematerializing the Human Body in the Social Sciences of Religion', Journal for the Scientific Study of Religion, Vol. 2, 3:283-296.

McGuire, M.B. (1996), 'Religion and Healing and the Mind/Body/Self', Social Compass, Vol. 43, 1:101-116.

McGuire, M.B. & Kantor, D. (1988), Ritual Healing in Suburban America, New Brunswick, New Jersey: Rutger University Press.

McIntosh, D. & Spilka, B. (1990), 'Religion and Physical Health: The Role of Personal Faith and Control Beliefs', Research in the Social Scientific Study of Religion, Vol. 2, 167-194.

Miles, M.A. & Huberman, A.M. (1994), Qualitative Data Analysis, London: Sage Publications.

Miles, M.A. & Weitzman, E.A. (1994), 'Appendix: Choosing Computer Programs for Qualitative Data Analysis'. In Miles, M.A. et al Qualitative Data Analysis, London: Sage Publications, 311-315.

Mitchell, Clyde. J. (1974), 'Social Networks', Annual Review of Anthropology, Vol. 3, 279-299.

Morgan, Michael. (1994), The A-Z of Alternative Medicine, London: Abercorn Hill Associates Publications, Issue 1.

Morgan, Michael. (1995), The A-Z of Alternative Medicine, London: Abercorn Hill Associates Publications, Issue 2.

Mullen, Kenneth. (1990), 'Religion and Health: A Review of the Literature', International Journal of Sociology and Social Policy, Vol. 10, 2:85-96.

Mullen, Kenneth. (1994), 'Control and Responsibility: Moral and Religious Issues in Lay Health Accounts', The Sociological Review, Vol. 42, 3:414-437.

Mullen, Kenneth. (1998), 'Illusory Bodies: A Sociological Account of a Buddhist Healing Meditation', Paper Presented to the British Sociological Association Annual Conference, 'Making Sense of the Body: Theory, Research & Practice', University of Edinburgh, April 6-9 1998.

Murphy, Donald. (2000), 'Developing Research Methodology in Spiritual Healing: Definitions, Scope and Limitations', The Journal of Alternative & Complementary Medicine, Vol. 6, 4:299-300.

Murray, J. & Shepherd, S. (1993), 'Alternative or Additional Medicine? An Exploratory Study in General Practice', Social Science and Medicine, Vol. 37, 8:983-988.

Needleman, J. & Baker, G. (Ed.) (1978), Understanding the New Religions, New York: Seabury Press, 49-266.

Nelson, G.K. (1968), 'The Concept of the Cult', Sociological Review, Vol. 16, 351-62.

Nelson, G.K. (1969), 'The Spiritualist Movement and the Need for a Redefinition of Cult', Journal for the Scientific Study of Religion, Vol. 8. 1:152-160.

Nesti, Arnaldo. (1990), 'Implicit Religion: the Issues and Dynamics of a Phenomenon', Social Compass, Vol. 37, 4:423-438.

Newell, Rosemarie. (1993), 'Questionnaires', In Gilbert, N. (Ed.), Researching Social Life, London: Sage Publications, 94-115.

Oerton, S. (1998), 'Life May Take it Out of You, But Touch Can Put it Back: Women

Bodyworkers and the Postmodern Self', Paper Presented to the British Sociological Association Annual Conference, 'Making Sense of the Body: Theory, Research &Practice', University of Edinburgh, April 6-9 1998.

Oppenheim, A.N. (1992), Questionnaire Design, Interviewing and Attitude Measurement, London: Pinter Publishing.

Otterloo, Anneke van. (1995), 'Regimens of the Body and Spirituality in New Age: Paradox or Contradiction?', Paper Presented to the SISR Annual Conference, Quebec: Canada.

Otterloo, Anneke van. (1999), 'Selfspirituality and the Body: New Age Centres in the Netherlands since the 1960's', Social Compass, Vol. 46, 2:191-202.

Otto, H & Knight, J. (1979), Dimensions on Wholistic Healing, New Frontiers in the Treatment of the Whole Person, Chicago: Nelson-Hall.

Patel, Mahesh. (1987), 'Evaluation of Holistic Medicine', Social Science and Medicine, Vol. 24, 2:169-175.

Peters, David. (1994), 'Sharing Responsibility for Patient Care: Doctors & Complementary Practitioners', In Budd, S. & Sharma, U. (Ed.), (1994), The Healing Bond, London: Routledge, 171-192.

Percy, Martyn. (1995), 'Fundamentalism: A Problem for Phenomenology', Journal of Contemporary Religion, Vol. 10, 1:83-91.

Pilisuk, M. & Parks, S. (1980), 'Structural Dimensions of Social Support Groups', The Journal of Psychology, Vol. 106, 157-177.

Piliuk, M. & Parks, S. (1981), 'The Place of Network Analysis in the Study of Supportive Social Associations', Basic and Applied Social Psychology, Vol. 2, 2:121-135.

Piliuk, M. & Parks, S. (1986), The Healing Web: Social Network and Human Survival, Hanover: University Press of New England.

Poloma, Margaret. (1991), 'A Comparison of Christian Science and Mainline Christian Healing Ideologies and Practices', Review of Religious Research, Vol. 32, 4:337-350.

Polsky, Ned. (1969), Hustlers, Beats & Others, New York: The Lyons Press.

Porritt, D. (1979), 'Social Support in Crisis: Quantity or Quality?', Social Science and Medicine, Vol. 13, 1:715-721.

Posner, T. (1985), 'Transcendental Meditation, Perfect Health and the Millennium', In Jones, R.K. (Ed), Sickness and Sectarianism, Aldershot: Gower Publications, 94-113.

Press, Irwin. (1980), 'Problems in the Definition and Classification of Medical Systems', Social Science and Medicine, Vol. 14, 45-57.

Puttick, Elizabeth. (1995), 'Sexuality, Gender and the Abuse of Power in The Master-Disciple Relationship: The Case of the Rajneesh Movement', Journal of Contemporary Religion, 29-40.

Rieff, Phillip. (1966), The Triumph of the Therapeutic, Harmondsworth, Middx: Penguin Books Limited, 199-224.

Robbins, Thomas. (1983), 'Sociological Studies of New Religious Movements: A Selected Review', Religious Studies Review, Vol. 9, 9:233-238.

Robbins, Thomas. (1979), 'Cults and the Therapeutic State', Social Policy, Vol. 10, May/June, 1:42-46.

Robbins, Thomas. (1988), 'The Transformative Impact of the Study of New Religions and the Sociology of Religion', Journal for the Scientific Study of Religion, Vol. 27, 1:12-31.

Robbins, T.A. & Richardson, J. (1978), 'Theory and Research in Today's "New Religions"', Sociological Analysis, Vol. 39:95-123.

Robbins, T.A. & Anthony, D. (1978), 'New Religious Movements and the Social System: Integration, Disintegration, or Transformation', Religion, Vol. 2, 1-28.

Robbins, T.A. & Anthony, D. (1982), 'Deprogramming, Brainwashing and the Medicalization of Deviant Religious Groups', Social Problems, Vol. 29, 3:282-297.

Roberts, Richard. (1994), 'Power and Empowerment: New Age Managers and the Dialectics of Modernity/Postmodernity', Religion Today, Vol. 9, 3:3-13.

Rose, David. (1995), 'Official Social Classifications in the UK', In Social Research Update, Issue 9, Guildford: University of Surrey.

Rose, Nikolas. (1989), 'The Therapies of Freedom', In Governing the Soul. The Shaping of the Private Self, London: Routledge, 255-259.

Rose, Stuart. (1998), 'An Examination of the New Age Movement: Who is Involved and What Constitutes its Spirituality', Journal of Contemporary Religion, Vol. 13, 1:5-22.

Ross, Steven. (1983), 'Another Look at God', Ethics, Vol. 94, 87-98.

Saks, Mike. (1992), Alternative Medicine in Britain, Oxford: Oxford University Press.

Scott, John. (1991) 'Trend Report: Social Network Analysis' Social Network Theory: A Handbook, Sage: London, 109-127.

Scott, M.B. & Lyman, S.M. (1968), 'Accounts', American Sociological Review, Vol. 33, 46-62.

Sebald, Hans.(1984), 'New Age Romanticism: The Quest for an Alternative Lifestyle as a Force of Social Change', Humboldt Journal of Social Relations, Vol. 11, 2:106-127.

Sharma, Ursula. (1994), 'The Equation of Responsibility: Complementary Practitioners and their patients', In Budd, S. & Sharma,U. (Ed.), The Healing Bond, London: Routledge, 82-103.

Shaw, William. (1995), 'Weird Words', The Observer Newspaper Supplement, Observer Life, 28th May.

Shimazono, Susumu. (1999), '"New Age Movement" or "New Spirituality Movement and Culture?"', Social Compass, Vol. 46, 2:121-133.

Silverman, David. (1993), Interpreting Qualitative Data, London: Sage Publications.

Smith, David. (1993), 'The Premodern and the Postmodern: Some Parallels with Special Reference to Hinduism', Religion, Vol. 23, 2:157-165

Smith, M. (Pseudonym) (1997), Meditation, Development and Healing Group, Booklet produced and printed by a National Federation of Spiritual Healers therapist. Printed on 23rd January 1997, Surrey.

Stacey, Margaret. (1988), The Sociology of Health and Healing: A Textbook, London: Routledge, 156-160.

Stalker, D. & Gylmour, C. (Ed.), (1985), Examining Holistic Medicine, New York: Prometheus Books.

Stark, R. & Bainbridge, W.S. (1980), 'Networks of Faith: Interpersonal Bonds And Recruitment to Cults and Sects, American Journal of Sociology, Vol. 85, 6:1376-1395.

Stark, R. & Bainbridge, W.S. (1984), 'Formal Explanation of Religion: A Progress Report', Sociological Analysis, Vol. 45, 145-158.

Stark, R. & Bainbridge, W.S. (1985), The Future of Religion, Chicago: University of Chicago Press.

Stevens, David. (1989), 'Meditation in Six Steps', Self and Society, European Journal of Humanistic Psychology, Vol. XVII, March/April, 2:52-59.

Stoecker, R. (1991), 'Evaluating and Rethinking the Case Study', Sociological Review, Vol.39, 88-112.

Stone, D. (1976), 'The Human Potential Movement', In Glock C.Y. & Bellah, R.N., The New Religious Consciousness, Berkeley & London: University of California Press, 93-115.

Sullivan, Karan. (1994), Collins Gem of Alternative Remedies, London: Harper Collins Publications.

Sutcliffe, Steven. (1995), 'The Authority of the Self in New Age Religiosity: The Example of the Findhorn Community', DISKUS, Vol. 3, 2:23-42.

Sutcliffe, Steven. (1997), 'Seekers, Networks, and 'New Age'', Scottish Journal of Religious Studies, Vol. 18, 2:97-114.

Sutcliffe, Steven. (1999), Private Correspondence. Stirling University, Initiated 10th April 1999.

Sutcliffe, S. & Bowman, M. (2000), Beyond New Age: Exploring Alternative Spirituality, Edinburgh University Press. 1-13.

Swatos, William H. (1990), 'Spiritualism as a Religion of Science', Social Compass, Vol. 37, 4:471-482.

Taussig, Michael. (1980), 'Reification and the Consciousness of the Patient', Social Science and Medicine, Vol. 14, 3-13.

Taylor, Charles. (1989), Sources of the Self. The Making of the Modern Identity, Cambridge: Cambridge University Press.

Taylor, S. & Bogdan., R. (1984), Introduction to Qualitative Research Methods. The Search for Meaning, New York: John Wiley and Sons.

Telles, J.L. & Pollack, M.H. (1981), 'Feeling Sick: The Experience and Legitimation of Illness', Social Science and Medicine, Vol. 15, 1:243-251.

Tesch, R. (1991), 'Software for Qualitative Researchers: Analysis Needs and Program Capabilities', In Fielding, N. & Lee, R. (Ed.), Using Computers in Qualitative Research, London: Sage Publications, 16-37.

Theobald, Robin. (1981), 'The Politicization of a Religious Movement: British

Adventism Under the Impact of West Indian Immigration', British Journal of Sociology, Vol. 32, 2:202-223.

Thompson, J. & Heelas, P. (1986), The Way of the Heart: The Rajneesh Movement, Northamptonshire: The Aquarian Press, 20-31.

Towler, Robert. (1974), Homoreligiosus, Sociological Problems in the Study of Religion, London: Constable & Company Limited, 128-201.

Towler, Robert. (1984), The Need for Certainty: A Sociological Study of Conventional Religion, London: Routledge & Kegan Paul, 1-18.

Trevathan, Wenda, R. (1995), 'Evolutionary Medicine: An Overview', Anthropology Today, Vol. 11, 2:2-5.

Trier, K. & Shupe, A. (1991), 'Prayer, Religiosity, and Healing in the Heartland, USA: A Research Note', Review of Religious Research, Vol. 32, 4:351-358.

Turnbull, Liz. (1997), 'Narcissism & the Potential for Self-transformation in the Twelve Steps', Health, Vol. 1, 2:149-165.

Turner, Barry. (1981), 'Some Practical Aspect of Qualitative Data Analysis: One Way of Organising the Cognitive Processes Associated With The Generation of Grounded Theory', Quality and Quantity, Vol. 15, 225-247.

Turner, Bryan. (1980), 'The Body and Religion: Towards an Alliance of Medical Sociology and Sociology of Religion', Annual Review of the Social Science of Religion, Vol. 4, 247-286.

