CONTEMPORARY HEALING WORK

CONTEMPORARY HEALING WORK:

A SOCIAL WORLDS ANALYSIS OF REIKI IN PRACTICE

BY

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ABSTRACT

This dissertation examined the social history and organizational structure of Reiki (ray-key) and explored the shared ideology and intersecting involvements of fifty practitioners who are engaged in this form of energy healing work. Through a social worlds analysis I illustrate how the central process of segmentation is influencing this social world. My research reveals that Reiki is a heterogeneous set of practices with a diffuse organizational structure. Practitioners hold mixed allegiances to varying traditions and schools of practice and often develop their own unique working styles. Through their discovery of Reiki, practitioners choose to make a commitment to a twin or conjoined practice; that is, to both self healing and to the healing facilitation of others. In this dispersive and differentiated world participants developed a shared therapeutic ideology. This encompasses a core 'energetic world view' coupled with common values that include qualities of virtue, fulfillment, and respect for tacit knowledge. This therapeutic ideology buttresses personal creativity and diversity amongst practitioners. I also found that practitioners confront a continuum of public acceptance or social approval for their work that shifts from hostility to receptivity. For practitioners, although managing public acceptance was largely about defending their social world, it was also about maximizing opportunities to increase public awareness and about creating bridging opportunities that expand the boundaries of Reiki in other social world segments. This study is unique in the sociology of CAM because it offers an in-depth look at the practice of Reiki. It provides a novel sociological analysis of the processes and interactions that form, shape, and direct a contemporary healing practice. My study contributes to social worlds theory by foregrounding the salience of the actions, interactions, and experiences of front-line practitioners engaged in this community of practice.

DEDICATION

I dedicate this thesis

in loving memory of my father Ernest Reid Vokey

and with love and gratitude

to my mother Annie (LeLievre) Vokey

my husband Richard,

and children, Amanda and Daniel.

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INTRODUCTION

> *But really, where my heart is it's Reiki, and it's not shamanism, and it's not crystal, and it's not bach flowers. It's the pure energy, the energy of 'reiki' which I am interested in. That's my path.* (Reiki practitioner)

Increasingly, complementary and alternative medicine (CAM) practices are becoming part of how people deal with preventative health and/or chronic illness issues (Kelner and Wellman 1997a; Low 2004; Pawluch et al. 2000). While the challenge that this poses to biomedicine has been a central focus of sociological research in the field of CAM (Kelner and Wellman 1997b; Kelner, Wellman, and Welsh 2002; Kelner et al. 2004a; Kelner et al. 2004b; Kelner at al. 2006), less emphasis has been placed on how specific CAM practices evolve and how this impacts practitioners and their involvements in healing work. Reiki (ray-key) is one such CAM practice. Although Reiki is growing in popularity and is increasingly becoming part of how people who are receptive to CAM deal with health concerns (Kelner and Wellman 1997a; Low 2004; Pawluch et al. 2000), there has been no in depth sociological exploration of the practice or of those active in this kind of work.

In this dissertation I address this knowledge gap by focusing on how contemporary healing, in the form of Reiki practice, is structured and experienced. Substantively, I ask where does Reiki come from and how, at the present time, is it structurally organized in North America, what beliefs are attached to Reiki, and what does practitioner involvement with Reiki look like? In answering these questions, I examine the social history, organizational structure, ideology, and front-line involvements of practitioners engaged in this form of energy healing work. Beyond these

important substantive issues, the case of Reiki practice is also theoretically interesting, sociologically, because it offers a novel lens through which to gain a more comprehensive understanding of the processes around CAM practices and healthcare provision. I draw on Social Worlds Theory (SWT) to better appreciate how Reiki has evolved and how the distinguishing features of Reiki practice impact the healing work of Reiki practitioners.

As this is a relatively unexplored area of sociological enquiry I chose a qualitative approach to gain a deeper understanding of the significant actions, interactions, and processes that constitute this practice. This choice is also consistent with the application of SWT, which is part of Anselm Strauss's (1993) broader theory of action. Rooted in the symbolic interactionism perspective, SWT offers concepts that are well suited to guiding qualitative projects. I decided to focus my enquiry on experiences of front-line practitioners because they are the people most intimately involved in this form of healing work. Over an eight month period between 2007 and 2008 I spent seventy-two hours as an active participant with two Reiki practitioner groups in the greater Hamilton area and conducted semi-structured interviews with fifty practitioners in Atlantic and Central Canada. My constant comparative approach to data collection and analysis was informed by the strategies of Adele Clark (2003, 2005), Kathy Charmaz (2006), and Robert Prus (1996).

It is helpful, particularly for the neophyte to this practice, to begin with a brief description of Reiki. Next, I highlight the main gaps in our current knowledge about

Reiki. Then, I outline my application of SWT to this case and emphasize my theoretical as well as substantive contributions. Lastly, I provide an overview of my dissertation.

What is Reiki?

Reiki, as it is mainly practiced today in North America, is a method of natural healing that originated in early 20th century Japan. The Japanese word 'reiki' is a general term for rei 'universal' and ki 'life force energy'. Those who practice this form of healing use 'Reiki' (in uppercase) in reference to the 'Usui System of Natural Healing'. In lowercase, reiki is a generic label for 'healing' or 'life force' energy.

Although the contemporary practice of 'Reiki' began in Japan the idea of 'ki' or 'life force energy' has ancient roots and parallels the notion of 'vitalism'. The latter term became popular in elite universities of 18th and 19th century Europe (Micozzi 2006:54). The concept of vitalism is etched in the belief that life arises from a "non-material vital principle" (Canter 2008:152). The fundamental idea is that life cannot be fully explained by physical or mechanical laws: "life's agency and healing potential can be found in a vital energy or presence distinct from the ordinary mechanical forces" (Micozzi 2006:54). Canter explains that the same principle was expressed in the Greco- Roman notion of humors, the East Indian yogic idea of prana, 'doshas' in Ayurvedic medicine, and the Chinese concept of chi or qi. Aristotle also believed in the "soul as a life force" and Descarte argued that a "spiritual entity' guides 'organisms' (2008:152). "Life force energy" or 'vitalism' is central in the philosophy of CAM practices (Boon 1998; Cant and Sharma 1995).

Contemporary researchers have coined the phrase "subtle energy" to refer to "life force energy" and refer to this as a "physical electromagnetic" force (Micozzi 2006:56; also see Esmail 2007). Proof that this energy exists is based on personal perceptions of healing such as sensations of heat, tingling, or vibratory motions (Micozzi 2006:56). Even though the institution of Western biomedicine largely dismisses the concept of a 'life force' Micozzi notes that "some conventional researchers hover on the edge of this type of healing and continue to investigate the phenomenon scientifically" (Micozzi 2006:56). Science is the medium through which current CAM researchers (many who are doctors trained in western medicine) represent 'reiki' or healing energy.

Some of the healing practices that revolve around a belief in a "life force" are associated with formal religion and involve prayer, religious ceremonies, and rituals (White and Verhoef 2006). Others are more directly linked to the idea of 'spiritual healing'. These hold more extensive or secular meanings than "organized religious" practices (White and Verhoef 2006:117). In this broader context, spiritual healing and CAM mind-body techniques are commonly juxtaposed. For example, guided imagery and meditation are often considered to be forms of spiritual healing. The practice of Reiki is represented by some academic scholars as "religious healing" and by others as "spiritual healing" (McGuire 1988; Glik 1990; White and Verhoef 2006).

Over the last two decades Reiki has spread globally and is increasing in popularity as form of CAM. In tandem with this interest, clinical researchers in the field of CAM have classified reiki as "bio-field energy" and the therapy as a form of "energy medicine" (NCCAM 2008). In Canada, practices classified as energy therapies include

Reiki, therapeutic touch, healing touch, acupressure, acupuncture, homeopathy, polarity therapy, qigong, reflexology, Tai Chi, Yoga, magnetic therapy, and crystal therapy (Tataryn 2002)[1]. All energy medicine practices, similar to other forms of CAM are commonly linked to the notion of 'holistic' (Boon 1998) and/or spiritual healing (White and Verhoef 2006). At the present time, Reiki is described by the Atlantic Usui Reiki Association (AURA 2007) as "natural healing" and by the Canadian Reiki Association (CRA 2003) as an "energy based modality". These representative groups claim that practitioners transfer "life force energy" to the client through light touch and that the healing energy activates the body's healing potential. The CRA (2003) describes Reiki in this way:

> *Reiki is a Japanese holistic, light-touch, energy-based modality. Working as a support mechanism to the body, Reiki re-establishes a normal energy flow of ki (life force energy) throughout the system, which in turn can enhance and accelerate the body's innate healing ability. Through a series of hand positions either directly on or just above the body, the energy worker allows for the flow of energy through their body. The client's body then draws off the amount of energy that is required. The simplicity of a Reiki session may raise some skepticism, however, after experiencing it, many clients keep coming back for more of those relaxing feelings. Reiki is simple and produces measurable results (CRA 2003).*

Previous Research on Reiki

Compared to other forms of CAM Reiki has attracted little sociological attention. While current studies provide important insights, an in-depth understanding of Reiki is lacking. For example, findings on the social history of Reiki are short and purely descriptive accounts (see Chu 2004; Engrebretson 1996; Gilberti 2004; Shankar and Liao 2004; Wetzel 1989). Most of what is known about Reiki practice in Canada pertains to

[1] For a description of these therapies please see Esmail (2007).

the professionalization of Reiki practitioners in Toronto, Ontario (Kelner et al 2004a; Kelner et al. 2004b). This research points to practitioners' lack of interest in pursuing conventional routes to gain legitimacy in mainstream health care as well as to the resistance of health professional groups and government officials to the professionalization of Reiki practitioners. This focus does not capture other forms of practitioner involvement or how Reiki practice is interfacing with mainstream healthcare. Finally, research that contains information on Reiki use is multidisciplinary and has revealed varied findings about the practice (Foot-Ardah 2003; Glik 1988, 1990; Heelas. 2007; Kelner and Wellman 1997a, 1997b; Low 2004, 2005; McGuire 1988; Pawluch et al. 2000; Voas and Bruce 2007). This speaks to the complexity of Reiki within the broader context of CAM. While this also implies that there is a high level of diversity amongst practitioners few studies address how Reiki is experienced (for exceptions see Foot-Ardah 2003; Low 2004, 2005; Pawluch et al. 2000). To date, there have been no sociological studies that have looked exclusively at Reiki as a community of practice nor have studies looked solely at the ideology and/or world views of Reiki practitioners. My study fills these gaps in the literature by explicating the social world that is Reiki.