Turner, Bryan. (1982), 'The Government of the Body: Medical Regimens and the Rationalization of Diet', British Journal of Sociology, Vol. 33, 2:255-260.

Turner, Bryan. (1984), The Body and Society: Explorations In Social Theory, London: Basil Blackwell Publications Limited.

Van Hove, H. (1995), 'Higher Realities and The Inner Self: One Quest?' Journal of

Contemporary Religion, Vol. 11, 2:185-194.

Van Hove, H. (1996), Private Correspondence. Department of Sociology, University of Leuven, Belgium, Initiated December 22nd 1995.

Van Hove, H. (1999), 'L'émergence d'un "marché spiritual"', Social Compass, Vol. 46, 2:161-172.

Wallis, Roy. (1989), 'Religion: The British Contribution', British Journal of Sociology, Vol. 40, 3:493-513.

Wallis, Roy. (1984), The Elementary Forms of the New Religious Life, London: Routledge and Kegan Paul.

Wallis, Roy. (1985a), 'The Sociology of the New Religions', Social Science Review, Vol. 1, September: 3-7.

Wallis, Roy. (1985b), 'Betwixt Therapy and Salvation: The Changing Form of the Human Potential Movement', In Jones, R.K. (Ed.), Sickness and Sectarianism, Aldershot: Gower Press, 23-51.

Wallis, R. & Morley, P. (Ed.), (1976), Marginal Medicine. Perspectives on Culture and Society, London: Peter Owen Press, 77-109.

Wallis, R. & Bruce, S. (1983), 'Accounting for Action: Defending the Common Sense Heresy', Sociology, Vol. 17, 1:97-110.

Wallis, R. & Bruce, S. (1984), 'The Stark - Bainbridge Theory of Religion: A Critical Analysis and Counter Proposals', Sociological Analysis, Vol. 45, 11-28.

Wallis, R. & Bruce, S. (1985), 'Homage to Ozymandias: A Rejoiner to Bainbridge and Stark', Sociological Analysis, Vol. 46, 73-76.

Walsh, Kathy. (1995), 'The Age of Aquarius', The Tablet, 20 May, 629-630.

Walter, T. (1993), 'Death in the New Age', Religion, Vol. 23, 2:127-145.

Walter, T. (2001), 'Reincarnation, Modernity & Identity', Sociology, Vol. 35, 1:21-38.

Weber, Max. (1966), The Sociology of Religion, London: Social Science Paperbacks in association with Methuen and Co. Limited.

Weber, Robert Philip. (1990), Basic Content Analysis: Qualitiative Applications in the Social Sciences, London:Sage Publications.

West, Ruth. (1992), 'Alternative Medicine: Prospects and Speculations', In Saks, M. (Ed.), Alternative Medicine In Britain, Oxford: Oxford University Press, 201-211.

Westley, Frances. (1978), 'The Cults of Man: Durkheim's Predictions and New Religious Movements', Sociological Analysis, Vol. 39, 2:135-145.

Whaling, Frank. (1996), Christianity and New Age Thought, Oxford: Second Series Occasional Paper 1, Published by the Religious Experience Research Centre: Oxford.

Wijngaards, John. (1988), 'Praying with the Body', The Tablet, 24th September:1086-1087.

Wikler, Daniel. (1985), 'Holistic Medicine: Concepts of Personal Responsibility for Health', In Stalker, D. & Glymour, C. (Ed.), Examining Holistic Medicine, New York: Prometheus Books, 137-149.

Wildwood, Alex. (1993), 'Ritual and Transformation', Self and Society. European Journal of Humanistic Psychology, Vol. 21, November, 5:19-23.

Wilkinson, Paul. (1971), Social Movements, London: Pall Mall Press Ltd.

Wilson, Bryan. (1982), Religion in Sociological Perspective, Oxford: Oxford University Press.

Wilson, Bryan. (1990), The Social Dimensions of Sectarianism: Sects and New Religious

Movements in Contemporary Society, Oxford:Oxford University Press.

Wilson, Bryan. (1996), Religious Experience: A Sociological Perspective, Oxford: Second Series Occasional Paper 2, Published by the Religious Experience Research Centre: Oxford.

Wolsko. P, Ware. L, Kutner. J, Chen-Tan. L, Albertson. G, Cyran. L, Schilling. L, Anderson. R,. (2000), 'Alternative/ Complementary Medicine: Wider Usage Than Generally Appreciated', The Journal of Alternative and Complementary Medicine, Vol. 6, 4:321-326.

Wooffitt, Robin. (1993), 'Analysing Accounts', In Gilbert, N. (Ed.), Researching Social Life, London: Sage Publications, 287-305.

Wooffitt, Robin. (2000), 'Some Properties of the Interactional Organisation of Displays of Paranormal Cognition in Psychic-Sitter Interaction, Sociology, Vol. 34, 3:457-479.

•

Wood, Matthew. (1995), 'Holistic Health Therapies in Comparative Analysis', Paper Presented tot he Third Annual Conference on Contemporary and New Age Religions in the British Isles, Bath College of Higher Education, 13th May 1995.

Wood, Matthew. (1999), 'Spirit Possession in a Contemporary British Religious Network: a Critique of New Age Movement Studies Through the Sociology of Power' Unpublished PhD Thesis, University of Nottingham.

Wood, Matthew. (Forthcoming 2001), 'Kinship Identity and Nonformative Spiritual Seekership', In Coleman, S. & Collins, P. (Ed.), Religion, Identity and Change: British Perspectives on Global Transformations, Aldershot: Ashgate.

Woodhead, Linda. (1993), 'Post-Christian Spiritualities', Religion, Vol. 23, 2:167-181.

York, Michael. (1994), 'New Age in Britain: An Overview', Religion Today. A Journal of Contemporary Religion, Vol. 9, 3:14-21.

York, Michael. (1995), The Emerging Network: A Sociology of the New Age and Neo-Pagan Movements, Rowman & Littlefield Publishers, Maryland, USA.

Zinnbauer, Brian et al. (1997), 'Religion and Spirituality: Unfuzzying the Fuzzy', Journal for the Scientific Study of Religion, Vol. 36, 4: 549-564.

Zola, Irving Kenneth. (1972), 'Medicine as an Institution of Social Control', Sociological Review, Vol. 20, 487-505.

Zollman, C. & Vickers, A. (1999a), 'Clinical Review. ABC of Complementary Medicine: What is Complementary Medicine?, eBritish Medical Journal, Vol. 319: 693-696.

Zollman, C. & Vickers, A. (1999b), 'Clinical Review. ABC of Complementary Medicine: Complementary Medicine and the Doctor', eBritish Medical Journal, Vol. 319: 1558-1561.

APPENDIX 3.1

BBC Interview. The Sunday Programme
Sunday 4th December 1994
The Holistic Health Centre

Eve - BBC Interviewer
Sandra - Holistic Health Representative
Penny - Holistic Health Client
Pullman - Writer and Publisher in Mind/Body/Spirit

Eve.- It's a busy afternoon in Chelsea and I'm outside a beauty salon called Holistic Health.[1] Although in calling it a beauty salon I'm selling it rather short. Yes you can come here for a facial, a manicure, to have your eye lashes dyed or your legs waxed but you could also take advantage of such treatments such as Holistic Massage, Hypnotherapy, Shiatsu and Acupuncture and even something called Electro-Crystal Therapy. You see nobody here believes that beauty is only skin deep, they believe it comes from within .... (Entering the centre).. Hi, I'm Eve, I've got an appointment with Sandra at 4 o'clock. (Commentary... Sandra Green trained as a conventional beauty therapist and for six years ran a conventional salon before recognizing its limitations).

Sandra.- I was getting people coming in with skin problems and nail problems and expecting you to be able to, with a few creams, lotions and potions, to sort them out. When most of the time there is no way we can treat skin problems etc. with a few creams. It has to be tackled internally.

Eve. - One of Sandra's client's, Penny, had internal problems caused by taking too many prescription drugs. I arrived in the middle of one of her weekly Acupuncture sessions.

Penny. - I came here about seven weeks ago feeling really bad and lethargic and just fed up with it. But now it's just brilliant, completely different person. I just feel so much better.

---

[1]For confidentiality pseudonyms have been given to centre, centre location and interview participants.

Eve. - But it's not for me. I'm not keen on needles at the best of time and certainly not sixteen or so in different parts of my body at the same time. And so Sandra offered what I thought would be a less painful treatment.

Sandra. - I'll just do a bit of Reflexology on you. First of all have you had Reflexology before?

Eve. - I haven't and I don't know what it is.

Sandra. - Right well you're in for a big surprise then. We start with your feet. Basically each part or organ of your body maps onto a different area of your foot and by working at reflex points we can determine if there is a problem in a specific area. And hopefully by working on the reflex we can unblock that area and allow the body to re-balance and heal itself.

Eve. - Sandra stresses that clients have to believe in the treatments to get the best effects from them. They are valuable in themselves, she says, they are all about getting the body and the mind to work in harmony together. Interestingly she uses the word "faith', that's what counts", she says. Is this a sort of 90's religion? Some practitioners would say definitely not, but Sandra's not so sure.

Sandra. - What is religion? Religion is a belief in a thing. It's something that you adopt as a lifestyle. It's something you follow as part of your daily routine and adopt into your routine. Complementary therapy for a lot of people has become that. I personally would call it more a therapy than a religion, but as long as it helps, does it matter what it's called?

Eve. - Have you had people critical of what you do because of their religious beliefs?

Sandra. - Yes. On anything to do with the mind. Meditation that sort of thing, even Yoga came under criticism under a couple of my clients. There are people that believe in

emptying the mind and allowing evil spirits to dwell in their mind... [it] can be very very dangerous and clients that come here for Refleoxology or Acupuncture would in no way ever have Hypnotherapy or Meditation classes.

Eve. - But whatever the right and wrong of the various therapies, why are more beauticians incorporating them into their beauty packages and many more women trying them out?

Mary Pullmans, a publisher specializing in the whole Mind, Body, Spirit area, sees it as part and parcel of the enormous amount of interest being shown in New Age ideas and Eastern spirituality.

Pullman. - In terms of the relevance of beauty it's often observed that Eastern women have grace and femininity which Western women lack. This is partly confirmed by the style of spirituality and people are realizing that beauty is caused by inner serenity being more central, more grounded, more at peace with oneself.

Eve. - But is it?

Pullman. - Well, I've certainly noticed personally and it's often been observed that people who do a lot of meditation or are involved in some form of spirituality have this inner glow which gives them a different kind of beauty from that which is conferred by cosmetics.

Eve. - Meanwhile back on the Reflexology table I continue practising the age old philosophy my mother drummed into me from an early age. That pride must take a pinch ....(while taking the treatment)...This is really painful.

Sandra. - I'm really sorry.

Eve. - That's all right. I just wonder what it's telling me about my body...that I'm just a

physical wreck..Is their anything that's working well?

Sandra. - Your mouth!

APPENDIX 3.2

Preliminary Observational Field Notes - June 1995
Comparison Between Health and Healing Centres

1. Different Names. The Healing Centre concentrated on healing and creative arts. Holistic Health dealt with beauty and health care services and products. The Natural Centre was concerned with natural methods to achieve health. Do the names of the centres give an indication of what type of person each is trying to attract? The words, *healing*, *holistic* and *natural* I assume would attract widely different people.

The Healing Centre stands out as it emphasizes a somewhat different approach than the others as it uses the esoteric term *healing*. The centre's focus, judging from the decor, location, environment, and first impression of therapists, implies more of a supportive and personal environment than the other centres. It there a significance to the term healing being in the title?

If many treatments overlap between centres, how is it that they all focus on different features? For example Holistic Health was concerned with beauty. From this perspective I believe that the selection of the centre would determine the research focus. Therefore, should one be looking to a specific type of health centre?

I assume that by knowing the correct definitions of the terms (for example alternative, fringe, traditional etc). Then it would make it easier to select a centre in which to study. For example, a healing centre, I would imagine, would be better tuned into the belief system underlying complementary health than would a beauty centre.

2. Location. Residential area or high street. The Healing Centre was located in a quiet residential area. Others were either on a high street or near one. I think this also influences people, e.g spontaneity. You have to actually know where The Healing Centre was located to be able to visit it. It does not look as though you could walk in just off the street. Hence, it implies a regular, core clientele, perhaps even local people. The Natural Centre, on the other hand, was located on the first floor of a conventional dance and fitness centre. This would also change the clientele and might even influence which therapists worked there.

3. Clients. As The Healing Centre was located in an affluent area it naturally attracts certain types of clients, and for that matter therapists too. Price lists reflect this difference. Holistic Health attracted less affluent clients who come off the street to book sessions. The Healing Centre bookings are made with the individual practitioner via the centre. The Natural Centre, as it is based in a dance and fitness studio, attracted the young, affluent client, but my impression of The Natural Centre was that complementary health played a secondary role to that of the fitness centre located below. Those who attended The Natural Centre would, therefore, visit as part of their dance or fitness session. However, the Natural Centre still managed to cover one floor of a very large building and claimed to be 'London's leading natural health centre'.

Only a certain proportion of the population can afford complementary health and healing care. These people are located in the upper income bracket. So far I have yet to see a price list from any centre on open display. This could be that prices are negotiated between the client and practitioner on booking.

Is there any significance in the fact that almost all clients, I have seen, so far, have been women? Ages of clients seemed to be equally spaced between the mid twenties to around forty years of age.

4. Therapists. The Healing Centre had a greater number of therapists, both local, national and even international. These practitioners may have their own practices elsewhere. Holistic Health was more locally based. One therapist I spoke to taught at the local college. Also at Holistic Health all therapists wore a uniform.