Reiki as a Social World

The notion of a social world hinges on the view that groups exist in and through common activities held together by a network of communication (Shibutani 1955; Strauss 1984). Such communities are described as diverse and constantly changing environments with fluid boundaries which actors continually reshape through their actions. These can be as diverse as the world of art (Becker 1984), a recreational activity such as baseball

(Strauss 1993) or a form of 'healing work' such as the practice of Reiki. Actors are usually part of multiple social worlds and often display varying levels of commitment to the social worlds within which they are participants. As described by Strauss (1978:121), such communities involve any network of people held together by forms of communication, symbolism, discourse, activities, memberships, technologies, and/or organizations. Sociologist, Adele Clarke, a former student of Strauss (1991: 131), defines social worlds as "groups with shared commitments to certain activities, sharing resources of many kinds to achieve their goals, and building shared ideologies about how to go about their business". Further development of the concept and applications of the theory have largely been in the area of formal organizations, disciplines, and professions (see Adams 2001, 2004; Adams and Tovey 2001; Clarke 1990, 1991, 1998; Clarke and Casper 1996; Clarke and Montini 1993; Clarke and Star 2008; Miall and Miall 2002; Sanders 2007; Tovey and Adams 2001, 2002, 2003). In one notable exception, David Unruh (1980, 1981) looked at the group activities of seniors to uncover how they engaged in social life.

In my analysis chapters I show that segmentation, a process which refers to how social worlds come to distinguish themselves from each other by separating, coalescing, and/or intersecting (Strauss 1978), is central to the formation, shape, and direction of the social world of Reiki and that front-line practice is integral in this process. I argue that it is necessary to foreground the experience of social world members as most practitioners work independently and are not part of a formal organizational structure (see Chapters Five and Six). Further, from the analysis I uncover the heterogeneity of the Reiki practice

and its loose organizational structure (see Chapter Four). I tease apart practitioners' shared ideology, differing beliefs, and varying meanings attached to the core elements of Reiki that reciprocally shape the practice (see Chapter Five). Lastly, I show how front line practitioners confront, manage, and negotiate a continuum of public acceptance through their involvements in this healing work (see Chapter Six).

Thesis Contributions

To the Sociology of CAM

Within medical sociology, Reiki is embedded in current debates about the legitimacy of CAM practices and practitioners, and the integration of specific CAM modalities within the conventional Western biomedical model. In looking at the history and front-line practice of Reiki through a social worlds lens, my project informs these debates by providing fresh insight into how Reiki is evolving within mainstream healthcare; by giving voice to front line practitioners and by illustrating how practitioners are both active and implicated in this process. This is an important departure from the sociology of CAM literature that tends to focus on formal professionalization efforts of CAM practice groups. My findings suggest that Reiki is interfacing with mainstream healthcare in ways that are overlooked in current scholarship. The complexity, diversity, coherence, and value that social worlds such as Reiki hold for practitioners tend to be under acknowledged in current CAM scholarship. Similar to other forms of care-giving, the contributions that these practitioners make go largely unnoticed and are in many respects under-rated.

Further, the complexity and heterogeneity of holistic healing methods are not easily captured within current theories of CAM. These tend to rely on dichotomous approaches which frame either the *practice* or *use* of CAM. I introduce the concept of 'conjoined practice' to more accurately convey the joint nature of Reiki practice. As a twin or *'conjoined practice'* Reiki encompasses practice and use and resides in the multilayered crevices of both (see chapter 6). It is here, in particular, that a social worlds (SWs) analysis provides an innovative lens through which to explore the issues, tensions, and consequences linked to and encompassing the *practice and use* of CAM. This can be accomplished in a way that, theoretically, does not conflict with but rather supports the holistic tenets of CAM. This is an important contribution to the current sociological research on CAM.

To Social Worlds Theory

My thesis further contributes to debates in sociology in connection with SWT. As briefly noted above, SWT is concerned with the processes of social order and social change and is but one analytic approach developed within the late Anselm Strauss' broader theory of action (see Strauss 1993). Those who work in this tradition are concerned with questions about the history of a social world. For example, how does a social world "originate, where is it now, what changes have occurred, where does it seem to be moving" (Strauss 1978:127)? Is the social world "evolving, disintegrating, splintering, collaborating or coalescing" (Strauss 1978:127)? Social world theorists are also concerned with how social world groups "enter into collaborative relationships with

other segments" yet question why some worlds "struggle against severe social constraints" (Strauss 1978:127).

This theory has made major contributions in advancing our understanding of social order and social change specifically in the fields of science and technology and biomedicine. For example, previous studies have provided insights into the processes of homogenization, standardization, and formal classifications in professions, disciplines, and other work organizations (Clarke and Casper 1996; Strauss et al. 1964; Timmermans and Berg 2003; Tovey and Adams 2001; Tuunainen 2005). Processes of differentiation in the world of computer technology (Kling and Gerson 1977, 1978), insights into the intersecting work processes of emergency responders (Sanders 2007), and the weak intersecting processes indicative of biomedicine's selective adoption of CAM practices (Tovey and Adams 2001) are also illustrative of SWT analyses.

My thesis provides insights into how social change occurs by looking at the social world of Reiki. In order to more fully capture the processes of social change within the context of contemporary healthcare, I argue that social world theorists need to pay more attention to dispersive social worlds; that is, worlds that are less formally organized and less embedded within formal organizations. Further, I contend that in these kinds of social worlds it is necessary to accentuate the experiences of front-line workers; where social change is grounded, develops, and evolves. I will use my study of Reiki practitioners to show how the actions and interactions of members of dispersive social worlds are often overlooked but integral to the changing landscape of mainstream health care.

Dissertation Overview

Chapter 1: Previous Research on Reiki

In chapter one I detail the sociological and academic literature on Reiki and studies of CAM more generally that are pertinent to this investigation. For the purposes of this research I have included literature that falls under three broad themes: social history, practice, and use. The literature reviewed is intended to situate Reiki within the CAM literature and to add context, where possible, for the ensuing analytic chapters. It simultaneously points to gaps in our understanding of Reiki practice in relation to the dimensions under study.

Chapter 2: Theory

In this chapter I describe the main tenets of the theoretical approach I employ. I then describe SWT and its roots in symbolic interactionism and illustrate how SWT concepts inform this study. Finally, I discuss how SWT is applied in other studies relevant to my thesis topic.

Chapter 3: Methodological Approach

In chapter three I outline my methodological approach and the specific methods that I used to collect my data. I describe how I became involved in this research, the documents I worked with, and how I conducted participation observation. Then, I outline how I recruited participants for the semi-structured interviews, describe the interviews, present the profiles of my study participants, and explain how I analyzed the data. Finally, I point out some of the challenges I faced during the research process.

Chapter 4: Reiki as a Social World

In chapter four I provide insight into the early development of Reiki in Japan and its evolution in North America. My analysis highlights the ideological conflicts between key Reiki entrepreneurs in North America and their struggles to control the structure, content, and spread of the method. I argue that the fraught history has resulted in the development of Reiki into a "dispersive" or "diffuse" social world (Unruh 1981) that is comprised of many segments, sub segments, and individual social world actors. By looking at the social history I highlight the segmentation processes behind this dispersive formation.

Chapter 5: An Exploration of Shared Ideology and Operational Philosophy

In this chapter I explore how practitioners relate to beliefs and practices connected with their work. The main concept that guides this analysis is the notion of a *boundary object* (Star and Griesemer 1989). Objects are abstract ideas or concrete entities that hold diverse meanings in different social worlds. They can be anything that an individual or group act toward. In contrast, a boundary object is based on the premise that the form or structure of the object is common enough to be recognized by other actors, yet it can hold multiple "translations" (Star and Griesemer 1989: 393); for example, a checklist of zoology specimens (Star and Griesemer 1989:406) or a health care management technology (Allen 2009). In this study, 'the energetic worldview' of practitioners is an ideological "boundary object". I argue that varying beliefs allow for personal creativity and diversity amongst practitioners but that a core energetic world view buttressed by common values constitutes a therapeutic ideology which brings coherence to their everyday work.

In the analysis, I explore the varied interpretations of reiki energy and healing energy work held by participants. I tease apart their beliefs and the main principles and ideas that guide their practice and core technologies or tools that they use. The analysis reveals that the shared values that participants held about reiki reflect a common 'reality'; described as a sense of 'feeling', 'being', and 'knowing'. This meaning was further expressed in notions of Reiki practice and described as qualities of virtue, a desire for fulfillment that includes self and others, and a respect for intuitive and tacit knowledge. These interpretations align with principles of science and/ or spirituality, resonate with a core ideology or 'energetic world view', and form the basis of their *therapeutic ideology*. Shared values, then, play an important part in the coherence of this dispersive social world.

Chapter 6: Managing the Continuum of Public Acceptance

In this chapter I explore how practitioners confront and manage public acceptance (or lack thereof) through their involvements with the social world of Reiki. In the context of this research 'public acceptance' refers to a range of social approval that practitioners experience from people outside this community of practice. It is a *continuum* that spans from overt hostility to total receptivity. I show that for front-line practitioners, although the strategies they use largely encompass defending this social world, management also involves maximizing opportunities to increase public awareness and creating bridging opportunities that expand the boundaries of Reiki in other social world segments. I argue that front-line practitioner involvements are an integral part of the conditions and consequences that potentially fuel continued segmentation.

Conclusion:

In the concluding chapter I synthesize the main findings of the research, highlight the contributions of the study, and provide suggestions for future research. Overall, the findings show that as a community of practice, Reiki, similar to many other forms of CAM, is interfacing with mainstream health care. It is no longer a question of whether Reiki is becoming mainstream but how. Still, dispersive social worlds such as Reiki are largely overlooked in current sociological scholarship. Akin to other forms of care-giving, Reiki and similar healing practices fill liminal spaces in health care provision. Largely performed by women, they receive limited recognition, and are often under-rated.

Reiki in the Context of CAM Research

The prevalence of chronic illness, 'quest for health and well-being', and an interest in spirituality are intricately meshed with the growth of CAM (MacNevin 2003; Thompson 2003; Engbretson 1996; Kelner and Wellman 1997a; 1997b). Within this milieu, Reiki, as a specific CAM modality, offers promise to individuals searching for ways to manage health and illness issues. As a 'healing energy', reiki remains an enigma that is poorly understood, regarded with suspicion, and contested within and beyond the borders of biomedicine (see Albanese 2000; Di Nucci 2005; Engbretson 1996; Gilberti 2004; McGuire 1988; Ernst 2008).

Despite resistance (Ernst 2008; Kelner et al. 2004a) the practice is becoming more widely used in Western countries to complement conventional therapies (Barnett and Chambers 1996; Hodges and Schofield 1995; Baer 2008). While this suggests that a similar trend is happening in Canada, to date there has been little interest in Reiki as a topic of sociological interest (for exceptions see Kelner and Wellman 1997a, 1997b; Kelner et al. 2002; Kelner et al. 2004a). As a practice, Reiki is part of the CAM movement (Kelner and Wellman 2003; Schneirov and Geczik 2002). CAM is a concern within wealthy countries because of the dramatic increase in the use of non-conventional forms of medicine and the implications that this situation poses for 'conventional' health care.

In this chapter, I review the burgeoning sociological literature on CAM. While most of this empirical research does not address Reiki specifically it is relevant as it provides the context for my enquiry into this practice. Although I approach the review

through a sociological lens, CAM is a multidisciplinary field of enquiry. Therefore, I highlight the scholarship of academics from a variety of fields of social science and health professions. As much as possible I draw upon Canadian scholarship but due to the paucity of Canadian literature I rely on US, UK, European, and Australian sources.

The review is organized in the following manner. First, I review the evolution of CAM practice. Within this section I outline the themes of medical dominance, health professionalization, and relations with biomedicine. This is followed by an overview of literature on CAM use that considers trends, user profiles, beliefs and values, and the experience of CAM use. Where the literature specifically addresses Reiki I draw on these references in an attempt to provide as full a picture as possible of how sociologists have studied Reiki. I end my review with a summary of what the literature specifically says about Reiki.