Some treatments are tailored by the therapist so that some centres' may have treatments which are unique to themselves. Are there any differences or similarities between therapists who work in the health centres? For example do particular therapists share the same beliefs? Are there any differences of beliefs between practitioners of certain treatments?

All centres, so far, claim to have well qualified therapists. So far, most therapists have been women. Ages seem to vary. On my first visit to The Healing Centre I was not aware of any therapists' ages. (No therapists could be seen). However the therapists at Holistic Health were all quite young, around twenty-five to thirty-five. At the Natural Centre the

few therapists I saw were around thirty-five plus.

Procedures for therapists, dealing with clients, seemed to be different between centres. The Healing Centre and Holistic Health were both organised into one hour consultations, while the Natural Centre also had one hour consultations, but some sessions were dealt with over the phone!

5. Therapy rooms. In conference and workshop facilities. The Healing Centre plays a visible role in complementary health circles. It organizes open days and gives lectures and demonstrations at regular intervals. It also offers support groups and workshops. Holistic Health has no such role, or facilities for such events. Holistic Health does not advertise in similar 'new age' circles as the other centres. For example, Pathways publications. The Healing Centre and The Natural Centre were both initially found in the publication entitled A-Z of Alternative Health 1994. How far are the centres integrated into the wider health and healing network?

6. Decor. Holistic Health was designed like a shop. On entry one can see products for sale, a cash register and reception desk. The Healing Centre was a converted barn which has been restored and made to resemble a county house. Decor included bookshelves, sofas, pictures and plants. The Natural Centre was designed, in tune with its dance and fitness surroundings, to include large wall mirrors. Here the reception room was made to look like a conventional office (typewriter, filing cabinet, desk and telephone). Holistic Health and the Natural Centre seemed to be very clinical in appearance, while the Healing Centre seemed to portray a softer image. Consultation rooms in all three centres' were very similar, carpeted throughout, with consultation couch, chair, mirrors and plants.

I think the decor conveys different images to the clients, either clinical or homelike. As far as the decor is concerned there seem to be many differences between the centres. One must ask oneself what is each centre trying to portray? Do the environments and the furnishing play a significant role in the attraction of the client? Are the centres trying to be conventional in appearance (clinical) or is it the opposite, where the centre goes out of its way to look different from other centres? All have different reception rooms. The

Healing Centre has a lounge and is very homelike. Holistic Health looks like a shop and has a clinical appearance, while the Natural Centre reflected more an office environment.

7. Language. Respondents from all three centres used similar health and healing terms (for example energies) when describing treatments and health related ideas. Language, terms and phases isolated them from others they may speak to. When I was interviewing I was conscious that the terms and phrases I was using, to ask questions, were too harsh. Health and healing terms seemed softer and more rounded. Similar terms also seemed to have a universal meaning for practitioners. This raises the question: are there certain universal health and healing terms which are used in these centres? Are these significant in the understanding of treatments and health beliefs etc? Is it only therapists who use such terms? What do therapists and clients understand them to mean? Is there a gap between therapists and clients in their understanding of these terms?

8. Economics. Specific price lists not available at the Healing Centre or the Natural Centre. Prices are often negotiated between clients and therapists on booking. If clients are known to therapists some sessions can be paid for by bartering. Holistic Health was the only centre which had compiled a price list. Why does one centre advertise a price list of treatments while others do not? Is this a conscious effort to portray the environment of some centre as more homely or alternatively emphasize that some centres are purely a business enterprise?

9. General Impressions. Although all the centres offered similar treatments they seem to be different in many respects. The main question is why is there such a diverse range of health and healing centres available? It seems to me that they all cater for different segments of society. Those who attend the Healing Centre may be seeking something different (or something more substantial e.g a belief system) than they would find in Holistic Health which looked specifically at beauty and health.

APPENDIX 3.3

Client Interview Guide

What therapies do you take?

How did you become interested in complementary health?

What made you choose _____ therapy? How did you choose which therapy to take?

As a client what do you want out of using complementary health methods?

Energy

Have you every come across the notion of energy in your treatments?

What are you told about healing energy?

Is that where you first learned of energy ?

Do you know what the energy is?

Do you know what this energy does?

Where does energy comes from?

Are there different types?

Would you say energy is important to complementary health and healing?

Do you think you would have to necessarily believe in energy to be healed?

Do you think many clients believe in energies?

Do you believe in energies?

Can energies have a wider influence? (ripple effect)

Holism

Have you ever come across the notion of holism?

Where did you first hear this term?

What does it mean to you?

Do you think the holistic perspective is important in maintaining good health?

Would you say you had to be particularly committed to the notion of holism in daily life to find health and well-being?

Growth and Responsibility

Do you think you've changed since taking treatments? In what ways have you changed?

Would you say people have to behave in certain ways if they wish themselves to be well?

Are there any rules you think people should abide by if they wish themselves to be well?

Do you think more people should take responsibility for their own body?

Therapists

Do you think therapists believe in energies and holism?

How important are the health sessions to you?

Networks

Do you attend any health shows, exhibitions or visit any healing centres, health clubs etc?

APPENDIX 3.4

Therapist Interview Guide

First of all, could you tell me about _____ therapy?

How did you first get into _____? (What courses did you do?)

Energy

When did you first learn of energy?

Where does the idea of energy come from?

What is the energy?

Where does energy come from?

What do these energies do?

Are there different types of energy?

What part does energy play in the healing process?

How important is the notion of energy in _____ therapy?

Do therapists necessarily have to believe in energies to give treatments?

Do clients necessarily have to believe in energies to be healed?

Would you say energies have a wider influence (ripple effect)?

Does the notion of energy emerge in all complementary health treatments or only certain ones? (Can you have healing without the idea of energy?)

Is there such a thing as negative energy?

Holism

Does the idea of holism play an important role in _____ therapy?

When did you first hear this term?

What do you see to be the meaning of holism? What does the term holism mean to you?

Does holism lie at the heart of all complementary health treatments?

What are the origins of holism?

Does holism play an important role in healing?

Is holism influential to individuals?

Can holism be seen to be influential to the wider society?

Do therapists have to believe in holism?

Once adopting a holistic perspective do you think clients or practitioners change things in their lives? (In what way can this be seen?)

Clients

Do you think clients are aware of these ideas? (energy/holism)

Do you find that clients take on board these notions?

Do you think your clients change once they have taken your treatment? In what ways?

Would clients have to behave in prescribed ways if they wish themselves to be well?

Would you have to understand these ideas (energy/holism) to get the best result from the treatment?

Do you think clients have to be particularly committed to these notions to find good health?

Therapists

As a therapist do you think you need to be particularly committed to notions such as energies/ holism to fulfil your role as a healer?

Are there any moral/ethical rules which arise in being a healer and giving treatments?

What role does the therapist play in the healing process of the client?

As a therapist what do you hope to achieve for the client?

Growth and Responsibility

Do you think more people should take responsibility for their own body?

The end requirement in complementary health and healing seems to be the idea of transformation or growth of the individual. Would you necessarily agree?

Networks

Do you attend any health exhibitions, conferences etc?

Are you part of an association, healer network?

APPENDIX 3.5

Interviewee Descriptions

No questions relating specifically to interviewee personal details (such as occupation, age, background) were asked throughout the interview process. Such questions were believed to infringe upon the informal interview style and perhaps have even threatened participants' sense of confidentiality. The disclosure of such data could also have undermined the responses given by therapists and clients. However, in order to contexualize the interviewees, information freely disclosed by respondents is shown below. As mentioned previously pseudonyms have been given for interviewees. Interviewee descriptions have been categorized into cell groups.

The following information is shown:

i. Name
ii. Sex
iii. Therapist's Previous Occupation (PO)
iv. Client's Occupation
v. Approximate Age*
vi. Nationality
vii. Class. The majority of respondents were categorized as Class 2 on the National Statistics Socio-economic Classifications (NS-SEC). This classification replaces the Registrar General's Social Classes (RGSC) scale. This category covers lower managerial and professional occupations such as journalists, musicians and nurses.[1]
viii. How interviewee became interested in complementary health and healing.
ix. Marital Status, (Married, Separated, Single, Co-habitating)
x. Resident Area

---

[1]For a further description of the NS-SEC contact the Occupational Information Unit at The Office of National Statistics. Also see David Rose's (1995), 'Official Social Classifications in the UK', The Social Research Update, Issue Nine, University of Surrey.

Cell A	
Colour Therapist	Patricia, F. Previous occupation (PO) - Freelance Musician/Orchestral Player. Age 45*. British. Patricia previously suffered from stress, mental and physical exhaustion. Patricia is married and resides in South London.
Colour Healing Client	James, M. Current occupation - Freelance Orchestral Player. Age 50* British. James suffers from stress, mental and physical exhaustion. James is married and has one son. He resides in South London.
Colour Healing Client	Sara, F. PO - Journalist. Age 35*. British. Sara became interested in complementary health by investigating mental health issues. Sara was a Colour Healing client who was also training to be a therapist. Sara resides in South London
Colour Healing Client	Erica, F. Age 28*. British. Erica became interested in complementary health while seeking alternatives to a possible hysterectomy operation. Erica wanted to address infertility and thyroid problems. She also suffered from depression. Erica also practices Yoga. Erica is single and resides in South London.
Colour Therapist	Ann, F. PO - Florist. Age 46*. British. Ann was introduced to complementary health through various visions/ dreams. Ann is married and has one son and daughter. She resides in an affluent home in an affluent home in Surrey.
Colour Therapist	Annabel, F. PO - Journalist/Film-maker. Age 40*. British. Annabel became interested in complementary health after a serious car accident. Annabel claimed that the accident subsequently alterered her attitudes towards life. Annabel is single and resides in South London.
Colour Therapist	Lisa, F, PO - Beauty Therapist. Age 36. British. Lisa encountered complementary health therapies while feeling dissatisfied with life. She separated from her husband and began retraining at the age of 30. Lisa has a six year old son. She lives in Surrey.
Crystal Therapist	April, F. Age 42*. British. April has always been interested in divinatory practices and wanted to develop her intuitive/ spiritual side. Her interest in complementary health increased while caring for her ill mother and while deciding to break from an unhappy marriage. April lives in Surrey.
Crystal Healing Client	Emma, F. Current Occupation - Advertising. Age 23*. British. Emma suffers from congestion and sinus trouble. Emma lives in Surrey.
Rebirthing Practitioner	Anthony, M. Age 29*. British. Anthony became interested in energy work as a consequence of visions/revelations induced by drugs while travelling. Anthony believes his career is a spiritual path. He trained as a journalist before encountering complementary health and healing. Anthony lives in North London.
Rebirthing Client	Anton, M. Anton was previously an Aid worker but is now a Ticket Inspector for London Underground. Age 33*. Austrian. Anton became interested in Eastern philosophy and world religions while living in Nepal. He is single and lives in West London.

Cell B	
Creating Prosperity/ Natural Healer	Himal, M. Age 38*. Indian. Originally interested in complementary health because he wanted to find a direction in his life. Himal has been involved in complementary health and healing for over ten years. Himal is married and resides in South London.
Reiki Therapist	Emily, F. Age 36*. Thai. Emily became interested in complementary health after discovering her healing abilities. Emily is married and has a nine year old daughter. She resides in an affluent area of North London.
Reiki Therapist	Suzanne, F. PO - Computer analyst/ programmer. Age 28*. British. Suzanne suffered from ME (Myalgic Encephalomyelitis) and subsequently discovered that she had healing abilities. Suzanne resides in North London.
Reiki Client	Elizabeth, F. Current occupation - office worker. Age 23*. British. Elizabeth has always been interested in spiritual beliefs and practices. She subsequently attended a spiritualist church and various self-discovery courses. Elizabeth also found it very difficult to get on with her work colleagues. Lisa is single and resides in Essex.
Reiki Client	Ben, M, retired. Age 57*. British. Ben suffered a stroke and was left with no feeling down his left side of his body. He is wheelchair bound and has speech difficulties. Ben began to use complementary health techniques as he wanted to regain some sensation on his left side of his body. He also wanted to improve his general mobility. He additionally sought a more positive view of life. Ben is married and resides in Essex.
Reiki Client	Kathryn, F. Current occupation - Hairdresser and Beauty therapist. Age 24*. British. Kathryn has always been interested in spiritual beliefs and practices. She is particularly interested in divinatory practices such as Tarot. Since she has taken treatments Kathryn claims she has discovered her own aura reading abilities. Kathryn resides in Essex.
Reiki Client	Janette, F. Age 33*. British. Janette suffers from sore and cracked skin on her hands and legs. She is married and has two young children. Janette resides in North London.
Reiki Therapist	Lilly, F. Age 33*. British. Lilly was introduced to complementary health and healing therapies while grieving for the death of her mother. She is married and resides in West London. Lilly is a pagan.
Reiki Client	Amanda, F. Current Occupation - Stock Trader. Age 28*. British. Amanda suffers from congestion, phlegm and allergy problems. She is married and lives in West London.
Reiki Therapist	Dawn, F. PO - Professional Singer. Age 36*. British. Dawn became interested in complementary health after a kitchen accident. She gradually discovered her own psychic abilities. Dawn is single and resides in South London.
Reiki Therapist	Diane, F. Diane is training to be a counsellor. Age 28*. British. Diane suffers from gynaecological problems due to a cyst on her ovaries. She encountered complementary health therapies while seeking alternative routes to alleviating the pain caused by the cyst. Diane has had conventional operations to reduce the risk on infertility. Diane lives in North London

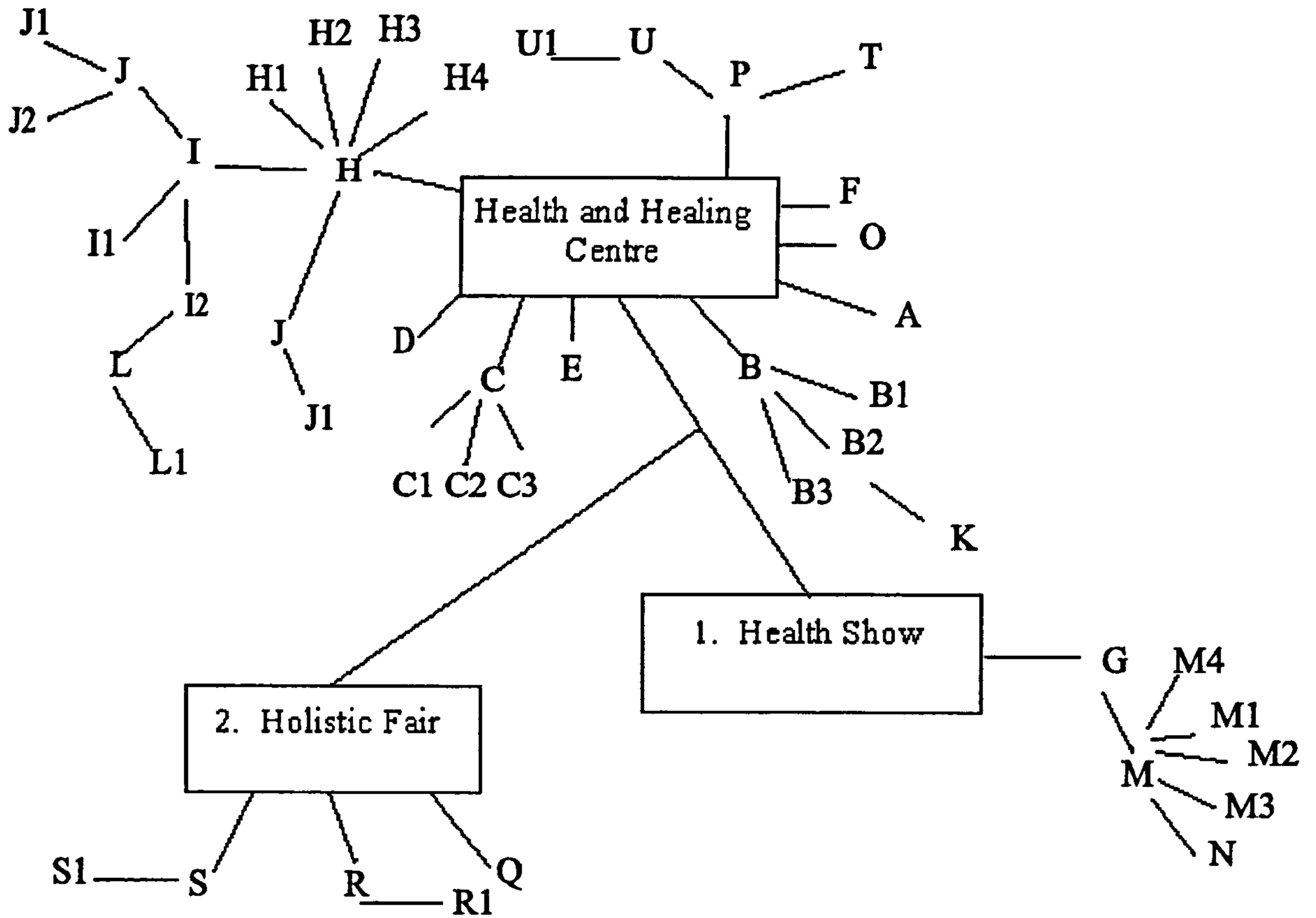
Spiritual Councillor/ NFSH Practitioner	Luke, M. Age 35*. British. Luke has always been aware of his psychic abilities. He has followed health and healing as a career choice since the age of eighteen. British. Luke resides in Yorkshire but regularly travels to Surrey to give treatments and present papers at local healing centres.
NFSH Practitioner	Madeleine, F. Age 45*. British. Madeline became aware of complementary health through her psychic abilities. She is married and resides in Surrey.
NFSH Client	Joyce, F. Current occupation - office worker. Age 42*. British. Joyce suffers from chronic back trouble and fatigue. She has practised Transcendental Mediation for twelve years. Joyce also advocate Natural Healing Therapies. Joyce is single and resides in Surrey.
NFSH Client	Felicity, F. Age 47*. British. Felicity suffers from a chronic back condition, arthritis and several allergies. Due to her state of health she has always been interested in complementary health practices. Felicity is married and lives in Surrey.
NFSH Client	Lee, M. Age 55*. British. Lee suffers from depression and has previously experienced a nervous breakdown. Lee has become more interested in complementary health since he has started seeing colours and auras. His NFSH treatment runs in conjection with conventional health care (counselling and medication). Lee is married and lives in Surrey.
NFSH Client	Julie, F. Age 40*. British. Julie suffers from back problems. She has always been interested in notions of self-development and spiritual beliefs. Julie has previously experienced Reiki. Julie is married and lives in Surrey

Cell C	
Bowen Technique Therapist	Claire, F, PO - Dance and Aerobic Instructor. Age 27*. British. Claire became interested in Bowen Technique through suffering from a knee injury. Claire is single and resides in North London.
Bowen Client	Susan, F, current occupation - Actress/ Singer. Age 30*. British. Susan suffers from back problems and Repetitive Sprain Injury (RSI). Susan is single and resides in North London.
Bowen Client	Martin, M, current occupation - Dietician. Age 40*. British. Martin came across complementary health practices while seeking specific forms of self-improvement. He has recently begun Bowen Training. Martin demonstrated an affluent lifestyle. He resides in North London.
Bowen Client	Jane, F, current occupation - Nurse/Health Visitor. Age 40*. British. Jane became interested in complementary health after her divorce. Jane is interested in Bowen training. She resides in Hertfordshire.
Bowen Technique Therapist	Kelly, F. Age 28*. British. Kelly suffers from congestion problems. She became interested in complementary health after she recognised her healing abilities. Kelly was introduced as a client but was also interested in training to be a therapist. Kelly resides in South London.
Natural Healer	Frances, F. PO - Dancer/ Teacher. Age 35*. South African. Frances became interested in complementary health via her prediction of a student dance accident. Frances is married and has two children. She resides in Surrey.

Natural Healing Client	Louise, F. Current occupation - hairdresser. Age 35*. British. Louise suffered from back and neck strains. Louise also suffered from stress due to her mother's demise and her acrimonious divorce. She did not want to take medication to combat the stress. Louise has a four year old son. She resides in Surrey.
Natural Healing Client	Daniel, M. Current occupation - aspiring musician and actor. Age 22*. British. Daniel desired greater self-knowledge and peace due to his past bad behaviour and hectic lifestyle. Daniel resides in Surrey.
Homeopath	Harpal, M. PO - Medical Doctor. Age 32*. British. Harpal has always been interested in spiritual beliefs and practices. Harpal recognised his healing abilities from the age of nineteen. He resides in North London.
Homeopath Client	Janine, F. Current Occupation - Medical Doctor. Age 37*. British. Janine suffered from the sense of isolation and loneliness since the separation and divorce from her partner. She lives in South London
Reflexologist	Heather, F. PO - Secretary. Age 35*. British. Heather became interested in complementary heath after her son developed asthma. She gradually became involved with healing and energy work. Heather is married and lives in Surrey.
Reflexologist	Samantha, F. PO - Public Relations Director. Age 33*. British. Samantha suffered from work related stress. She has always been interested in different philosophies and world religions. Samantha lives in North London.
Shiatsu Therapist	Sally, F. PO - Actress/ Teacher. Age 35*. British. Sally suffered from ME for several years. She wanted to reduce the pain encountered throughout this illness. She is married with two young children. Sally lives in East London.

APPENDIX 3.6

Interview Snowball/ Network Diagram



The letters indicate therapist interviewees, while the accompanying numbered letters indicate client interviewees. The interviews appear in chronological order and are sequenced alphabetically. This plan illustrates the progressive snowball affect of interviews.

APPENDIX 3.7

Participant Observation at a Reiki Healing Workshop 28th-29th October 1995

My role as participant observer in the Reiki workshop was not altogether a role which I had expected. I was invited to the Reiki weekend by the Reiki masters previously met at the Healing Centre's open day (2nd July 1995). I was once again able to meet these individuals at a Natural Health Show (Esher on the 27th and 28th August 1995) where an invitation to participate in the Reiki weekend was offered. I believe that the Reiki masters' previous knowledge of me gave me further recommendation in gaining access to practitioners and clients. This I considered an excellent way to gain access to the Reiki healers and later access to a sample of their clients. The serendipitous event of being invited to participate in a Reiki Healing workshop became an important experience in the formation of the research design. The following events also contributed to my own understanding of the significance of the encompassing beliefs and practices on adherents' daily lives. This appendix will be grounded on ethnographic participant observation work undertaken during my attendance at an Reiki weekend workshop. The workshop took place over the weekend of the 28th-29th October 1995.

The central beliefs I wish to concentrate on within these observation notes are the notions of holism and energy. These two concepts had recurred significantly throughout the Reiki weekend. These research notes aim to highlight Reiki beliefs and question the importance of these, not only within the healing process but also to analyse the significance of these beliefs for both the client and therapist. Through analysing these research notes I hope to distinguish the wider influences of these notions, particularly as offering guidance about an approved lifestyle and ultimately providing a social reality by which participants might live.

There are four parts to this appendix. These subjects are all inter-related. The appendix will begin with a small discussion of healing and its role in Reiki Therapy. Part Two will concentrate on holism, one of the key beliefs which arose throughout the Reiki weekend. The concept of holism will be discussed to include not only notions in relation to individualism (self, potential and personal growth), but also holism in relation to participants' beliefs concerning society and the cosmos. In the discussion of holism the

paper wishes to argue that holistic beliefs offer a specially constructed perspective which ultimately gives meaning to participants. The notion of energy constitutes part three. Here the paper will identify the beliefs in supernatural and divine energies which are used in Reiki and seek to analyse their role as a direct experience with a higher force. Finally I will look at prayer and worship and its role in Reiki. This will be explained in the context of my own participation in a Reiki initiation ceremony.

The relationship between healing holism and energy incorporates a collection of additional issues. While discussing these, I would also like to draw on the notions of responsibility and accountability as they, too, contribute to the wider argument.

Reiki means universal life force or energy. It is said to have re-emerged in Japan when a Dr Usui was given 'the knowledge back in the last century' (Reiki Handout, 28th-29th Oct. 1995: 1). (This is the only indication of historical ancestry and dates given for the chronicles of Reiki). Dr Usui was described to the group as being given the 'knowledge' through 'fasting and meditating on a mountain top in Japan for a long period' (Reiki Handout, 28th-29th Oct. 1995: 1). Reiki is a Japanese form of laying on of hands, involving an energy transfer which catalyses the universal life force to promote healing and well-being. The method by which Reiki is performed is optional as to whether one lays one's hands on the body itself or by touches to the recipient's aura, which surrounds the periphery of the body. The universal life force was described to the group as the energy which coats the earth atmosphere.[1]

Energy is perceived to be everywhere (society), in everything (objects) and in everyone. Reiki was explained to comprise of vibrations which constitute everything and everyone. Hence, all things emanate energy. Energy therefore was believed to originate through an object's vibrational frequency. For example, illnesses were believed to manifest due to the body's blocked or unbalanced energy levels. Only through recognizing and utilizing this energy are we therefore able to awaken our own healing skills. Part of the workshop's aim was to attune participants to this life force. It was said that this energy would always stay within us and through daily self-healing we would

---

[1]It must be noted, however, that this description differs from what was described in the Reiki handout. Here it was described as originating from the 'Highest Divine Source', which implies God. (Reiki Handout, 28th-29th Oct. 1995: 1). See Chapter Five regarding terms used to describe healing energy.

eventually be purified enough to heal others. The Reiki course therefore aimed to initiate us to the first level of becoming a Reiki Healer. (The Reiki qualification achieved is illustrated at the end of this appendix. Such qualifications open up discussions of 'professionalization' and legitimatization of healers).

Reiki can be used (a) to heal *oneself*, to become more balanced, (through equalizing one's chakras), and to become more spiritually aware; (b) To *help others*, friends and relations, clients; © *animals*, pets, working animals which are needing help; (d) *plants*, to help germination; (e) the *planet*. In healing the planet we were told: 'Imagine, think or visualise the planet or any particular area between your hands to help heal or transform any situation. Why stop at this planet?' (Reiki Handout, 28th-29th Oct. 1995: 2). And, finally, (f) *food and water*, which can be energized to heighten their vibration level (the higher the vibration level the greater the purity and goodness).

The workshop consisted of eighteen people in total. Fifteen of these were women and three were men. Two Reiki masters taught the course, one male and one female. Half of the group were already complementary practitioners in some form and wanted to learn Reiki to add to their skills. Others claimed an unhappy situation with an element in their lives. These problems included work, home life or usually health. During the Sunday herbal tea break one participant mentioned that she was 'looking for something', but she had difficulty in finding a spiritual direction. She said she 'has tried several people and beliefs but has ultimately felt lost' (Reiki Ethnographic Notes, 29th Oct. 1995: 4). One lady came as she wanted to cure her terminally ill cat.