Evolution of CAM: Practice and Practitioners

Non Conventional Medicine Practice in North America 20th Century

Prior to the 1900's healing approaches in western countries were pluralistic, that is not separate from the realm of medical practice (Saks 2001). Through a series of 20th century legislative acts in the UK, the US, and Canada, the scope of practice of non-allopathic care providers was restricted and attempts at statutory recognition of 'irregular' medicine practices blocked (Crellin, Anderson, and Connor 1997; Saks 2001; Winnick 2005).[1] Such 'marginal' medicine practices posed a threat to allopathic practice because practitioners functioned independently from conventional medicine and were able to prescribe and treat patients within their specific modalities (Wardwell 1994).

Hence, the monopolization by allopathic medicine began by positioning century old practices (such as midwifery and folk medicine) and newer modalities like homeopathy and chiropractic medicine outside the accepted norm (Crellin et al. 1997). Reiki was introduced into the US in 1938 and was but one of many non conventional healing approaches.

The contemporary evolution of CAM, then, began during the first half of the 20th century during the 'golden era of medical dominance' (Winnick 2005). The idea of *medical dominance* was introduced by Freidson in 1970. Since then other scholars have used, outlined, developed, and debated the concept (a few examples include Light 2000; MacDonald 1995; Turner 1995; Witz 1992). Freidson (1970) argued that what sets allopathic medicine apart from other occupations is the ability to gain and maintain a market monopoly (Freidsen 1970). Winnick (2005:41,42) explains that this was achieved through claims to esoteric scientific knowledge, increasing the standard and standardization of medical education, gaining state endorsement for perceived societal benefit and cultural authority, and garnering legal support for control over competitors. This subsequently secured a degree of professional status that medicine has enjoyed for a number of decades.

Some healing practitioner groups actively resisted. Fierce conflicts between various medical factions ensued and after years of legal wrangling some groups managed to make notable occupational advancements. The expansion of chiropractic medicine in Canada, the United States, and the United Kingdom is a case in point (Coburn 1994; Coburn and Biggs 1986; Mills 1966). In varying degrees and ways other modalities such

as naturopathy and homeopathy in Canada (Boon 1998; Gilmour, Kelner and Wellman 2002; Kelner et al. 2006), osteopathy in the US (Wardwell 1994), and homeopathy in the UK (Cant and Sharma 1995), have also attained 'enhanced legitimacy' (Cant and Sharma 1995). This means that although some groups have not successfully attained state sanctioned professional status they have attained 'a degree of social legitimacy' that they did not have before (Sharma and Black 2001:914). Regardless, the main strategy that these groups used in their attempts to gain legitimacy and increased occupational status was to embark on their own legally sanctioned professionalization pursuits.

There are fewer scholarly insights with respect to what was happening with Reiki practitioners during this time and limited information about the practice itself. Within academic scholarship, the history of Reiki practice is presented mainly in brief descriptive summaries (see Chu 2004; Engrebretson 1996; Gilberti 2004; Shankar and Liao 2004; Wetzel 1989). Basically, details concerning the origins of Reiki in Japan remain sketchy and inconsistent. There is no consensus as to its ancient origins but it is clear that religion and medicine were involved in its contemporary configuration. Most scholars contend that the healing system is rooted in sacred scriptures originating in Tibet but it has also been suggested that Reiki probably originated in China and derived from Qi Gong, a healing practice rooted in martial arts (Micozzi 2006:134). I expand on this information in chapter four.

CAM Practitioners: the legitimation of CAM practices

While Reiki was evolving in Japan in the early 20th century the face of medicine in North America was also changing. During this time, biomedicine became an

established 'profession' (Coburn 1994:140) and the contemporary gold standard of medical practice. Conceptually, the idea of a professionalization project was first introduced by Larson (1977). The term was used to describe the strategies that groups use to establish a monopoly over an occupational service. Professionalization affords a group higher social status and control over the content and parameters of their work. Larson's conceptualization links two theoretical approaches: social closure theories based on state sanctioned jurisdictions over expertise and services (for example see Larson 1977; Freidson 1970; Johnson 1972; Parkin 1979; MacDonald 1995) and class theories that emphasize the socio-political context in securing state sanctioned licensing (for example Johnson 1977; Larson 1977). For the purpose of this discussion and at its most simplistic level, a professionalization project involves four interrelated steps. These include: becoming established as a distinct occupation; standardizing the body of knowledge of the occupation; creating and developing training courses, certification, licensure, and accreditation processes; and gaining legitimacy for a higher status through public support (Siapush 1999:166). Since the 1980's research on alternative healing practices in Canada has largely focused on how various healing groups are involved in this course of action.

In Canada, specific practices that have taken this route have been studied extensively. Some examples include: chiropractic medicine (Mills 1966; Coburn and Biggs 1986), naturopathic medicine (Boon 1998; Verhoef, Boon and Mutasingwa 2006), midwifery (Benoit 1991; Bourgeault 2000), and herbalism (Hirschkorn 2005). Similar

studies in other Western countries have also been done (see Cant and Sharma 1995; Saks 2000, 2001, 2003).

Although each of these groups has its own unique history the common thread between them lies in the compromise that groups make in order to become 'legitimate mainstream practitioners'. The more successful groups, such as chiropractic medicine, naturopathy, and midwifery transformed their 'lay' approaches to training and practice to fit within the scientific model (Coburn and Biggs 1986; Bourgeault 2000; Boon 1998; Sharma 1992). Reiki is one of the many CAM practice groups that have resisted pursuing formal routes to professionalization even though their 'legitimacy' has been contested by representatives of health professions and the state. Such issues were explored in several research projects that I outline below.

Kelner et al. (2002) examined chiropractic, homeopathy, and Reiki practitioner views on the need to show the cost-effectiveness, safety, and efficacy of their therapies and practices. They found Reiki practitioners were the least interested in proving effectiveness. Most saw no need for providing proof of safety and all felt confident that Reiki therapy is cost-effective. In contrast, chiropractic practitioners were most inclined to say that it is imperative to show effectiveness. They were unanimous in expressing the necessity to prove the safety of their therapies and all thought that chiropractic care is cost-effective. The homeopaths disagreed on the need for research on safety and effectiveness. The authors of this study argued that the integration of Reiki into the public health system is even more tenuous than other forms of CAM (Jonas 2002; Kelner et al. 2006). Still, the degree to which Reiki is a fringe therapy remains unclear (Tataryn

2002). One route that Reiki practitioners have not embarked on entails state sanctioned professionalization.

Kelner et al. (2004a) examined the responses of ten leaders from medicine, nursing, physiotherapy, clinical nutrition, and public health concerning their receptiveness to the professionalization of CAM practitioners. The CAM groups included chiropractors, naturopaths, acupuncture /traditional Chinese doctors, homeopaths, and Reiki practitioners. Overall, the health care professionals did not endorse professionalization, and were unsympathetic toward CAM groups especially "naturopaths, homeopaths, and Reiki" (Kelner et al. 2004a:920). While physicians distanced themselves from CAM practitioners, interestingly, nurses seemed most interested "in taking over CAM practices rather than referring patients to CAM providers" (Kelner et al. 2004a:922). Other health professionals paid little attention to the notion of integrating CAM into the present system. All ten leaders were against CAM practitioners being included in the provincial health insurance scheme and all were resistant to the notion of any government funding for CAM groups.

In a second study in 2004, Kelner et al. (2004b) interviewed ten government officials at the federal, provincial, and municipal levels regarding the inclusion of five CAM groups into the Ontario health care system. While the informants were sensitive to consumer pressure to implement CAM, they were more concerned with public safety issues. Reiki practitioners were noted to be the least organized and unified of the groups and the least likely to pursue state lobbying for professional status. The authors concluded that in order "to move from the margins to the mainstream", CAM occupations

would have to engage in ongoing dialogue and negotiations with the state (Kelner et al. 2004b:87). Despite a lack of co-operation between Reiki practitioners, and other health stakeholder groups, Reiki is implicated in more recent trends in the evolution of CAM.

Conditions Influencing the Resurgence of CAM: 1960's -1990's

While biomedicine or allopathic medicine maintained a dominant position through the first half of the 20th century the so called 'alternative' or 'irregular' (Wardwell 1994) healing groups did not disappear. They were eclipsed by the medical profession. This began to change in the 1960's in the US, in part, because of the health and countercultural movements of this era and in particular due to the holistic health and the New Age movements. [2]

The holistic health movement encompasses various alternative medical systems and therapies. According to Baer et al. (1998:1495) holism embraces "parapsychology, folk medicine, herbalism, nutritional therapies, homeopathy, yoga, massage, meditation, and the martial arts". Various practitioner groups are involved and these include an array of "lay alternative practitioners, psychic or spiritual healers, New Agers, holistic MDs, as well as chiropractors, osteopathic physicians, and naturopaths" (Baer et al. 1998: 1495).

In part, the holistic health movement evolved in response to a crisis in Western health delivery that was characterized by rising health care costs and limited resources, (Armstrong 2002; Armstrong and Armstrong 2003; Coburn 2001; Gabe and Calnan 2000; Lowenberg 1989), the diminished effectiveness of medicine to treat chronic health care conditions in combination with the iatrogenic effects of conventional treatment, dissatisfaction with medical encounters, and a growing consumer movement (Illich 1976;

Lowenberg 1989). The holistic health movement in the US was also part of what Lowenberg (1989:67) termed a "coalition of sixties movements". These include the feminist movement that focused on women's reproductive rights, physician patient relationships, public awareness of iatrogenesis and the demystification of medical knowledge (Lowenberg 1989; McGuire 1988). Lowenberg (1989) notes that the human potential movement was also part of this trend. Pertinent in her description is the link to Abraham Maslow's notion of self-actualization that features personal development and self-responsibility. The concept became popular amongst holistic practitioners and was incorporated with other Eastern psychotherapeutic approaches; one example being transpersonal psychology. Based in "Eastern wisdom", this school of psychology has spiritual dimensions and explores transforming the consciousness of self and society (Lowenberg1989:68). The adoption of such notions overlapped with other countercultural ideas and philosophies.

The New Age movement was influenced by both the influx and adoption of Eastern philosophical ideas and practices. Particular to New Age philosophy is the idea of a 'new planetary culture'. Proponents claim that this is to come about through the attainment of "inner peace, wellness, unity, self-actualization, and the attainment of a higher level of consciousness" (Baer et al. 1998:1496). Numerous techniques have been associated with New Age healing. These range from "centering, channeling, astral projection, guided visualization, iridology, reflexology, chromotherapy, rebirthing, shiatsu, and healing with the power of pyramids and crystals" (Baer et al. 1998: 1496).

This phenomenon first emerged on the West coast of the US and Canada, then over time spread to countries worldwide (Baer et al 1998: 1496).