There was a diverse cultural mix of people in attendance. Some were from the London area but many had travelled from elsewhere. One lady came from Italy, others came from Iceland, Spain and Germany. All had been working in the UK. and had been recommended to attend the course through friends. Others participant were from Essex and the surrounding Home counties. Many of these people were already advocates of a wholesome lifestyle. Everyone, except me, was vegetarian or vegan. Almost everybody was teetotal and a few people also mentioned abstaining from reading newspapers or listening to the news, as these all vibrated negative energy. Although on the surface the group appeared to be quite dedicated to the complementary health lifestyle, I imagine the participants would not consider themselves to be new age members, in the wider sense

of the word. All participants were from middle class backgrounds. Many had professional jobs which ranged from a practising Reflexologist, computer programmer to a business consultant. The average age of participants was around 35.

As soon as we had all arrived we started the workshop by holding hands and praying. The healers called upon the angels, the 'ascended' (deceased) Reiki masters, and all divine life forces which ranged from Jesus to Buddha, to bring unconditional love and energy to all participants within the room. Throughout this exercise we were told to visualize the energy flow through and between us. Once the initial prayer was over the therapists said thank you to mother-father God and we were brought back into the workshop environment. The next stage was for us to introduce ourselves and find out why each of us had decided to take part in the course. While we were each introducing ourselves, almost everyone believed they had come to take part in the workshop as they were 'guided' to. One participant told the group that he wanted to pull out of the workshop, yet after a talk with one of the Reiki masters he had changed his mind. He was told that he was meant to come on the course as it was destined for him. Throughout the introduction, therefore, he felt he was justified to stay on the course as he believed it would help him on his spiritual path.

The workshop would include the first Reiki initiation along with practical sessions on self-healing, healing others and various talks on the uses of divine energy. Reiki aimed to introduce participants to healing skills by utilizing the life force's energy. This life force passes through the healer's body ultimately to mend any physical, mental and spiritual imbalance. As student Reiki healers, the life force was an essential part, not only to help us tune into our own healing powers but in the development of our own health. The weekend, therefore, aimed not only to introduce us into Reiki healing but also to cleanse us of physical, mental and spiritual impurities. Over the weekend and throughout the following 21 days after the course had finished, we were told the life force would be cleansing us. This cleansing process would begin from our crown and continue down through each of our chakras. Each chakras would take three days to be cleansed. The results of this purifying procedure would enable us to become more spiritually aware and allow our consciousness to be raised.

In this review of Reiki, four themes will be identified: healing, holism, energy

and worship. We will begin by concentrating on healing as it played a significant role throughout the Reiki initiation weekend.

Healing

The principal belief when discussing complementary health is of course healing. Complementary health includes not only a multitude of techniques by which healing can take place, but healing can also be seen to offer a belief system of its own. Being healed, or at least being helped to this state, goes beyond just feeling physically better. It comes with connotations which aim to promote mind, body and spirit unity by which healing can take place. Initiating total health is based on the idea that almost all illnesses can be overcome by the implementation of various beliefs and practices, which are assessable to everyone.

Within the Reiki course itself healing, and especially our own self-healing, played an essential role. The course emphasized the necessity of identifying our own needs and to accept that we ourselves have the ability to change. In interpreting our own body and relating what we see to Reiki theory, we were able to distinguish illnesses and problem areas. We can therefore label and put names to our complaints. Through this process we are able to make amendments to how we live and our attitudes towards ourselves. In this way we eventually make our illnesses manageable and become our own self-carers/managers. For example, if someone has problems with creativity and communication then they should be concentrating healing on the throat chakras. At a physical level the throat chakra has connections with the thyroid gland.

Reiki ultimately wishes to establish an individual's sense of autonomy and self-development through teachings of physical and social responsibility. This can be achieved by teaching healing skills and being accountable for ourselves. It was emphasized in the workshop that everyone has healing powers. These healing skills can only be accessed when an individual's true self is recognized. The primary step towards this identification of one's true self begins once initiated into the healing rays of Reiki. McGuire and Kantor in their book, Ritual Healing in Suburban America, say: 'Healing is linked with personal empowerment; issues of meaning, moral order and responsibility;

and an alternative understanding of the self in relation to society' (1988:202). Reiki healing can be seen to encapsulate these characteristics. It begins with the ideas that everyone has the ability to take control of their lives and change these for the better. This change is installed once individuals acquire healing powers. Meaning is given in Reiki healing through its ability to provide an explanation for illnesses and especially offering a manageable solution to them. Order and responsibility can be identified by Reiki's belief that one alone can be responsible for one's own body by implementing specific self-regulatory rules and of course by practising self-healing. Finally, by means of the Reiki initiation, we were told we would have the ability to focus on our self-identity and our role in relation to one's surrounding environment. That is, we were given the opportunity to analyse ourselves and see how we can eventually help those people which surround us by means of healing.

Reiki healing can be recognized to go further than McGuire and Kantor's notion as Reiki is seen especially, to link supernatural and divine forces to that of the individual. Reiki can be described as a Psychological/Spiritual treatment, as its emphasis lies on the movement of 'healing energy'. This energy descends from 'above' and flows through a healer's body, penetrating the client's seven main chakras. Negative energy is removed either by cupping them and throwing them into a 'Violet Void' (which was located visually as part of the floor and was imaged as purple flames), or alternatively by its continuous descent down the healer's body to the feet, where all negative energies are 'earthed'. The human body therefore was believed to be the vehicle for a divine force by means of the energy's path through the body. Healing energies, through their various forms, enable individuals, both therapists and clients, to believe that they have had a direct experience with a supernatural and divine force. The outcome of this experience can be seen to materialize by means of healing and well-being. The Reiki handout says 'imagine, know or visualize a line of light coming into you from your higher self or soul star above your head. It enters you through the crown and flows down in a straight line through your seven main chakras. It then flows down both legs and way down into mother earth' (Reiki handout, 28th-29th Oct. 1995: 3).

Healing, therefore, can be seen as stemming from not only a universal light or power but also from what could be described as an individual's 'higher self' which

resides above. Lewis and Melton, while reviewing the new age, recognize the concept of self as divine. They say: 'Within the New Age one theological affirmation has found popular support, the identification of the individual as a one in essence with the divine' (1992: 250).

The causes of illness can also be addressed while looking at Reiki. Within the workshop itself, healing and the cause of illness can all be explained by means of studying the individual and identifying neglected areas. One primary neglected area that Reiki concentrated on was the spiritual milieu. The Reiki handout explains this further by saying:

> When man first incarnated in a physical body he was still attuned to his spirit and soul. He was able to teleport, channel and use psychic abilities such as ESP, the like of which we are only vaguely aware of today. In this divine state there is no illness or disease, only ability to live for hundreds of years in a healthy state. As he gradually became more and more immersed in matter, becoming denser in vibration and desirous in nature, attached to material things (known to some as the fall), so he started to develop a denser, lower frequency physical body allowing tiredness, illness and disease to enter. The cause of ill health is the same today as it was all those thousands of years ago. Where there is dis-harmony between the body and soul, no higher guidance, overwork, wrong diet, lack of exercise, unbalanced emotions, rigid thought patterns, fear and guilt, so there will be dis-ease in the physical body. The vehicle designed to be an expression of God has become a tool of the ego. (Reiki Handout, 28th-29th Oct. 1995: 1)

Within this Reiki workshop illness was said to occur primarily due to a lack of spiritual awareness. By teaching us to become aware of our spiritual self we would consequently know the key to healing, health and well-being. The eventual wish of self-healing seems to be not only the desire to change ourselves, but ultimately the desire to heal society and the global world. Healing, therefore, is seen as the medium towards total change. This change is believed to enable a harmonized world to develop by allowing greater connections between ourselves (as healed and whole beings in contact

with our ESP etc.), our social surroundings and the cosmos.

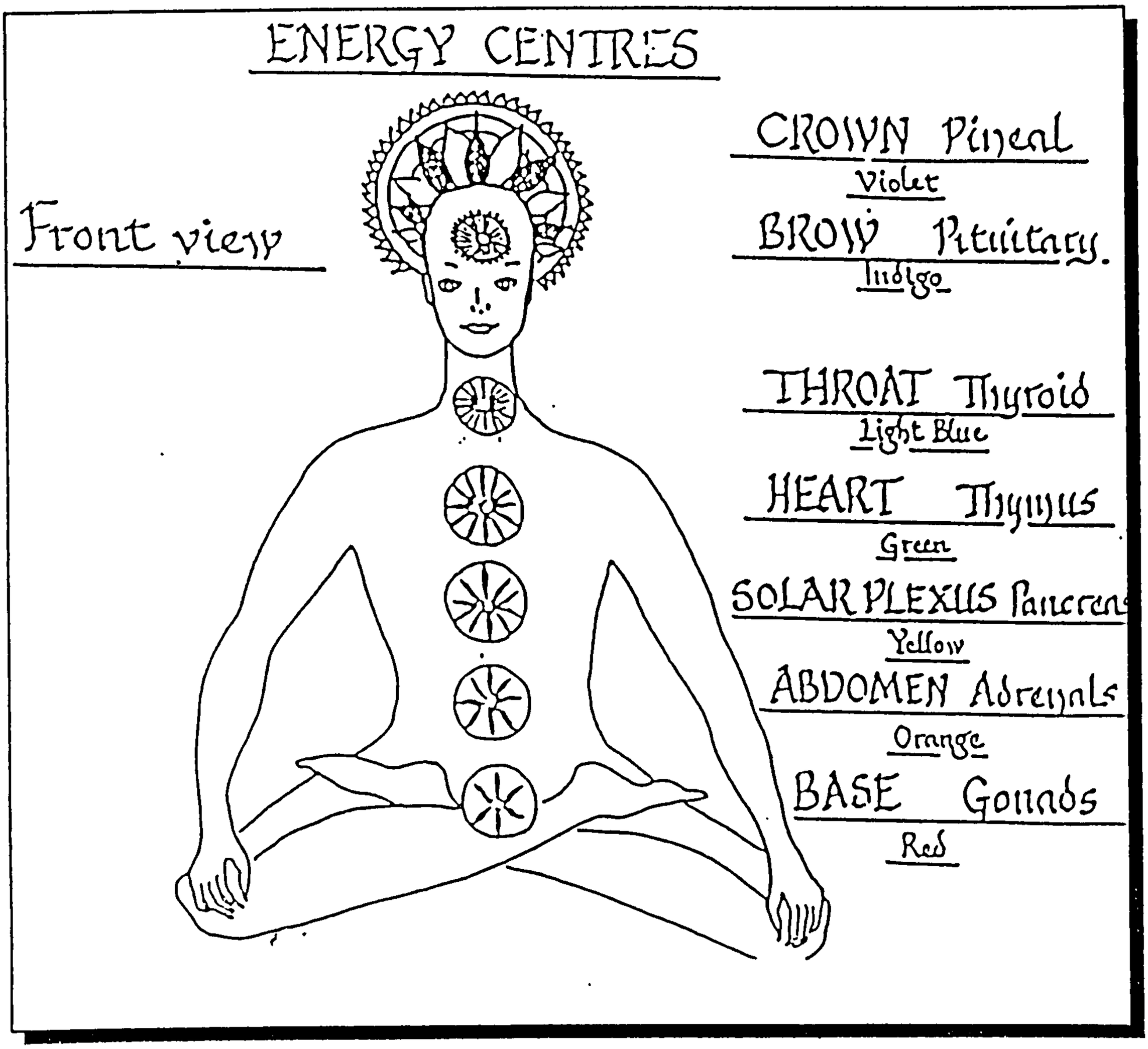
Holism

It appears that Reiki offers more than just a direct experience with a divine force. Reiki brings along with it the opportunity to recognize and develop one's true self and to identify oneself in relation to society as well as the exterior universe. This perspective is known as holism. Holism means that looking at an entity in an all inclusive manner, in relation to its constituent parts, results in a greater understanding of that object. Holism is a term which is not exclusive to health. Complementary health has to some extent adopted this perspective in looking at the human body. By studying a person, their diet, work and lifestyle a picture can be drawn of an individual's health, or illnesses. States of health have stemmed from, not only the biological but also from a social or spiritual realm. Thus in her book entitled Holistic Health In Perspective, Mattson says holism is 'a new approach to treating and preventing disease, but it really stands for more: It is a point of view, a philosophical perspective that places the person in a total environment' (1982:9).

The notion of holism was emphasised as playing an integral part in Reiki. Holism was seen to simultaneously promote beliefs about ourselves and especially emphasise our links with those people which surround us, our society and the cosmos.

At an individual level holism can manifest itself through a variety of perspectives. These can range from the concept of chakras to notions of individual potential and self-identity. The notion of body chakras can be interpreted as the principal starting point. Chakras are areas of the body which correspond to various features of the physical body as well as relating to spiritual characteristics. Reiki is believed to work on any disharmony which occurs between the body's chakras. In Reiki any disharmony which occurs in these centres may develop eventually into illness. Such disharmony manifests itself through 'no higher guidance, overwork, wrong diet, lack of exercise, unbalanced emotions, rigid thought patterns, fear and guilt' (Reiki Handout, 28th-29th Oct. 1995: 1).

Illustration of Chakra Positions on Body: Front View



In the complementary health book entitled The Complete Healer by David Furlong, chakras are perceived as 'carrying a particular quality or flavour of energy through to the physical. Each chakra was associated with a Hindu deity, a god or goddess, and each has its own sound, geometric pattern and colour association' (1995:188). [2] An example of a chakra is the Brow (Ajna) chakras (forehead), which is

---

[2]Although this seems to be the background of chakras no mention of this religious association was made within the Reiki workshop. The Reiki master claimed, while introducing the course, that Reiki had no religious role or foundation.

usually called the Third Eye. This chakra is believed to 'make us aware of other dimensions and realms of consciousness' and relates us to our 'intuition and inner knowledge' (D. Furlong, 1995:202). Furlong goes on to say: 'The chakras have three specific aspects - they both give and receive energy across all the spectrum,[3] they are linked to a specific spiritual quality, in the physical world they have a specific location within the body' (ibid., p. 208).

The chakras were the beginning point to the workshop's 'hands-on' and aura healing. With four people standing on each side of a therapy couch we could each take control of specific chakra points. From here we would pray that the energy would come to us so that we could help the recipient laying on the couch.

These chakra centres, I will argue, are the starting points in the concept of holism. Chakras simultaneously act as a tie between the person and their wider surroundings. This can be seen as the body's chakras can, first of all at an individual level, be interpreted as the medium between health and illness. The chakra centres are believed to be relative and influential to each other. Therefore, if one's chakras are not equally balanced illness occurs. On a wider scale the chakras' system can be interpreted as a micro system by which an individual's total environment can be mirrored. Hence environmental conditions are also influential to chakra centres. This can be argued as part of each chakra corresponds to an external spiritual or societal entity (nature). An example of this can be seen in the Heart chakra whereby this is seen as the centre of unconditional love and compassion and 'links the physical and spiritual aspects of the individual reflecting the emotions and revealing how the person relates to others and to nature' (Reiki Handout, 28th-29th Oct. 1995: 6). Chakras can therefore be seen to be reflective from an individual to an environmental/societal level. The desired consequence of such a self and society juxtaposition is ultimately a desire for individual and societal development and change. These chakra centres can also shape believers' ideas on what can be considered unhealthy on a daily level. The Reiki handout goes on to describe the heart chakras, that 'it is a centre that can be easily abused through excessive emotional tendencies and through alcohol, drugs and smoking' (Ibid., p. 6). Through the eventual healing and unity of each chakra a person is expected to

---

[3]I see this to mean all dimensions of an individual e.g. mind, body and spirit.

acknowledge and develop their 'true' or 'higher' self.

James Beckford discusses the concept of holism in relation to the individual when he says:

> the assumption that, since humans possess a basic, irreducible self with the capacity to act, to feel and to will independently, it is possible and desirable to restore a sense of the *wholeness* lacking in many people's lives by facilitating the discovery and enactment of the 'true self'. It is believed that the power or potentials for self-realization and self-expression can be released or unblocked by appropriate thought and action. There is also a strong presumption that the 'released' self stands naturally in harmony with other selves and the forces of nature (1984:262).

One's true self can be discovered and improved, according to the teaching given in the workshop, once all chakras are unblocked of negative energy and replaced with good. Transformation and growth is the desirable outcome in finding one's true identity. Once we have chosen to change ourselves we have taken the primary steps in unearthing our potential and 'true' self. This transformation of the individual is usually seen independently of social forces. It is believed that everyone can overcome any amount of bad luck or illness just by adopting appropriate actions and beliefs. An example of one such belief emerged within the Reiki workshop while participants discussed healing through the life force energy. This life force, if believed and called upon by practising healing, will enable an individual to become fully conscious of themselves (in mind, body and spirit). The results of such faith materializes in good health and well-being. The life force will cause one's chakras to be open to receiving life force energy and expelling negative energy. Such practices result in the individual going through a transformation process as changes occur within each chakras area (e.g. heart chakras bring about greater unconditional love).

While discussing energy in the workshop lunch (28th Oct. 1995), the discussion led to various actions which were thought to suppress our positive energy. Things like meat, alcohol, newspapers and even television were all mentioned as pollutants. One of

the therapists who was taking the session said: 'Chatter interferes with our thinking, we are unable to concentrate on our intuition or our own minds' (Ethnographic Notes, 28th Oct. 1995: 5).

Such recommended practices alone unleashed unlimited discussions regarding issues of responsibility and self-determinism and even seemed to imply notions of self-fulfilling prophecy and moral accountability. Reiki seems to imply these notions as it hints at a wider perspective of how to achieve total well-being simply by adopting specific health beliefs. Systems of meaning can be constructed by means of interpreting and applying one's wider lifestyle to that of complementary health and healing beliefs.

(Slightly out of context, while I was trying to gaining access to the Reiki masters at the Esher Natural Health Show on August 28th-29th 1995, there were specific books on display throughout the show on how to overcome or delay the processes of HIV and Cancer. The methods by which this process would take place included a positive mental attitude and a good diet. Although I assume these points are used in caring for these illnesses it is presumed that these steps alone were needed to overcome these illnesses. This example relates only to the particular association displaying the books. This type of health literature alone illustrates a perspective which seeks essentially to help slow down a progressive illness.)

The issues raised so far all emanate from the concept of holism beginning at an individual level. Beliefs of potential, change and growth originate in Reiki from the desire to identify with our true self. Recognition of one's true self can only occur, therefore, once one has taken on specific beliefs regarding oneself, which include healing of all chakra centres. Societal links can also be identified within the concept of holism. This is especially understood by Reiki's wish to heal and transform the surrounding environment. This itself begins primarily in the workshops' discussions of what Reiki can heal and how Reiki can benefit others. An example of this is seen in the workshop prayers which were concerned with sending energy to countries in need of healing, help and support. Another medium through which a link with society can be identified is in the belief that, if we ourselves change for the better, we have the ability to influence those people directly associated with us, thus creating societal change. This notion was supported throughout the weekend resulting in a handful of participants

agreeing to meet on a regular basis to discuss Reiki and offer their skills to friends, neighbours etc.

The final stage to the concept of holism is the additional link with the cosmos. Cosmic and universal connections are made as they represent the origins of healing energy. Cosmic connections are also made as they represent the extremities of potential change. The nature of holism, therefore, is not only seen at an individual and societal level but also identified at a universal level. An element of universal faith appears. This manifests itself in adopting a new perspective and insight around the notion of Reiki which ultimately wishes to transform individuals, society and the cosmos. A universal perspective in health and healing appears in McGuire and Kantor's work while they discuss an 'alternative world image'. They say: 'These world images were emphatically holistic - beyond the sense of body-mind holism, to an insistence upon the interdependence of all aspects of the cosmos' (1988:244). This was illustrated in the Reiki workshop through a number of mediums. The primary link between the individual and the cosmos was through the alleviation of ill health symptoms using universal/ divine energy. Another universal connection was made by means of our prayers to the 'ascended' Reiki masters (who reside above in the cosmos). These Reiki masters guide the life force to participants. Consequently change would occur on all levels, that is self, society and the cosmos. Holism therefore, relies on the interdependence of all these aspects.

(Another less significant cosmic connection was made. In the tea break on the Sunday morning our discussion led to our beliefs about the planet and future. This discussion led to the subject of extra-terrestrials. It was noticeable that many of the participants in the discussion believed in their existence. One male participant noted that such beings were showing earth the way to greater harmonization by means of promoting greater awareness and spirituality of individuals, through techniques like Reiki. Due to this promotion he said 'there would be an eventual amalgamation of all religious beliefs'. He noted especially Hinduism, Judaism and Christianity. These would merge into one unified belief system. I asked if this would mean a holistic belief of many religions. He said that it would be a holistic belief system where all are joined and equal (Ethnographic Notes 29th Oct. 1995:4). He explained that the harmonization of the

worlds' religions would be down to universal extra-terrestrials guiding us. (At the end of the discussion he implied that one's awareness, in promoting universal harmonization, stems from experiences of the life force. This in turn provides participants with a greater spirituality).

The Reiki workshop highlighted many beliefs within the concept of holism. These beliefs emanate from a desire to change at an individual level together with a wish to create social and universal reform. Holism, through its various forms, can be argued to be a world view by which participants understand the world around them, and how they perceive their social reality. Such notions offer an additional benefit by presenting substantial meaning to everyday events, for example illness and accidents.

Turning to literature based in the Sociology of Health and Illness, it has previously been argued that health issues have an increasing role and significance in people's everyday lives, and especially their perceptions of health. An extreme view is put forward by Irving Kenneth Zola. Zola identifies areas which indicate the prominence of health consensus in everyday life. He begins his article by saying:

> medicine is becoming a major institution of social control, nudging aside, if not incorporating, the more traditional institutions of religion and law. It is becoming a new repository of truth, the place where absolute and often final judgements are made by supposedly morally neutral and objective experts. And these judgements are made, not in the name of virtue or legitimacy, but in the name of health (1972:487).

Although I am not adopting Zola's view that medicine has nudged aside religion it can increasingly be argued that there is greater relationship between them. Zola on the whole talks of conventional medical practices, but such conventional health practices are not too far attached to the beliefs, practices and influences incorporated within complementary health today.

Zola goes on to say that the process of medicalizing has not occurred, 'through the political power physicians hold or can influence, but is largely an insidious and often undramatic phenomenon accomplished by 'medicalizing' much of daily living, by

making medicine and the labels 'healthy' and 'ill' *relevant* to an ever increasing part of human existence (1972:487).

The Reiki workshops emphasis on analysing one's health and lifestyle can be seen to be at the forefront of the aims of complementary health. This can be applied to Zola's idea that health is increasingly taking on a prominent role in many people's lives. Part of the consequence of making health a prominent issue are the notions of responsibility and accountability. Bodily responsibility and accountability were thought of as essential doctrines when searching for good health. Through recognition of one's lifestyle and the changing of it, in line with health beliefs, one is essentially becoming aware of one's needs and consequently taking personal responsibility for one's health and well-being. While discussing responsibility, in the workshop, one master remarked that, 'you have the choice of whether to take this energy and use it productively or not' (Ethnographic Notes 28th Oct. 1995:3). By using Reiki healing in an everyday routine, individuals are given a choice as to how to respond to this responsibility.

The issue of accountability also emerged while talking of responsibility. The Reiki course presented an alternative method by which one could take better care of oneself and those around us. By teaching us the skills necessary to do this one is consequently given a choice as to whether one uses these skills or not. One therefore becomes accountable for one's actions, health and future lifestyle according to one's own wishes. It could be argued, therefore, that by learning Reiki one is given the opportunity to account for one's health but simultaneously given a tool to justify one's illness in the same terms. For example, if one has good health then one can say that is due to practising self-healing. Alongside this explanation, one can equally account for any illness by claiming neglect or abuse of a specific chakra centre.

Robert Crawford mentions the significance of responsibility in complementary health. He writes:

> Central to the holistic health and self-care models is the concept of individual responsibility. This notion appears in virtually everything that has been written on these subjects... Self or individual responsibility is the mechanism believed to propel the transition from a medically dominated experience to one more

meaningful, autonomous and effective for health maintenance and promotion (1980:376).

The notion of holism can be discussed to include a multiple of issues within Reiki. Holism in relation to the individual, society and universe all lead to the desire to recognize potential and if possible institute change and growth. Such a world view not only incorporates and uses issues of responsibility and accountability to maintain health, it also intervenes to change individual's beliefs surrounding causes of illness and methods of prevention. The result of these beliefs can be interpreted as acting as a guardian for lifestyle, and ultimately offering a philosophy and social reality for participants.

Energy

I have discovered so far that the concept of energy has several meanings and different influences according to whether one is talking to therapists, clients, or even about different treatments. This has a direct influence on finding a universal definition through which to explain this notion. See Chapter Five for an analysis of terms used in discussing healing energy. However, in this appendix I will be using the meaning assigned it by the Reiki masters taking the workshop.

The origin of the life forces or energy was explained to us as the periphery layer/aura which coats the earth's surface called 'the source' (Ethnographic Notes 28th Oct. 1995: 1), which exudes natural energy. Christ and universal consciousness were also terms used to describe the life giving energy. This term was clarified not only to mean Christian energy but the energy of the amalgamation of many religious beliefs. These forces are therefore relative to the belief of whoever may be calling upon them. The desired outcome when using the energy is the belief that this power can enable individuals to heal all dimensions of themselves.

The concept of energy or life force throughout the research to date can be interpreted to exist in three separate ways. Firstly, there is an energy which stems from 'above' which is used in Reiki when praying to the 'ascended' Reiki masters. Secondly,

there is an energy which is all around us and is in all things. If, for example, one was to talk to someone who was very depressed or low, they would be seen to be drawing away one's positive energy. Thus one is in a process of constantly receiving and expelling surrounding energies. Energy was primary seen to originate from external sources. However, the final identification of energy was a source of energy within everyone. This can be interpreted, throughout the research, as a balance of energies within *each* chakra centre and naturally, a balance of *all* chakra centres. These three sources of energy are interdependent. (Energy can be illustrated to be similar to holistic belief in as much as there is a self, society and cosmic dimensions).

The notion of energy plays a central role in almost all complementary health techniques. The belief that energy is present in all things almost implies, at its most extreme form, a pantheistic belief. If, therefore, all things exude life force is it possible to argue that everyone, everything etc. can be seen as becoming, being in some sense, divine? Energy from 'above' was the principal source called upon throughout the weekend.

The practice of using Reiki energy is remarkably simple. The process begins with a participant lying on a therapy couch. Reiki healers are situated on each side of the couch so that each chakra centre can be covered by means of 'hands-on' or aura touch. Once healers are situated around the couch the healers pray to the 'ascended' Reiki masters asking the divine force to be channelled through them. The Reiki handout gives guidance on using the energy. It says:

> Do not try to force the energy through, just allow it to be. Your do not have to direct the energy anywhere. It has its own Divine Intelligence and will choose its own path, healing exactly where you or the other person needs it best, IN THE MOMENT. Remember you are not God, you may not have access to that person's path, Divine will or soul's purpose (Reiki Handout 28th-29th Oct. 1995: 4).