Goldstein (1992) discussed the ideas associated with New Age conceptions of healing. He explained that New Agers generally emphasize the unity of body, mind and spirit, and focus on individual responsibility, anti-professionalism, self care, and personal transformation. Similarly, Engbretson (1996:540) conducted a nine month ethnographic study of urban healing touch groups. Although she does not discuss an alternative ideology or alternative world view in her work, she found that the participants valued "spirituality, group connection, egalitarianism, and intuitiveness" and used these forms of CAM in conjunction with biomedicine for "spiritual and general well being". She further claimed that there is a demand "for spiritual aspects of healing" on the part of consumers.

While the notion of 'New Age' has been widely used within the context of CAM, it has taken on multiple meanings (Levin and Coreil 1986; York 1995). The concept has been used to describe overlapping religious and healing practices (Kaptchuk and Eisenberg 2001; Levin and Coreil 1986; Low 2004; McClean 2005) and is often linked to health consumption and spiritual materialism (Bowman 1999). Perhaps more often than not 'fringe' practices are categorized as 'New Age' because researchers have imposed this description. Forms of energy healing tend to be categorized in this way even though some practices, such as Reiki, did not originate in the US, the home of the New Age movement, and practitioners may or may not identify with the mixed and multiple interpretations designated as 'New Age'. As this movement was part of the 1960's counterculture (Levin and Coreil 1986; Heelas and Woodhead 2005; Voas and Bruce

2007) and coined as an "American phenomenon" (York 1995) it is curious that the term continues to be used carte blanche to describe anything that is perceived to be 'non conventional', whether it be in a religious or health context and whether or not it is consistent with practitioners' world views (Kaptchuk and Eisenberg 2001).

Within the evolution of the practice, scholars have examined Reiki through different and often competing lenses. In US and UK scholarship Reiki has often been framed within religious or new religious contexts (see Garrett 2001; Glik 1986, 1988, 1990; Klassen 2005; McGuire 1988; Melton 2001; Heelas 2007; Heelas and Woodhead 2005; York 1995). Seminal ethnographic work on both orthodox and unorthodox 'healing' in various suburban areas in the US, which included the practice of Reiki, dispelled the myth that religiously oriented 'ritual healing' practices were a reserve of the poor and uneducated (Garrett 2001; Glik 1986, 1988, 1990; McGuire 1988). Despite its religious roots, other scholars argue that Reiki is not a religion because it is not associated with any particular doctrine or creed (Gilberti 2004; Wetzel 1989). Reiki has more recently been referred to in secular terms such as 'holistic' or 'alternative spirituality' (Heelas 2007; Heelas and Woodhead 2005; Voas and Bruce 2007) but it is most often linked to the notion of 'New Age' spirituality (Bowman 1999; Low 2004; McClean 2005).

Wetzel (1989) provides some interesting points about the practice of Reiki in North America. She maintains that in 1989, there were just over three hundred Reiki Masters on the continent and most of these taught on an independent basis. Between 1980 and 1990 this relatively small group of Reiki Masters traveled "extensively throughout

the year, building their own networks of therapists and supporters" (Wetzel 1989:48). Since then Reiki has spread globally and by 2004 the number of practitioners worldwide was estimated to be in the several hundreds of thousands (Gilberti 2004).

Reiki practitioners: 'quasi-professionals'

Classifications of Reiki in the CAM literature tend to marginalize the practice and the practitioners. Within the context of health practices, biomedicine tends to be the standard by which other forms of healing and health practitioners are judged. For example, within a classification scheme of health practitioners Wardwell (1994) describes 'quasi-professional' groups that are inclusive of Reiki practitioners. This is a category that includes folk healers, magical healers, faith healers and quacks. Quacks are described as giving the impression that they are acting scientifically: "Quacks pretend to be scientific and to believe sincerely in the merits of their machines, procedures or healing rituals" (Wardwell 1994:1064).[3] Sociologists have pointed out that the medical profession tends to label particular CAM approaches, such as 'energy medicine' and/or spiritual healing approaches such as Reiki as 'quackery' (see Foltz 1994; Low 2004; McGuire 1988). Such bias continues to be reflected, intentionally or unintentionally, in current classifications of CAM practices (see Esmail 2007; Kaptchuk and Eisenberg 2001; NCCAM 2008; Tataryn 2002).

There is also an insistence that these 'pseudoscientific' practices have no place in conventional health care because they lack 'real' scientific grounding and evidence (Charlton 2008; Ernst 2008). Some scholars argue that such classifications perpetuate the subordination of other practitioner groups while maintaining the dominance of the

medical profession (McGuire 1988) and that this 'traditional' approach to measuring professional status against and in favor of orthodox medicine "reinforces assumptions about what occupations count as professions" (Cant and Sharma 1995:744). The idea that such depictions are part of the political strategies of more powerful groups is further exemplified in Jonas' (2002:34) description of energy healing practices as 'frontier therapies' that "challenge our conceptual and paradigmatic assumptions about the nature of biological or scientific reality. Examples are homeopathy, prayer, and healing practices such as therapeutic touch."

Still, there are less inflammatory portrayals of CAM users and practitioners such as Astin's (1998) term 'culturally creative' types. Hence, it can also be said that classifications change over time and group status is neither fixed nor stagnant. For example, midwifery in Canada, prior to the 1970's was neither legally sanctioned nor officially recognized (Bourgeault 2000). Despite opposition from the medical profession and other more established health professionals within two decades the 'marginalized' practice became fully licensed and funded within Ontario's health care system (Bourgeault 2000). This fluidity is apparent in changing conceptions of non conventional healing practices.

The Changing Face of Non Conventional Healing Practices: 1990's

Integrative Medicine

The model of 'integrative medicine' in Canada is postulated by Boon et al. (2004) to be a seamless pluralistic and egalitarian system of health care. The goal behind this new medical model is to combine CAM with biomedical practices (Kelner and Wellman

2003). Similar models are being introduced in other Western countries (see Baer 2008; Cant and Sharma 1999; Coulter 2004).

Indeed, the most abundant source of current scholarly literature on Reiki has been produced by health professional researchers whose interests lie in the 'integrative' medicine model. The primary focus is on efficacy (Mansour et al. 1999; Olson, Hanson and Michaud 2003; Tsang, Carlson, and Olson 2007; Wardell and Engrebretson 2001, Wardell et al. 2006). With the 'ideal' of integration as its impetus, studies of Reiki have been done in relation to stroke patients (Shifflett et al. 2002), Alzheimer's disease (Crawford, Leaver and Mahoney 2006), and practitioner well-being (Rubik, Brooks and Schwartz 2006). Reiki has also been studied in clinical trials involving fibromyalgia, prostate cancer, coronary disease, diabetes, and stress (NCCAM 2008). While some studies show promising results, results on efficacy remain inconclusive.

Although conceptually the integrative model is intended to bring together "the best of both CAM and biomedicine' (Baer 2008:52), substantively there is less evidence to support that this is happening. As Kelner at al. (2004a) point out, integration continues to mean different things to different stakeholder groups. For instance, even though CAM has been introduced into medical and nursing training programs and general practitioners are showing an interest in adopting some CAM practices (Kelner et al. 2004a; Hirschkorn, Andersen, and Bourgeault 2009), there is also evidence that the relationship in integrative care settings in Canada remains hierarchal rather than egalitarian (Hollenberg 2006). Most often, becoming part of the mainstream translates into conforming to biomedical standards (Kelner et al. 2004a). This situation is not unique to

Canada. For example, Coulter (2004) argues that for integrative medicine to be realized in the US, it has to entail the inclusion of CAM in predominantly hospital based medical programs. Such a scenario implies an assimilation of CAM into the biomedical model in a way that Fadlon (2004) has described as the 'domestication' of CAM into biomedicine. Researchers who have looked at integrative medicine in the UK (Cant and Sharma 1999; Saks 2001) and Australia (Baer 2008) contend that biomedicine is engaged in a process of co-opting CAM practices. Nevertheless this is an arena that is constantly changing.

CAM Practice: Relations with Biomedicine:

Health practices, conventional and non conventional, are neither monolithic nor homogeneous and how they are perceived, accepted, and represented changes over time. For example, in 2005 a study on the coverage on CAM in five US medical journals showed that during the 1960s and 1970s the medical profession condemned CAM but by the 1990s attempts to disparage CAM had been abandoned (Winnick 2005). In this review the literature suggests that there is greater acceptance of CAM within the UK and European Community than is evident in Canada and the United States. Although current research indicates that the conventional medical community is becoming more supportive of certain kinds of alternative practice, the types of practice, and the kind of support, varies across groups, regions, and countries. As well, much of the research focus has been on the medical profession's reaction to CAM practices, CAM practitioners, and patient use of CAM.

The selective adoption of CAM by the conventional medical profession is largely supported in the literature. In other words, current research suggests that although doctors

are adopting and/or supporting CAM use, this only extends into specific practices (Adams 2004; Cant and Sharma 1995; Fadlon 2004; Goldner 2004; Hollenberg 2006; Kelner et al. 2004b; Saks 2001; Tovey and Adams 2001; Tovey, Easthope and Adams 2004; Verhoef and Sutherland 1995). Evidence also suggests that a similar trend is occurring in nursing (Adams and Tovey 2001; Tovey and Adams 2002; Tovey and Adams 2003; Tovey, and Bourgeault 2008; Shuval 2006). Saks (2001) refers to this as 'limited incorporation'.

In Canada, Verhoef and Sutherland (1995:105) surveyed 200 general practitioners in Alberta and British Columbia. While more than half supported the use of some practices including acupuncture, chiropractic, and hypnosis only sixteen percent of the participants actually practiced forms of alternative medicine. A variety of factors were found to impact referral and practice patterns. Referral patterns were influenced by "province of practice, place of graduation, training in alternative approaches, the number of alternative approaches perceived useful, and attitudes toward alternative medicine...Sex, age, type of practice, training in alternative medicine, referring to alternative practitioners, the number of alternative approaches perceived useful, and attitude toward alternative medicine" influenced whether a physician practiced alternative therapies.

A more recent national survey of 13,088 Canadian physicians also showed that organizational settings, such as hospitals, discourage physicians from offering CAM (Hirschkorn, Andersen, and Bourgeault 2009). Hirschkorn et al. (2009) found that region and place of training were related to whether CAM was used and practiced amongst

family physicians. Doctors in British Columbia were more receptive to offering CAM services than physicians in other provinces and doctors who trained in French- language medical schools in Quebec were the least inclined to do so Hirschkorn et al. (2009).

Adams (2004) conducted interviews with twenty-five general practitioners in Edinburgh and Glasgow who used CAM therapies, including acupuncture, homeopathy, hypnotherapy, and neurolinguistic programming. He found that the doctors both denigrated lay therapists and appropriated their practices.

In contrast, some research supports the idea that family physicians are more receptive to CAM than specialists. Kolstad et al. (2004) examined the use and effects of CAM on a group of oncology health workers in Norway. The sample included eight hundred and twenty-eight Norwegian oncologists, nurses, clerks and therapeutic radiographers. These researchers found that few oncologists had tried CAM compared to the other health care worker groups. The most popular forms included acupuncture, homeopathy, aromatherapy, and massage therapy. Differences in use were dependent on gender, profession, age, and religion (Kolstad et al. 2004).