I asked whether it was necessary for the client to believe in the energy for healing to take place. I was told that the client does not have to believe in the energy to receive it but therapists must as they are the channel through which the energy will pass.

In the Reiki handout we were told that the energy may be experienced as:

a warm glow through the body. The hands may become warm, hot, tingling, energized. You may experience Reiki as coolness, light, colour, as light breeze or in many different ways. You are a unique individual and whatever you experience will be right for you (Reiki Handout, 28th-29th Oct. 1995: 4).

My own experience of Reiki did not, at first, fit into any of these sensations. Throughout both giving and receiving Reiki I was very conscious of wanting to feel some sensation. It was only when one Reiki master specifically passed life force through the throat chakra (while I was performing healing on a third person) that I felt an incredible swelling heat around my neck. This feeling was very unexpected (as I had not experienced anything similar to it before). It left me very happy that I had experienced, what was explained to me, as contact with life force. It seems clear, however, that by constantly analysing and being conscious of oneself throughout Reiki many senses and feelings could be susceptible to be explained as an direct experience with the life force. That is any sensation an individual may feel would be explained by means of Reiki.

Once the recipient had received around 15-20 minutes of healing facing downwards he/she is turned over on to their backs and the exercise is repeated again. We were told to trust our higher self and intuition which would guide us to chakra centres in need of healing.

After repeating the exercise, and if one feels as though the energy has ceased flowing, then it is time to stop. It is considered most important after this point that one closes one's eyes and 'GIVE THANKS to God, Divine Intelligence' (Reiki Handout 28th-29th Oct. 1995: 4).

The concept of energy can be argued to offer an explanation for and even a legitimization of illnesses. Illness and even social events can all be explained depending on whether one expels negative energy and allows new energy to be received. Thus one's health depends on energy levels being either high or low. Such explanations can be given as energies are seen as part and parcel of an individual's life. For example, one of the last discussions the work group had on the Sunday night was on society and how events

in one's environment can influence and ultimately hurt us. One participant wanted to attend a self-defence class as she felt unsafe when she was by herself at night. The female therapist explained to her that self-defence classes would not help her. Self-defence classes were thought of as a fear-based session which would rather attract negative energy (bad events) rather than retracting them from her. By taking part in a self-defence class, therefore, she was not helping herself as she would become a 'magnet' for bad events. Even personal alarms were thought of as producing negative energy and should not be carried if one wanted to be safe. Energy can therefore provide an explanation for almost any event. Rosalind Coward notices this concept in the more fringe health therapies. She says: 'Energy theories of health and illness tend to be accompanied by an insistence that the whole world is made up of energy. This is especially true of the fringe therapies where states of energy are offered as explanations for all phenomena' (1989:54).

By studying participants' energy beliefs, then, we are able to identify how adherents' develop explanations to everyday events and how these beliefs are tied to notions of self-fulfilling prophecy and self-determinism. Although energy gives meaning to events it also, to some extent, takes away explanation (which is contradictory to the aims of complementary health). Belief's in energy can be used as a barrier to hide behind in dealing with issues. For example, 'I was not able to perform this task as there was too much negative energy'. However it also implies self-determinism in as much as individual's choose whether or not to use their healing skills.

The concept of energy can be used by individuals as a pick-and-mix belief depending on whether the individual accepts that illnesses, events and people etc., have either a high or low energy level. The consequences of an energy belief are to be seen in the highly selective way it is used to provide meaning.

Rosalind Coward in her book The Whole Truth, picks up on this while discussing energy. She says:

> On the whole, ideas about life forces and energy fields are not just grudging elements, lurking at the bottom of these therapies. The idea of the fundamental energy of the body is explicit in most other 'alternative' ideas of illness and

healing. The disruption of energy, their blocking and the resultant imbalance of the body are invariably blamed for illness or susceptibility to disease (1989:53).

Energy levels, therefore, are seen to be used as a perspective for understanding illness and to some extent may provide explanations for such events.

Turning to my own experiences of Reiki, I felt my experience did not really fit into any of the Reiki sensations mentioned to the group. At the end each day and especially by the end of the weekend I felt exhausted. This state can be explained either through my continuous awareness and role as a researcher within the work group or by an explanation given to me by one Reiki master. That was, my exhaustion was due to the cleansing cycle I was going through after my initiation ceremony. Thus I would be undergoing processes of change which would drain all my negative energy and replace it with pure Reiki rays. This process would, consequently, leave me drained. This experience can be illustrative of McGuire and Kantor's writings as they say: 'A bodily experience has no inherent meaning; meaning must be applied, drawing upon a range of culturally available explanations. Alternative healing systems give their adherents a repertoire of possible meanings to apply to their sensations' (1988:188).

Worship

Worship and prayer constitute the final issues in this appendix. Worship could be seen to have played an important role within the workshop. Its ongoing role in joining the group together as well as to initiate common identity and goodwill among us was very much apparent. Many of these prayers were begun by a visualization and meditation exercise to bring us to a state of relaxation and calmness. The practice of this was for the class to hold hands and pray to past 'Reiki masters, angels and all divine life force' (Ethnographic Notes 28th Oct. 1995: 1). We prayed to receive energy and unconditional love in which all the workgroup could share. This exercise was repeated every morning and evening of the workshop.

On the Sunday we prayed as usual but this time we were told to visualize the revolving world in the centre of the circle. We were asked to feel the energy flow from

person to person as we were holding hands and to visualize the world receiving this energy. The Reiki masters asked for our healing skills to be received in Bosnia, areas of famine and anywhere healing was required. We ended this session with thanking the energy and saying 'Amen'.

We were asked after this prayer whether anyone had seen an area where our healing energies had been sent. Many people had not seen the recipient countries but many confessed to seeing amazing lights. One lady described how she had had a vision and that she was talking with Dr Usui, one of the 'ascended' Reiki masters. The Reiki master taking the group then described how she had seen our combined energy go to specific areas in the Baltic States and somewhere is South Africa. She asked the group if any events had taken place that morning or late the previous night (as she was known for not listening or reading the News due to their negative energy). One participant mentioned that there had been a train crash in the Baltic States that morning and what seemed to be an earthquake elsewhere, the previous night. The Reiki master explained, to the group, that she felt our combined powers had indeed gone to those areas in need.

Prayer and worship represented several key issues in Reiki. The principle of these was seen in providing a shared meaning between participants and their beliefs in healing energy. Prayer becomes the medium through which Reiki rays are called upon. With the prayer our bodies form the vehicle by which Reiki energy would descend. Secondly, the initiation ceremony itself can be identified to represent notions of prayer and worship.

There are three levels of Reiki initiation. The first 'Degree' begins with the primary initiation and instructions on healing. This includes hand positions on and off the body, discussions of auras, chakras and use of intuition. The second level of Reiki initiation teaches distant healing and symbolism. The third and final level is the mastership. This level includes an initiation into the various *new* rays of healing which had been taught to our Reiki master through visions.

Worship throughout the Reiki initiation was to be the process through which each participant of the group would be introduced and cleansed as a healing channel. Its aim was to initiate us by means of a ceremony which:

> will start to open you up to the Universal golden healing ray known as Reiki. The

initiation will start you off on a 21 day cleansing cycle. 3 days at each of the 7 main chakras, starting at the base and working upwards. This will cleanse and release toxins from the physical and/or subtle bodies. Any discomfort felt from this cleansing will soon pass. REJOICE. Your body is becoming a purer healing channel (Reiki Handout 28th-29th Oct. 1995:2).

Before we began the initiation, the Reiki masters demonstrated the various procedures of the ceremony together with a brief explanation of each stage. The ceremony began with all eighteen participants sitting in a circle, as we did with the prayers; this time however our spines faced inward. Our spines signified the centre of our bodies, within which Reiki energy would pass. With the movement of the Reiki Master between participants and through the centre of the circle (in which we sat), it was believed the passage would bond all members together by a line of energy passing through each of our spines.

Items such as glasses, shoes and crystal jewellery were taken off as these were said to interfere with the path of the energy. Our feet were bare as we would need physical contact with the ground to enable all negative energy to be absorbed. Once our eyes were closed and our hands were cupped into a prayer position the Reiki master took us into a meditative state by means of a visualization exercise. The exercise began with the workshop being asked to relax and blank our minds of all thoughts. Subsequently we were told to visualize walking through fields. As we visualized walking we were asked to notice the colour of the flowers. (The flower colours, in the following discussion, would offer an indication to the states of one's health. This lasted for a few minutes until everyone had relaxed. I then waited around 25 minutes until I heard the master approach.

Once she had approached she made signs of sacred symbols in the air above my head. I can only assume she was focusing on my crown chakra. All the time, throughout the ceremony, she seemed to be talking in tongues which was just about inaudible. After this she laid her hands on my brow chakra (third eye), and repeated the procedure. She removed her hands from my brow and blew onto this area. She had explained previously that by blowing onto us she was in fact unblocking chakra areas and allowing Reiki

energy to be received into these centres. She repeated this exercise next onto my throat chakra. She then moved to my heart chakras where she drew more symbols and blew onto me. After this point she took my cupped hands and held them between hers. She blew into my cupped hands and closed them together. This too had previously been explained to mean energy being forced into the body, through our hands, and passing down into our body. To finalise the ceremony she knelt and touched my feet. This principally completed the Reiki journey by enabling all negativity to pass from me to the earth.

The ceremony only took around 5 minutes for each individual, but the duration of initiating all eighteen participants took substantially longer than an hour. This I can assume was directly influential on my own experience of the initiation as throughout most of it I felt great anticipation and coldness. It was only when the Reiki master approached and initially drew symbols on my brow chakra that I experienced again, an extreme moment of swelling heat. After everyone had been initiated we prayed to give thanks for the healing energy. There was a great emphasis after the initiation that we should be aware that we had been introduced to the Reiki energy. We were told this channel of energy would always be open within us and that our healing ability was exclusively ours unless others too had been initiated.

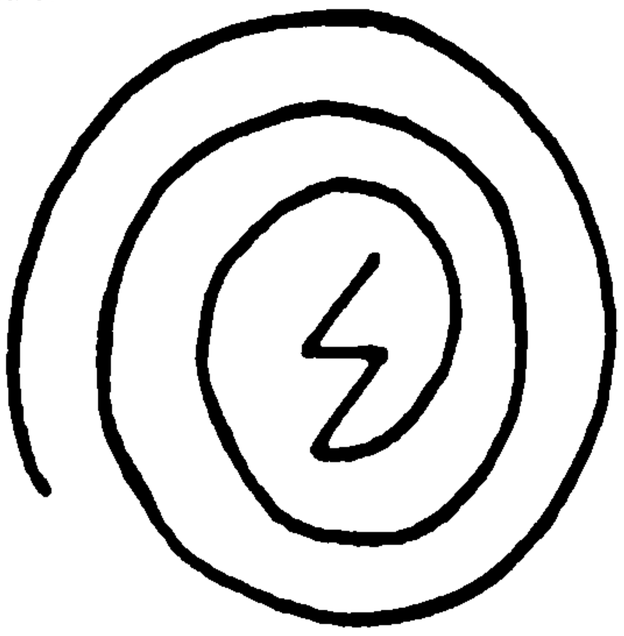
Hence it was observed after the ceremony that we would have access to the healing frequency 'for the rest of your life' (Reiki Handout 28th-29th Oct. 1995). This would allow us to tune into the healing rays and continually use them to help ourselves and others.

After our Reiki initiation especially, we were led to understand that we were now different having been introduced and initially purified into the Reiki rays. If we practised our Reiki routine daily, and strove to become aware of ourselves, we could eventually lead a life which was not only free from illness but also free from the negative events of the surrounding society. One example brought up was being able to walk the streets safely at night.

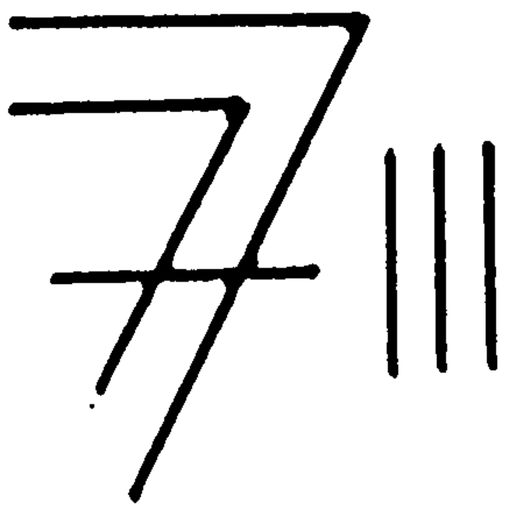
Illustration of Four Reiki Symbols

SYMBOLS

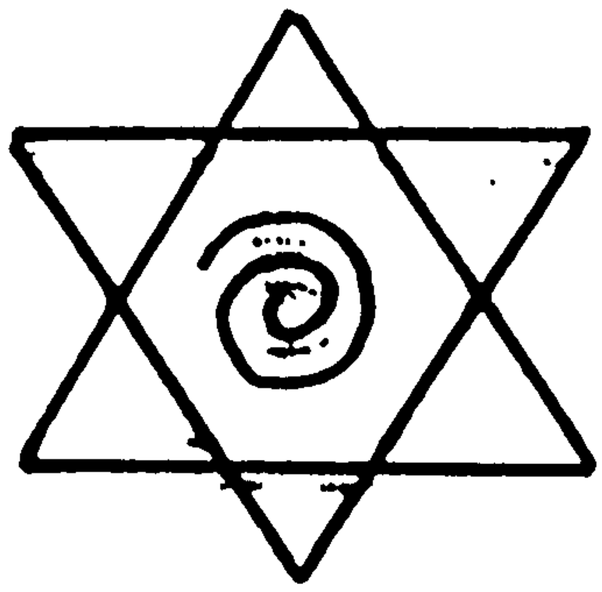
Here are a few clear symbols which have come through. They are clear & light, use them if you feel guided to. Others have been sent to me which are more specific but I have not been guided to give them out.