Adams and Tovey (2001) argue that nurses have been intricately involved in adopting CAM practices in the UK but point out that they are also selective in the therapies that they choose. For example, in their investigations they found that nurses favor aromatherapy, reflexology, and massage over chiropractic and acupuncture. These kinds of therapies are not the types that the medical profession seems interested in adopting. The salience of this is exemplified in a qualitative study of nurses working in both biomedical and CAM settings in Israel. In this research, Shuval (2006:1784) argues

that the adoption of CAM practices by nurses does not challenge biomedicine and that the nurses are constrained by a medical profession that keeps "the boundaries of biomedicine closed". The adoption of different sets of therapies by doctors and nurses suggests that more traditional divisions of labor persist despite signs of some reconfiguration in 'conventional' health professional scopes of practice. The implications for non-health professional CAM practitioners are more precarious.

Tovey and Adams (2002: 14) discuss CAM use and practice by nurses in the UK and indicate that the implications of this phenomenon for non-health professional practitioners are uncertain. They state: "this relationship is potentially complex. For example, the appropriation of therapies and the authenticity of providers are essential to the strategies of these groups and long-term viability of CAM provision by them. The desired end points may or may not be compatible."

Alternatively, despite public demand and growth in interest, CAM remains foreign to some health care professionals. Brown et al. (2007) surveyed health professional attitudes toward CAM in a tertiary care center in Nova Scotia, Canada. They found that health professionals are supportive of the use of selected therapies by patients even though they reported having limited knowledge about CAM, were uncomfortable talking about CAM, and rarely asked patients if they used CAM. Health professionals were found to be supportive of CAM in both Brown et al. (2007) and Hirschkorn et al.'s (2009) studies. Hirschkorn et al.'s findings also indicated that physicians in Atlantic Canada are no less likely to offer CAM services than doctors in other provinces.

CAM USE

CAM Utilization Trends

Similar to people in other countries, Canadians are drawn to CAM. Trends showing the increased use and out of pocket spending on CAM in industrialized countries are well documented (Bodeker, Kronenberg and Buford 2007; de Bruyn 2002; Furnham and Vincent 2000; Eisenberg et al. 1998; Ernst and White 2000; Kitai et al. 1998; MacLennan et al 1996; Millar 2001; Sharma 1992; Thomas et al. 2001; Wiles and Rosenberg 2001; Zollman and Vickers 1999). It is now estimated that over 70 % of Canadians have used some form of CAM (Esmail 2007; Bodeker et al. 2007) and despite recent reports that the rapid growth in the CAM industry has reached a plateau (Esmail 2007, Tindle et al. 2005; Kelner 2005) there are strong indications that the business of CAM continues to thrive (Andrews and Boon 2005). More than one half of Canadians used alternative therapies in 2005 and spent more than $5.6 billion out of pocket just on visits to alternative care practitioners; this is double the reported spending in 1997 (Esmail 2007). According to Esmail (2007:4) the most commonly reported CAM therapies were "massage (19%), prayer (16%), chiropractic care (15%), relaxation techniques (14%) and herbal therapies" (10%).

There are no national statistics that reflect the utilization of Reiki practice in Canada. In a 2005 survey of CAM use by breast cancer survivors in Ontario it was found that 4.9% of the 541 respondents used the services of a Reiki practitioner. Reiki ranked third after massage therapy and nutrition therapy (Boon et al. 2007). In the US, the 2007

National Health Interview Survey reported that more than 1.2 million adults had used an energy healing therapy, such as Reiki, in the previous year (NCCAM 2008).

CAM Utilization Profiles

Research on the use of CAM has shown that Canadians use complementary and alternative medicine (CAM) for a myriad of reasons (see Boon et al. 2000, 2007; Coulter and Willis 2007; Furnham 2007; Furnham and Vincent 2000; Kelner and Wellman 1997a; Low 2004; Millar 1997; Pawluch, Cain, and Gillett 1994). Most studies agree that individuals use CAM to cope with chronic illness, prevent illness or to improve health and well-being (Adams, Easthope and Sibbrit 2003; Astin 1998; Barnes et al. 2004; de Bruyn 2002; Foot-Ardah 2003; Goldstein 2000, 2002; Kelner and Wellman 1997a; Low 2004; Pawluch et al.1994; Wiles and Rosenberg 2001; Testerman et al. 2004). Middle-aged, affluent, well-educated, white women are noted to be the highest users of CAM (Adams Easthope and Sibritt 2003; Astin 1998; Ernst 2000; Kelner and Wellman 1997b; Park 2005; Wiles and Rosenberg 2001). Alternatively, some US studies indicate that there are no racial or gender differences (Astin 1998) in the use of alternative medicine and some Canadian findings suggest that CAM use in Canada is not necessarily confined to the 'highly educated and affluent' (Andrews and Boon 2005:22). There are also some obvious exceptions within specific patient populations such as in patients with prostate cancer (White and Verhoef 2006) and the HIV/AIDS population (Pawluch et al. 1994; Foot-Ardah 2003; Gillett et al. 2002). Despite these differences, studies overwhelmingly indicate that the typical users of CAM are affluent, well educated women who use CAM to manage chronic illness and/or to maintain health and well- being.

In a study carried out in Toronto during the later 1990's similar patterns in Reiki use were noted. In a research project conducted in Toronto between 1994-1995, Kelner and Wellman (1997a, 1997b) examined the profiles and motivations of three hundred patients seeking care from five different CAM practitioners; chiropractors, acupuncturists /traditional Chinese doctors, naturopaths, Reiki practitioners, and family physicians. Of the sixty respondents visiting a Reiki practitioner, eighty-five percent were women, and most were well-educated, high income, Anglo Saxon, Canadian, and middle- aged. The Reiki respondents were the only group which emphasized health maintenance and prevention as a reason to seek help and more than a quarter reported using Reiki principally for emotional issues and self-development. This was markedly higher than for family medicine patients, many of whom also sought care for emotional problems. Fewer Reiki users rated their health problems as serious and more of these clients, compared to other groups, worked in the arts or as alternative practitioners. Nearly half stressed the importance of spirituality in their lives which was higher than other users and close to half reported no religious affiliation.

Ideology/Beliefs/Values: push and pull

The notions of 'push' and 'pull' have been used to capture the reasons that people are attracted to CAM (Astin 1998; Foot-Ardah 2003; Furnham and Vincent 2000, Pawluch et al. 2000). Generally speaking, people are said to be pushed toward CAM because they are dissatisfied with conventional medicine (Astin 1998) or because they are dissatisfied with the 'medical encounter' and/or 'doctor–patient relationship' (Siapush

1999:160). People are also pulled toward CAM because treatments are compatible to their world views and personal health beliefs (see Astin 1998; Siapush 1999).

The rise in popularity of CAM has been attributed to wider socio-political changes (Sharma 2000; Sointu 2006a) sometimes framed in terms of postmodern values (Coulter and Willis 2004, 2007) and postmodern consumer behavior (Saks 2001). For example, postmodernism has been described as an era where consumption is pervasive (Bury 1997), and shared meaning is replaced by individualism (Annandale and Clark 2000:54, 55). This tendency is intimated in an ethnographic study of spiritual healers in a center in the north of England (McClean 2005). McClean (2005:628) considers some of the debates prevalent in CAM scholarship; that CAM is an individualistic approach to health and illness and that by emphasizing self-responsibility there is a tendency to blame the victim. These were key themes identified in his research. He concludes that responsibility for health is illustrative of "the subjectification and personalization of public life"; in other words, toward increasing individualism in society.

There is little consensus as to whether CAM use is a reflection of postmodern values. Nevertheless, the notion of an 'alternative world view' with respect to CAM use is widely mentioned in current literature. For example, in a qualitative study of individuals with AIDS, Pawluch et al. (2000) contend that CAM use in this population is based on an 'alternative therapy ideology'. This encompasses defining illness as a chronic condition, a commitment to being proactive and taking a preventative approach to personal health, a holistic understanding of health as physical, mental, emotional and

spiritual well-being, an openness to trying whatever therapies are available, and an emphasis on self- responsibility in decisions about health.

More recently, in Low's (2004) qualitative study of twenty-one CAM users in the Hamilton area her main finding was that the participants held a holistic perspective that encompassed holism, balance, and personal control. She argued that this view influenced participants' reasons for accessing therapy, their client /practitioner relationships, and the specific kinds of therapy that they used.

While personal control over health has been emphasized in some research (Furnham and Vincent 1995; Low 2004; Wiles and Rosenberg 2001) studies have also pointed to the salience of self-responsibility in relation to CAM use (Glik 1990; Lowenberg 1989; McClean 2005; Pawluch et al. 1994). Further, while some of the literature accentuates self-responsibility as a uniquely Western value (McClean 2005; Sointu 2005) others have pointed out that "the idea of individual responsibility is not uniquely Western." (Pawluch et al. 2000:254). Notably, aboriginal peoples also emphasize the importance of self-responsibility in health care decision making processes (Pawluch et al. 2000). Other sociologists argue that both ideology and pragmatism play a role in making decisions about CAM use (Sharma 1992).

In a recent systematic review of ninety-four CAM studies, Bishop, Yardley, and Lewith (2007) identified a number of beliefs associated with CAM participation. These included: active coping styles, belief in personal control over health, and belief that psychological and lifestyle factors contribute to illness. CAM users valued natural holistic approaches and viewed themselves as 'unconventional' and 'spiritual'. Therefore,

the literature suggests that complementary therapies are related to spirituality in so far as this notion is part of broader value orientations that embrace holism (Astin1998; McClean 2005; Low 2004).

It has also been documented that some users become so enamored with holistic approaches that they decide to train as practitioners (Low 2004). This suggests that the reasons for training in CAM practices mirror those of CAM utilization. As already indicated beliefs and values are closely intertwined. In contrast, it is also recognized that there may be important differences between groups of CAM users and numerous pathways to use (Bishop et al. 2007). In part, this explains the extensive variability in findings presented in CAM studies (Goldstein 2002; Boone et al. 2004; Hirschkorn and Bourgeault 2008; Bishop et al. 2007). Further, these diverse findings reinforce the idea that users and practitioners are heterogeneous in their world views (Pawluch et al. 1994) and share beliefs common to non users/practitioners (Fadlon 2004; Goldstein et al. 1987; Pawluch et al. 2000).

Experience of CAM Use

The experience of CAM use cannot be divorced from the meanings attached to health, illness and disease. Disease refers to an abnormal functioning of organs or organ systems or a pathological state of the body, whereas illness refers to the one's experience of being sick (Blaxter 2004; Charmaz 1991).The notions of health and illness encompass a wide spectrum of conflicting and contradictory events and experiences that are wrought with tensions and uncertainty (Charmaz 1991). CAM therapies offer the ill tools for managing their illnesses (McGuire 1988). Interestingly, studies that have examined the

experience of CAM users have identified two key yet somewhat contradictory themes: personal empowerment and social stigma.

CAM healing approaches have been found to have transformative potentials that entail changes in perceptions of health and illness and or perceived changes in health (Glik 1986, 1988, 1990; McGuire 1983, 1987, 1988; Low 2004; Pawluch et al. 2000). In Sointu's (2006b:498) study, participants turned to CAM therapies because they found them to be 'empowering' and through these encounters received 'recognition' for life concerns and validation for their experiences and values. Sointu argues that changes to identity occur through the use of CAM practices. They "allow for experiences of profound change, interpreted and even experienced as the responsibility of the person, seen as a means of self-fulfillment and understood in terms of interconnectedness of the mind, the body and even the spirit" (Sointu 2006a:218-219). With respect to identity she discovered that participants believe well-being is achieved through introspection and understanding of 'one's inner core' (Sointu 2006b:498). Despite this, Sointu concluded that CAM use is not 'culturally valued' and this signifies "inferiority, exclusion and invisibility". She refers to this as 'biomedical misrecognition' (Sointu 2006b:498).

Low (2004) found that in healing through CAM participants sought to transform themselves by creating a "new sense of self which they perceive as healthy" (Low 2004:93). She also posits that interviewees were able to perceive themselves as healthy because they were engaged in a 'process of healing' (Low 2004:3). Over time, some of the participants adopted a 'healer identity'. This process came about through use and training in various healing modalities. Others noted changes in their personalities, such as

having more confidence, or being less worried. Still others claimed that their value systems and/or priorities concerning health had changed.

In contrast, in her studies on CAM users in Canada 2004 and in the UK in 2005 Low also notes that CAM users are labeled deviant and despite the reported positive benefits from the therapies participants often felt stigmatized because of their participation in CAM. To manage the stigma associated with CAM participants used a variety of strategies; for example, they avoided certain therapies, practitioners, or therapeutic environments that they perceived lacked legitimacy. Aside from distancing, participants used various psychological projection and/or displacement strategies in their retrospective accounts. Low argues that these techniques allowed participants to preserve a positive self-image.

Interestingly, in a qualitative study of people with HIV Foote-Ardah (2003) found that the use of CAM was a strategy that participants used to reduce the stigmatizing effects of their illnesses. Using Siapush's (1999) idea of push and pull factors she concludes that participants were pushed from conventional medicine due to a negative attitude toward medications and dependency on care and pulled toward CAM because of positive attitudes towards these practices. She further notes that these findings support an earlier study of CAM among HIV patients (see Pawluch et al. 2000).

In a recent Australian qualitative study of cancer patients and their use of CAM Broom (2009:71) found that despite the liberating and positive effects that participants experienced with CAM there was a tendency for an over reaction to the imperative of 'positive thinking' that was detrimental to some patients already compromised by their

illness situations. There is an expressed need for more studies on the experiences of people with chronic illness (Broom 2009; Foote-Ardah 2003; Low 2004).

Summary of Reiki Literature

While I have incorporated into this review references to Reiki where they exist, in this final section of the chapter my aim is to isolate what the sociological literature has to say about this particular form of CAM. First of all, similar to other CAM modalities, classifications of Reiki are problematic and these tend to differ between countries and across contexts. For example in the United States, the National Center for Complementary and Alternative Medicine's (NCCAM 2008) classification of energy medicine differs from Canada's (Tataryn 2002) and within countries taxonomies and definitions may differ depending on scholarly focus (Kaptchuk and Eisenberg 2001; Low 2005). This has contributed to the inconsistent findings in studies that try to track the prevalence of particular forms of CAM. Definitions and classifications also change over time in accordance with social and political changes. As Kaptchuk and Eisenberg (2001) note, what was unconventional yesterday may be conventional today. Reiki is but one example of a modality that has been framed and named in different ways. For example Reiki has been classified as a 'pseudoscience' by the medical profession (Wardwell 1994), a 'New Age' healing practice by religious scholars (Levin and Coreil 1986; Kaptchuk and Eisenberg 2001), a non-medical healing practice (McGuire 1988; Glik 1990), and is currently being constructed as 'bio-field energy medicine' (NCCAM 2008).

The classifications of Reiki by the medical profession and other social scientists tend to fuel the denigration of Reiki and similar practices within biomedicine (for

critiques of CAM see Ernst 2008). Opponents of CAM claim that practices such as Reiki have no scientific basis and therefore have no legitimate place in 'mainstream' healthcare (Charlton 2008). In the single Canadian study that considered Reiki and biomedical relations the researchers found that health professionals had little interest in adopting Reiki as a practice. The main exception was nurses who were found to be the most receptive to including Reiki therapy within their professional scope of practice (Kelner et al. 2004a).

The literature also suggests the Reiki practitioners are not interested in the 'conventional' professionalization route in order to gain public legitimacy. For example, Kelner et al. (2002a) found that the Reiki practitioners they studied felt no need to prove the efficacy of their approach and that they considered Reiki practice to be safe. Similarly, key stakeholders in a variety of health professions in Toronto were equally opposed to the professionalization of Reiki practitioners, as were provincial government officials (Kelner et al. 2004b). Although professionalization is important in gaining social legitimacy and raising occupational status, it nevertheless represents only one form of public legitimacy and one route to recognition in mainstream health care. With little evidence to support a quest for professionalization within this community of practitioners my approach to studying this group demanded that I look beyond the issue of professionalization.

The profile of Reiki users is similar to other CAM users (Kelner and Wellman 1997a; 1997b). People who use Reiki have been found to be interested in health promotion, self development, and spiritual growth (Glick 1990; Kelner and Wellman

1997a, 1997b; Heelas 2007; McGuire 1988) and are often linked to the New Age Movement (Levis and Coreil 1986; Heelas and Woodhead 2005; Voas and Bruce 2007). Other studies indicate that chronic illness is implicated in the use of Reiki (Pawluch et al. 2000; Foot-Ardah 2003; Low 2004). There are also mixed findings regarding stigmatization in relation to practice and use (Foot-Ardah 2003; Low 2004). Positive effects of Reiki have been noted by users of Reiki (Pawluch et al. 2000; Foot-Ardah 2003; Low 2004) and the possibility that Reiki may have potential transformative effects has also been suggested (Pawluch et al. 2000; Low 2004). Some sociologists have directly linked this to the power of healing through religious rituals (McGuire 1988; Glik 1990).

Conclusion

Compared to other forms of CAM, Reiki has attracted little sociological attention. While the studies that have been done provide important insights these remain few in number and limited in scope. For example, the findings on the social history of Reiki are short and purely descriptive accounts and there is no documentation on how the practice is socially organized (see Chu 2004; Engrebretson 1996; Gilberti 2004; Shankar and Liao 2004; Wetzel 1989). Most of what is known about Reiki in Canada is focused on the professionalization issues of CAM groups. These studies, while important, do not capture what is happening in communities of practice where the majority of practitioners show little interest in pursuing this route. Finally, research that contains information on Reiki use and experience is minimal and has produced varied findings (Foot-Ardah 2003; Glik 1990; Heelas 2007; Kelner and Wellman 1997a, 1997b; Low 2004, 2005; McGuire 1988

Pawluch et al. 2000; Voas and Bruce 2007). This speaks to the heterogeneity of users and the complexities associated with practice and use of CAM. To date, no in-depth sociological study on the practice of Reiki has been conducted. The areas of enquiry explored within this dissertation serve to address these gaps in the literature. My analyses draw upon social worlds theory to which I now turn.

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[1] The term allopath was coined by Samuel Hahnemann, the founder of homeopathy. He used the expression to differentiate physicians who practiced in accordance with his homeopathic philosophy of 'vitalism'.

[2] Between the 1960's and 1990's CAM practices were commonly referred to as 'holistic medicine', 'folk medicine', 'traditional medicine' or 'alternative medicine' (Low 2004:12). To capture the breadth of consumer interest in 'non conventional' approaches to healing the term 'CAM' was introduced by researchers in the early 1990's (Kelner et al. 2000). The underlying rationale was that 'alternative medicine' was used more as an 'adjunct to' rather than a 'replacement for' conventional medical care (Micozzi 2006: 9). What were once considered 'alternative practices', such as naturopathy and homeopathy are now more commonly referred to as 'complementary' (Sharma and Black 2001). There is no general consensus amongst CAM researchers as to what terminology is most appropriate. The expressions that are used may be intended to broadly and residually capture any health treatment, product, modality or system of medicine that does not fall under the jurisdiction of the conventional medical profession. For example, in 2001, Health Canada introduced the acronym to complementary and alternative health care (CAHC) to capture the myriad of approaches to health and healing (Low 2004). Alternatively, the language employed is often context specific and influenced by researcher perspectives and interests (Low 2004; McGuire 1988; Glik 1990).

[3] During this time CAM healers were not the only practitioners classified as subordinate to biomedicine. Some groups, however, fared better than others in achieving professional autonomy and status. For instance, dentists were quite successful in achieving professional status and have maintained a 'parallel status' with the medical profession, albeit within a narrower or more' limited' scope of practice than physicians. Nurses, however, were not as fortunate (Wardwell 1994). They still bear the classification of 'ancillary', meaning 'handmaiden' or para-professional and are classified as subordinate because their work is controlled by the medical profession (Wardwell 1994). 'Marginal' practitioners such as those described above are viewed as a threat to allopathic practice because they function independently from medicine and are able to prescribe and treat patients within their specific practices (Wardwell 1994).

Social Worlds Theory

My analysis of Reiki is theoretically informed by SWT. According to Strauss (1978:121), social worlds come in many shapes and sizes and may be rigidly or loosely configured. Key to any social world is the network of communication that is formed through activities, technologies, discourses, symbolizations, memberships and/or organizations (Strauss 1978:121). These varying permutations constitute constantly changing environments with fluid boundaries. People tend to hold memberships in multiple social worlds and often display varying levels of commitment to each.

In this chapter I lay out the basic tenets and concepts of SWT. Since the approach is rooted in the broader interpretive tradition of symbolic interactionism (SI), I begin by highlighting the SI premises that influenced how Strauss theorized social worlds. Next, I explain SWT and then more fully elaborate on the central concepts that frame my dissertation. These include the notions of "segmentation", "boundary objects" and "intersection". I then briefly outline additional social world concepts that are pertinent to my analyses. Next, I consider applications of SWT in recent studies. I conclude with a brief description of how the three central social worlds concepts inform my analysis chapters.

SI Roots

Strauss and others instrumental in the development of SWT were very much influenced by the University of Chicago style of SI. Historically, four sub-traditions impacted the development of this perspective. The first is German hermeneutics or interpretive understanding. The second sub-tradition is pragmatism, which emphasizes

human agency, morality, and a practical approach to understanding social life through empirical research. The third is the method of "sympathetic introspection". This is an empathetic approach aimed at uncovering the meanings and interpretations of research participants. The fourth is face to face ethnographic research as developed at the University of Chicago (Prus 1996).

The name most closely connected to the development of SI is George Herbert Mead (1863-1931). He was a social psychologist and philosopher who taught at the University of Chicago from 1894 until his death. Mead stressed (1934) the subjective meaning of human behavior, social processes, and pragmatism. He is best known for his work on the nature of the self and intersubjectivity, which refers to how individuals relate to one another. His philosophical and theoretical groundwork laid the basis for what would ultimately be named symbolic interaction.

Herbert Blumer (1969) coined the term symbolic interaction in 1937. Drawing on Mead's work he outlined the three defining premises for SI: that people act toward things based on the meanings that they attach to them; that meaning comes about through social interaction with others; and that meanings are revised and changed through the interpretation of these encounters. Anselm Strauss (1916-1996) was a student of Herbert Blumer and became fully trained in the Chicago school tradition during his graduate studies at the University of Chicago.