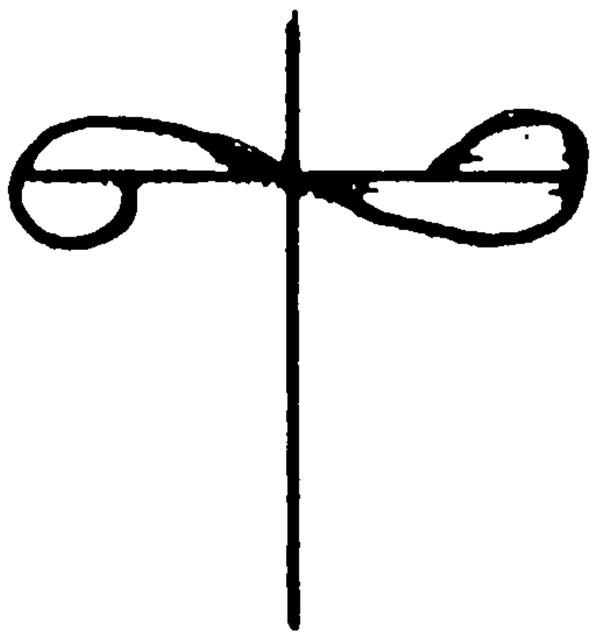
YAHZAR
Seems to clear electronics, etc., also for transmuting negative energy/elementals.



BONO
This one is from Chris Moore from St. Francis (again Kuthumi), for healing animals and the earth, particularly, "spiritual cuddles" for humans. "Bono" was the name given to me.



INTEGRATION
From Kuthumi for the integration of spirit & matter. I use it on anyone disconnected from their spirit, for soul integration.



Given to Tamishia from Archangel Michael for courage, strength and power. Good drawn down the spine.

The figure above illustrates various symbols used throughout Reiki. The Qualities and uses of each symbol are also given. The first line of the text which appears above the symbols was provided by one Reiki master. She explained that she had received these symbols through a dream.

Prayer within the initiation ceremony was continuous and deemed a necessary feature. Throughout this process we, as the recipients of a healing channel, were to imagine and visualize a golden light entering our bodies. We began such a visualization exercise principally by praying for our body and mind to be open to receiving life force. Such recipients of life force could, therefore, use their skills to benefit themselves and

others.

McGuire and Kantor pick up this theme while discussing Christian groups and healing. They say: 'Prayers without the correct intent were considered worthless because God judged the intent of those praying' (1988:218). Although we were not specifically praying to God the intent with which we used visualization in prayer could be considered to be an important issue while discussing Reiki healing (as the intent was to help oneself and others).

Within the Reiki environment it is considered essential that practising healers believe in the existence of a life force and that they have the ability to facilitate healing. Beliefs in one's healing abilities seemed to be meaningful to the extent that participants believed they were then special and were custodians of a special, almost sacred gift. The weekend ended with a final discussion of how Reiki could be incorporated into everyday life which included the desire, by some participants, to meet regularly to practise and talk about Reiki.

Beliefs which emanate in Reiki may not be consciously at the forefront of the participants' minds while they are taking part in treatments, training to be a healer, or in fact fostering these notions at a daily level, but they do seem to offer a world-view and can be considered influential to one's everyday life.

In all, the Reiki weekend highlighted may areas of interest within the Sociology of Religion, even though Reiki claims to have a non-religious role or foundation. However various beliefs and practices promoted throughout my time on the Reiki workshop might be analysed to suggest more than just a complementary health technique. The research, to date, wishes to interpret Reiki principally as a pick-and-mix belief system whereby one can draw on various themes (e.g. concepts of energy, holism), to provide meaning and order at times which suit one's needs. My participation in the Reiki Workshop provided me with an initial insight into this perspective and illustrated the significance of these beliefs for many complementary health participants.

Access to the Reiki masters who organised the Reiki workshop was denied due to their busy year schedule (a Croatia/ Bosnia Healing Tour). However referrals to colleague Reiki practitioners within the Healing Centre enabled me to have further access to their practitioners and clients.

USUI SHIKI RYOHO

This is to certify that

Freda Mold

Has received the REIKI 1 initiation
and instruction in healing.

Given This Day: 28th October 1995

♡ ♡

Reiki Master

APPENDIX 3.8

List of Codes - Theme Tree

The highlighted theme areas indicate ethnographic material used in chapters. Subcodes attached to main codes are indented.

The number represented in brackets indicates the number of text segments attached to a codeword. The second number represents the total number of lines dedicated to these coded segments. For example, 11 segments of text were coded under the codeword 'Beliefs in Holism'. These 11 segments constituted 147 lines.

Codeword	Number of coded segments attached to codeword: Total number of lines attached to codeword	Chapter Reference
Belief in Holism	[11:147]	
First Knew of Holism	[10:103]	
Mind, Body, Spirit link	[22:415]	
Understanding of Holism	[31:507]	
Belief in Treatment	[100:1796]	Chapter Four
Beliefs in Energy	[72:1140]	Chapter Five
Different Types	[53:582]	
Energy Experiences	[33:448]	
First Hear or Knew of Energy	[34:364]	
Function/ Role	[89:864]	
Illness Theories	[89:928]	
Importance to Healing	[16:161]	
Names	[47:124]	
Negative Energy	[29:713]	
Origins of Energy	[34:335]	
Understanding of Energy	[76:1248]	
Body Perspective	[51:819]	Chapter Six
Channelling	[22:247]	
Client & Therapist Relationships	[73:991]	Chapter Four
Health Sessions	[97:1479]	
Therapist Healing Skills	[69:701]	
Commitment	[26:443]	
Conventional Medicine	[44:516]	
Comparative Methods	[21:510]	
GP Experiences	[12:136]	
Medication and Drugs	[6:53]	
Conventional Religions	[6:162]	
Comparative Beliefs	[60:1298]	
Concepts of God and Angels	[21:475]	
Emotions	[15:343]	
Growth and Transformation	[96:1529]	Chapter Seven
Personal	[57:842]	

Family	[13:170]	
Societal	[19:492]	
Universal	[7:103]	
Healing Experiences	[31:493]	Chapter Four
Absent Healing	[11:243]	
Laylines, Homes	[7:223]	
Psychic Skills	[4:41]	
Regression, Past Lives	[23:526]	
Visions, Dreams	[14:329]	
Healing Instruments	[24:369]	
Movement to Health & Healing	[51:1087]	Appendix 7.1
Aims	[36:460]	Appendix 7.4
Illness	[27:319]	Appendix 7.3 & Appendix 7.4
Learning and Awareness	[29:363]	
Lifestyle Perspective	[95:1231]	Chapter Six
Moral/Ethical Rules	[30:824]	
Networks	[84:1310]	
Responsibility	[52:864]	
Spirituality and the Soul	[81:1474]	
Taking Sessions	[29:559]	
Therapists Stories	[20:782]	

APPENDIX 4.1

Clients' Healing Experiences

	Cell A	Cell B	Cell C	Total
Physical	+	-	+	+ -
Psychological/Spiritual	+	+	-	+ -
Absent Healing	1	1	-	2
Energy Experiences	1	5	4	10
Laylines/ Home Healing	-	2	-	2
Out-of-Body Experiences	-	-	2	2
Past Life	-	1	-	1
Visions/ Dreams	1	4	1	6
Communicative Experiences	1	-	-	1
Levitation Experiences	-	1	-	1
Total Experiences	4	14	7	25
Cell Total	5	9	6	20

Total number of clients n=20. This chart illustrates the total number of healing experiences by clients according to cell group. This chart is designed as a tally chart as many clients may have had multiple healing experiences. Not more than two experiences were recorded for each client. Energy experiences include sensations of: strong warmth/ coldness, numbness, feeling of levitation, feeling of euphoria, tingling.

APPENDIX 5.1

Client and Therapist Ill Health Theories

	Clients			Therapists			
	Cell A	**Cell B**	**Cell C**	**Cell A**	**Cell B**	**Cell C**	**Total**
Physical	+	-	+	+	-	+	+ -
Psychological/ Spiritual	+	+	-	+	+	-	+ -
Dis-ease	-	-	2	2	2	2	8
Energy Blockage	3	3	2	3	6	5	22
Stress Related	-	-	-	1	-	-	1
Everyday Problems	-	1	1	-	-	-	2
Negativity	1	1	-	-	-	-	2
Don't Know	1	4	1	-	-	-	6
Total	5	9	6	6	8	7	41

Total number of therapists n=21. Total number of clients n=20.

APPENDIX 7.1

Movement to Complementary Health and Healing

		Clients				Therapists			
	A	**B**	**C**	**Client Total**	**A**	**B**	**C**	**Therapist Total**	**Total**
Physical	+	-	+	+ -	+	-	+	+ -	+ -
Psychological/ Spiritual	+	+	-	+ -	+	+	-	+ -	+ -
Interest in Health and Spiritual Issues	1	2	1	4	1	4	2	7	11
Healing Gifts	-	1	-	1	1	3	1	5	6
Personal Problems & Family Crises	-	-	2	2	2	-	2	4	6
Illness	4	6	3	13	2	1	2	5	18
Cell Total	5	9	6	20	6	8	7	21	41

Total number of clients n=20. Total number of therapists n=21. Therapists were predominately aged between 30-50 years, while clients were predominantly aged between 25-45 years. Female clients n=14, male clients n=6. Female therapists n=17, male therapists n=4. Healing gifts included: healing hands, automatic writing, visions/dreams, predicting events and aura reading.

APPENDIX 7.2

Client Illnesses

Clients Illness by Cell Group	Cell A	Cell B	Cell C	Total
Physical	+	-	+	+ -
Psychological/ Spiritual	+	+	-	+ -
Back Problems	-	3	3	6
Stress/ Depression	2	2	2	6
Congestion	1	1	1	3
Gynaecological Problems	1	-	-	1
M.E (Myalgic Encephalomyelitis)/ Chronic Fatigue	1	1	-	2
Arthritis	-	1	-	1
Allergies	-	2	-	2
Repetitive Strain Injury	-	-	1	1
Skin Problems	-	1	-	1
Stroke	-	1	-	1
Thyroid Problems	1	-	-	1
Irritable Bowel Syndrome	1	-	-	1
Cell Group Total	7	12	7	26

This tally chart illustrates clients illnesses before attending health and healing sessions. Number of clients n=20. Although only thirteen clients attended complementary health and healing sessions initially for illness reasons, twenty clients subsequently remarked on their heath problem.

APPENDIX 7.3

Therapist Illnesses

	Cell A	Cell B	Cell C	Total
Physical	+	-	+	+ -
Psychological/ Spiritual	+	+	-	+ -
M.E (Myalgic Encephalomyelitis)/ Chronic Fatigue	1	1	1	3
Stress	1	-	1	2
Irritable Bowel Syndrome	-	-	1	1
Gynaecological Problems	-	1	-	1
Congestion	1	-	-	1
Knee Injury	-	-	1	1
Total by Cell Group	3	2	4	9

This tally chart illustrates illnesses encountered by therapists n=9.

APPENDIX 7.4

Therapists Aims

	Cell A	Cell B	Cell C	Total
Physical	+	-	+	+ -
Psychological/ Spiritual	+	+	-	+ -
Educate/ Guidance	3	-	5	8
Empower	5	2	1	8
Support/ Safe Space	3	1	2	6
Body Awareness	-	1	1	2
Spirituality	-	-	2	2
Relaxation	1	2	-	3
Self-Understanding	2	1	1	4
Encourages Positivity	1	-	-	1
Change	2	-	4	6
Overcome Illness/ Good Health	-	-	1	1
Peace of Mind	3	2	1	6

Therapists recorded an average of 2.2 terms to describe their aims. This tally chart illustrates that although clients attend health and healing sessions to alleviate illness, therapists aim to educate and empower. One noticeable distinction on this table refers to cell B therapists. Here we can see that only 2 practitioners aim to educate or to empower their clients.

APPENDIX 7.5

Therapist Skills

	Cell A	Cell B	Cell C	Total
Physical	+	-	+	+ -
Psychological/ Spiritual	+	+	-	+ -
Absent Healing	-	3	3	6
Access Spirit	-	1	-	1
Automatic Writing	1	-	-	1
Healing Hands	-	1	1	2
Laylines/ Home Healing	1	1	-	2
Out-of-Body Experiences	-	-	1	1
Past Life Experiences	1	3	-	4
Psychic Skills	2	1	-	3
See Auras/ Colours	-	1	1	2
Sensitivity	-	-	1	1
Sensed Energy/ Awareness	2	2	2	6
Visions/ Dreams	2	1	1	4
Total by Cell Group	9	14	10	33

Total number of therapists n=21. As many therapists claim to possess more than one healing skill, this tally chart is designed to illustrate the various skills by therapy group.