Strauss completed his Masters degree and PhD at the University of Chicago during the 1940's. With training in pragmatist philosophy and social psychology he became a faculty member at the Chicago School in 1954 (Atkinson 1997:367). Although

Strauss' career at the Chicago university was short (he left in 1958), he went on to teach Chicago style sociology the University of California, in San Francisco and taught and trained graduate students in this tradition. He researched and wrote extensively on both theory and methods and was an esteemed medical sociologist (Maines 1991). His work encompassed health professions, issues related to chronic illness, death and dying, and focused on both identity and the social organization of contemporary life.[1] Throughout his long career Strauss remained committed to the central tenets of the SI perspective and was particularly concerned with developing theoretical concepts and capturing social processes.

SWT retains the basic premises of the SI tradition. SI principles, central to this study include the inseparability of the individual and society and a concern for the actions, interactions, and processes of meaning making that jointly structure and guide individual and group behaviour (Blumer 1969). Other core assumptions are that social life is interpretive, reflective, negotiable, relational, and processual (Blumer 1969; Prus 1996, Strauss 1993). Social structures evolve through interactions between social actors (Blumer 1969). In other words, structure is a fluid process that is contingent on the individual/collective actions of people. Also central to the SI approach is the subjective interpretation of actors as well as the processes that shape change and maintain social order. While early interactionists concentrated on the former, as did Strauss, his followers more centrally consider the latter (Clarke 2005).

Social Worlds Theory

SWT is concerned with the processes of social order and social change and is but one analytic approach developed within the late Anselm Strauss' broader theory of action (see Strauss 1993). In 1978, Strauss published his initial work on SWT and described how this theory was informed by George Herbert Mead's ideas. The concept of a social world is rooted in Mead's concept of a 'universe of discourse' (Clarke 2005; Strauss 1993). Mead (1934: 269) defined this concept as "set of significant symbols which have a universal meaning" or common collective understanding. He further explained that there are different "universes of discourse" or multiple sets of collective meanings:

> *Back of all, to the extent that they are potentially comprehensible to each other, lies the ...universe of discourse with a set of constants and propositional functions, and anyone using them will belong to the same universe of discourse. It is this which gives a potential universality to the process of communication* (Mead 1934: 269).

In other words, in the process of communication, core meanings underpin and allow for shared collective understandings. Through "universes of discourse" individuals come to relate to a "larger social context or environment of social relations and interactions which surround it" (Mead 1934: 269). This supports the idea that common forms of communication within and between groups have no clear boundaries and are not "tightly organized" (Wiener 1981:13). In exploring the concept further, Strauss drew on the work of Tamotsu Shibutani.

Shibutani (1978:524) described "social worlds" as "culture areas" that lack formal membership, are not geographically circumscribed, and where individuals simultaneously take part in multiple communication networks. Boundaries, he argued, were determined

by the limitations of "effective communication". Wiener (1981:13) captures Shibutani's depiction of social worlds as follows:

> *Shibutani drew upon the earlier image of Simmel, depicting each individual as standing at that point at which a unique combination of social circles intersect. Our language reflects this understanding: expressions such as 'we come from different worlds', 'we are worlds apart,' he bridges different worlds' are commonly used. It is readily apparent that 'society' breaks itself down into worlds by people's own definition of who they are and what they do.*

The development of SWT was spurred by Strauss's (1993:209) interest in the nature of "contemporary society, how it can best be conceptualized, talked about, and studied." Interestingly, Strauss himself never provided a precise definition of how he understood social worlds. Much of his work revolved around outlining the features and processes constitutive of social worlds. The empirical work of his graduate students played a central part in the grounding of his theory.

Kling and Gerson (1978:26) were notably the first of Strauss's followers to define a social world as "a set of common or joint activities or concerns, bound together by a network of communication". Such groups were described by David Unruh (1981) as "an extremely large, highly permeable, amorphous, and spatially transcendent form of social organization" (Unruh 1981:20). Unruh contended that social worlds often give the impression that they are "relatively weak disjointed, and amorphous authority structures"; however, they characteristically have "multiple authority structures" (Unruh 1981:26). He argued that the "primary basis for [a social world] social organization radically differs from those which bind conventional forms of social organization" (Unruh 1981:19) and pointed out that some social worlds rely more on 'cognitive identification' than "formal membership, rational-bureaucratic lines, and innate or ascribed traits" (Unruh 1981:20).

Similarly, Strauss (1997:164) posited that "the central feature of social worlds is not their tightly knit nor extensive organization; just the opposite, for they are characterized by their looseness or diffuseness".

In his application of the social world concept, Unruh (1979, 1980, 1981) stressed the idea of "dispersiveness". A dispersive world has an undetermined number of participants. It is also spatially diffuse but includes actors, organizations, events, and practices and is "inevitability a mosaic of subworlds in which face to face interaction may occur with great frequency" (Unruh 1980:289). Subworlds are illustrative of social world organizations, associations, formal volunteer or interest groups, and individual actors who are conceived to be part of smaller local group networks that comprise "social circles" (Unruh 1981:65).

A decade later, sociologist Adele Clarke, a former student of Strauss, came to define social worlds as "groups with shared commitments to certain activities, sharing resources of many kinds to achieve their goals, and building shared ideologies about how to go about their business" (Strauss 1991:131) Further development of the concept and applications of the theory have largely involved formal organizations (see Adams 2001, 2004; Clarke 1991, 1997, 1998; Clarke and Casper 1996; Clark and Montini 1993; Miall and Miall 2002; Sanders 2007; Timmermans and Leiter 2000; Tovey and Adams 2001, 2002, 2003).

Social Worlds Concepts

While I have broadly described SWT as Strauss originally formulated it, in this section I present the central concepts that I employ in my analysis of Reiki. These include 'segmentation', 'boundary objects', and 'intersection'.

Segmentation

Segmentation refers to a process wherein particular groups come to differentiate themselves from other groups. Strauss (1978a) attributed this idea to George Herbert Mead. In segmenting, "groups emerge, evolve, develop, splinter, disintegrate, pull together, or parts fall away" (Strauss 1978a:234). Elaborating on the concept, Kling and Gerson (1978:26) describe the process as "the pervasive tendency for worlds to develop specialized concerns and interests within the larger community of common activities, which act to differentiate some members of the world from others". Strauss contended that one of the most salient characteristics of a social world is its "inevitable segmentation or differentiation into *subworlds*" (Strauss 1993:215).

Segmentation Subprocesses

Segmentation subprocesses refer to "how subworlds originate, evolve, maintain themselves, distinguish themselves from others, and break apart in further segmentation, decline and/or vanish" (Strauss 1993:215). Subprocesses are specific sets of activities. As outlined by Gerson (1983:361) these include: *forming the subworld* by establishing a distinct set of activities and recruiting members; *defining and differentiating core activities* of the subworld from other groups; *writing and rewriting history and or*

philosophy of the subworld to position founders and forerunners in their appropriate historical place; and *debating and manoeuvring* with respect to various issues (arenas) that the subworld is engaged in; and competing for resources that include "funds, recruits, respectability, and audiences". These are all processes that I examine in my analysis of the social history of Reiki (see Chapter Four).

Routes of Segmentation

Strauss described *avenues or routes* through which subsocial worlds develop. "*Splitting off* or *splintering* occurs when ideological differences between actors become "competitive or antithetical". As I illustrate in chapter four, ideological splitting off or splintering was the central route through which the segmentation of this social world occurred in North America in the 1980's.

Sources of Segmentation

A variety of "sources" or conditions may precipitate the process of segmentation (Strauss 1984:125; also see Unruh 1981). In chapter 4, I highlight how ideology and globalization are conditions that affect the complexity and speed of segmentation.

Boundary Objects

I use the concept of "boundary objects" in my analysis of the core ideology and operational philosophy (ideas and procedures) of practitioners at local levels of practice. Before describing what a boundary object is I will first explain the concept of an object. A symbolic interactionist understanding of the idea of objects is important because the concept is a precursor to Star and Griesemer's conceptualization of "boundary objects" in SWT (Star and Griesemer 1989). The SI tradition assumes that the world is comprised of

objects which are symbolically produced through social interaction. Blumer (1969:10) explained that:

> *The worlds that exist for human beings and for their groups are composed of 'objects' and that these objects are a product of symbolic interaction. An object is anything that can be indicated, anything that is pointed to or referred to- a cloud, a book, a legislature, a banker, a religious doctrine, a ghost and so forth.*

Blumer identified three categories of objects: physical objects, for example a chair; social objects such as people; and abstract objects like moral principles, philosophical doctrines or ideas such as compassion. As Hewitt (1994:61) notes "people live in, pay attention to and act toward a world of objects". These are not necessarily material things that we can see and touch (Hewitt 1994:61).

"Boundary objects" are described by Star and Griesemer (1989) as abstract ideas or concrete entities that hold diverse meanings in different social worlds. Although an object is anything that an individual/group acts toward (Blumer 1969), a boundary object is based on two additional premises; one is that even though an object may hold multiple meanings, the structure of the object is common enough to more than one social world to be " recognized as a means of translation" (Star and Griesemer 1989:393). The other assertion is that "boundary objects" bring social worlds/subworlds together in consensus and/or cooperation.

In what is now described as a classic Science, Technology, and Society paper, Star and Griesemer (1989) argued that boundary objects are things, either concrete or abstract, that exist at junctures or boundaries and crosscut different social groups of varying cultures (Law and Singleton 2005:334). These objects are flexible because they hold "multi–interpretable" meanings but are also consistent enough to be recognized by different social groups (Law and Singleton 2005:334). Star and Griesemer also stressed

that a boundary object, despite its flexibility, demands consensus and/or cooperation when groups meet over an issue of concern. The "basic social process is translating the object" to uncover the varying interpretations and demands of the different groups involved (Clarke 2005:50-51). In their analysis, Star and Griesemer (1989) illustrated how a group of actors in a zoology museum, despite their varied interpretations of animal specimens, worked collaboratively to develop a standardized classification system. Allen (2009:355), in her work on a health care management tool, also reinforces the idea that a boundary object commands collaboration between actors.

> *A boundary concept is a loose concept, which has a strong cohesive power. It is precisely because of their vagueness that they facilitate communication and cooperation between members of distinct groups without obliging members to give up the advantages of their respective social identities.*

In my study, the sensitizing concept of a "boundary object" is especially helpful in explaining how people can hold varied, contradictory, and shifting beliefs yet remain part of the same social world (see chapter 5).

Intersection

According to Strauss, intersecting processes are *not* "intersections of intersectional relationships" such as gender, ethnicity and/or class in relation to energy healing but refer to patterns or "sets of events as invading, defending, allying, cooperating, competing, borrowing, migrating from and into, fusing" (Strauss 1984:137). Therefore, local practitioner involvements are 'intersections' that mirror the strategies that they use to gain authenticity or "trustworthiness" and to carve out legitimacy; that is, a "deserved place" in the health service industry (Strauss 1982:175).

Intersections, "vary in intensity, duration, and significance" and one of the most important consequences of intersections is that they "foster the knitting together of sections of society in co-operative (if sometimes reluctant or temporary) action" (Strauss 1993: 217). Varying degrees of receptivity, understanding of Reiki, and opposition from other members of other social world segments create challenging conditions for practitioners involved with this social world.

Intersecting processes occur between different social world and subworld groups and/or actors with respect to their specific activities. Strauss (1984:137) maintained that segmentation or differentiation processes are directly linked to the intersection of social world segments or social subworlds and that one set of processes reflects the other. This means that "sometimes a given process can be one of the important conditions or consequences of a process from the other set". He also argued that in any study we may choose to foreground one but that the analytic presence of the other should not be ignored. Hence, a major analytic task of SWT is to *uncover the intersections* and "to trace the associated processes, strategies and consequences" (Strauss 1978a:237) that occur at these junctures (see chapter 6).

Additional Concepts

According to Strauss's theory there are other interrelated processes that are relevant to the analysis of any social world. These include *legitimacy*, *authenticity* and *arenas*. Legitimacy refers to how groups and their activities are distinguished, evaluated, and accepted or rejected within a social world and/or subworlds. Authentication refers to the processes of building worthiness or trust for an activity. Finally, the idea of an arena,

most simplistically conceived, refers to interactions around 'issues' (Strauss 1978, 1982, 1984, 1993). These are concerns that may or may not produce conflict within and/or between social world segments. The concepts of legitimacy, authenticity, and arenas although descriptively highlighted, do not serve as analytic tools in my analyses. Hence, the generic subprocesses that make up these concepts, for the most part, remain implicit in this exploration.

Previous Applications of Social Worlds Theories

Social worlds and arenas theory has mainly been applied in sociological studies of science and technology and has largely involved former students of Anselm Strauss such as Leigh Star, Adele Clarke, and Joan Fujimura (see Clarke 2005). In Canada, the theory has also been applied to emergency response and information technology systems (Sanders 2007) and to environmental technology (Miall and Miall 2002). Similarly, the concept of boundary objects (Star, and Griesemer 1989) has been recently applied in health management studies Allen (2009), and animal science Marie (2008). While Star and Griesemer's conceptualization is generally highly regarded, it has also been criticised for not fully capturing the complexity of various kinds of boundary objects. For example, in a study of alcoholic liver disease, Law and Singleton (2005) argue that alcoholic cirrhosis is a multiple disease that cannot be adequately represented through this concept.

The application of SWT to the study of CAM is rare (see Adams 2001, 2004; Tovey and Adams 2001, 2002, 2003). The few studies that have used the theory have applied it to the use of CAM by health care professionals in the UK. Tovey and Adams (2001) introduce the concept of "appropriation" which refers to a co-optation or take over

process. The authors use this concept to describe how general practitioners use rhetorical claims to establish the worth of CAM while simultaneously reformulating the practices within a Western conventional model. They then introduce the notion of "weak intersection" which they describe as a lack of collaboration between doctors and CAM practitioners. Through this concept Tovey and Adams explain how doctors distance themselves from CAM practitioners (Tovey and Adams 2001). They further critique how current studies on professions and occupations mainly examine "strong intersections" wherein individuals and groups "collaborate and cooperate to produce a new line of work" (Tovey and Adams 2001:703).

Tovey and Adams (2001) also point to some of the limitations of SWT in relation to CAM research. They specifically critique Strauss's idea of negotiation and argue that it does not adequately address the power differentials between health professional groups; specifically in reference to medical dominance- the dominance of the allopathic medical profession in relation to CAM practitioners. Negotiated order refers to how groups co-construct social structure or social order (Strauss 1993). Strauss argued that this is a fluid process that takes into account both consensus and conflict yet the term 'negotiation' has invited critiques from sociologists who argue that the power relations and hierarchies that exist within and between groups are ignored within this framework (Clarke 2005). Nevertheless, Strauss (1993:250) contended that the concept embraced "negotiation, persuasion, manipulation, education, and actual coercion". It is up to the researcher to uncover the processes that identify power differentials. In keeping with the tenets of the

symbolic interaction approach, as much as possible, one has to bracket as pre-existing assumptions about how power relations determine outcomes.

In 2003, Tovey and Adams shifted their attention to nurses in the UK and examined the rhetorical strategies nurses used to legitimate or authenticate the integration of CAM into nursing practice. They borrowed two additional sociological concepts, one from cultural analyses and the other from examinations of organizations to illustrate how nurses reference the past in the process of legitimation. They introduce the notion of "nostalgia" to describe how some nurses refer to the past as a representation of something better. Further, they use the concept of "nostophobia" to capture how in other instances negative references to the past are coupled with a view that the future offers an opportunity to overcome past constraints. There have been no applications of SWT to specific CAM practice groups.

Conclusion

SWT offers an innovative and flexible approach to analyzing Reiki, and serves my analysis well in several respects. I conceive of Reiki as a social world that has been undergoing a process of segmentation since its initial emergence. I am interested in the distinguishing features of Reiki and fundamental processes that Strauss and other social worlds theorists have drawn attention to and that manifest in the evolution of this practice community. I am fascinated by what unifies diffuse social worlds such as Reiki and attempt to glean insight into this coherency through the concept of boundary objects. I also am concerned with the arenas within which practitioners manage and negotiate their involvements with other social world actors. At the interface of these interactions, the

concept of intersection draws attention to conditions and consequences of participant involvements with this social world. Reciprocally, these conditions create the potential for further segmentation.

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[1] For more detailed accounts of Strauss's contributions see Atkinson 1997; Conrad and Bury 1997; Star 1997.

Methodological Approach

This chapter details the data collection and analysis process involved in this study. I describe how I became involved in this research, the documents I worked with, and how I conducted participation observation. Then, I outline how I recruited participants for the semi-structured interviews, describe the interviews, present the profiles of my study and explain how I analyzed the data. Finally, I point out some of the challenges that I faced during the research process.

Getting Started

> *In 1984 Dr J. [an East Indian physician] was at a monastery in India and he awoke one morning with a severe headache. He felt a surge of energy from the top of his head, down his neck. He was distressed and didn't know what to do, so he poured cold water over his head until his body calmed down. Then in 1991, in Canada a second incident happened, this time lasting three weeks. Finally in 1993, after the third time, the energy remained...He explained this feeling of energy, as not just a surge but a constant feeling of joy and peace. "It's like having a bottle of wine slowly and constantly dripping down through the top of your head" [I thought – lucky him!]* (Field note entry, September 5, 2005)

In the first year of my doctoral program at McMaster University I completed two field work assignments as part of my coursework requirements. For one of these I chose to study people who were interested in self-actualization, through the practice of Kundalini yoga. What I discovered is that people were learning how to become aware of 'kundalini energy' and how to appreciate that this energy is beneficial to health and well-being. For my second project I decided to follow up on the first by again focusing on a group interested in energy as a source of healing. Through one of my professors I was introduced to a Reiki group. I attended a few sessions and ultimately decided to take a 'first degree' or 'level one' course so that I could 'do' Reiki with group members in an

unobtrusive way. My contact with that group ended when the course finished. With comprehensive exams looming, I put aside my fieldwork but knew then that I wanted to make Reiki the focus of my dissertation research.

My research on Reiki began with a broad question, namely how does the practice of Reiki healing shape practitioners and reciprocally how do Reiki practitioners shape the healing practice? This kind of question lends itself best to qualitative research and I chose a multi-method or triangulation approach to uncover what was happening in this social world. Triangulation refers to the use of different methods to address the same question or topic (Morse and Richards 2002:76). In qualitative research, a triangulation strategy "can be attained by combining both interviewing and observations" (Patton 2002:248). I gathered data in the following ways: through public domain documents, participant observation, and semi-structured interviews.

Data Collection

Documentary Data

Once I was able to focus on my dissertation research, I started by collecting as much information on Reiki as I was able to find. This continued throughout the process of putting the dissertation together. I gathered data over the course of the project from Reiki association practitioner websites, You Tube clips on Reiki, open chat rooms, and popular literature including: Reiki books, magazines, newsletters, flyers, and newspaper articles. I began the search by looking at Reiki association websites in English speaking countries. These included Canada, the US, the UK, and Australia. From these sites I followed links to other organizational sites, personal practitioner websites, and public

chat rooms. I chose popular literature that was recommended on websites and through participant contacts. Periodically, I conducted random internet searches for local newspaper articles. I also purchased materials through local bookstores.

Eventually, the content that I looked for reflected historical details, frames of reference, views, and rhetorical claims of individuals and groups involved in the practice of Reiki. These data provided information that participant observation and interviewing did not fully generate and were especially useful in piecing together an understanding of how Reiki practice is socially constructed and organized (May 2001:175). The specific sources augmented information garnered through fieldwork and interviews concerning the history of Reiki and particular branches and styles of practice.

Participant Observation

With clearance from the McMaster University Research Ethics Board in place the involvement of human participants began. I carried out participant observation and interviews over an eight month period between the fall of 2007 and spring of 2008. I began by conducting twenty-five semi-structured interviews in Atlantic Canada. Upon my return to Ontario, I proceeded with active participation in two Reiki sharing groups, one in Hamilton and the other in Kitchener/Waterloo, while simultaneously carrying out semi-structured interviews with twenty-five practitioners in these areas.

I chose these regions primarily because I was concerned with conducting research outside of the city of Toronto, where much of the previous research on CAM, and in particular Reiki, has been conducted. I wanted to focus on areas of the country, such as Eastern Canada, where little research on CAM has been carried out. The choice of

Eastern Canada, and the Hamilton and Kitchener/Waterloo areas specifically was a matter of convenience; I attended university in Hamilton and lived in the Southern Ontario area. I also had connections in Atlantic Canada that made conducting interviews there more feasible.

Participant observation was well suited to gaining an in-depth understanding of practitioners' engagement in Reiki, as it involves interacting with the informants in their natural environment and systematically collecting data in an unobtrusive manner. "Active participation" rather than a "peripheral membership role" (Adler and Adler1987) proved to be the most beneficial way to build rapport and trust among group members. According to Adler and Adler assuming an active role means that the researcher is more than "marginally involved" in group interactions and participates in the "core activities" of the group (1987:50).

As a way to assume full participation, I completed second degree Reiki training in a one on one learning environment with a Reiki teacher. I became familiar with practice techniques and was able to fully engage in group healing activities that involved rituals, active visualization, breathing techniques, positive intention, and group discussions. I found this to be a necessary and effective way to build trust as practitioners are adamant that in order to understand Reiki one must be willing to experience it. Having the training eased my entry into the participant observation settings but also helped in recruiting participants for formal interviews. For instance, one practitioner that I recruited by telephone was initially reluctant to be interviewed but then agreed to participate after she

realized that I had taken Reiki training. She commented that practitioners "usually don't want to waste their energy talking to those who don't get it".

Hamilton Site:

In preparation for participant observation I first made contact with one of the Reiki Masters that I met in 2006. She held weekly Reiki sharing sessions in her home in Hamilton where people who have training in the therapy meet on a regular basis to share in the practice. I enquired about the possibility of doing participant observation with her group and was both relieved and pleased when she agreed. This Reiki Master helped to ease my entry into the group. She set up a meeting that enabled me to meet with group members and present my study to them. The discussion went well. After I addressed a few concerns around privacy of information, the group members consented to my active participation (see Appendix E pp. 218-228). I spent a total of sixty hours doing participant observation with this group. As many as thirteen participants attended a given session but most often a core cluster of between four and ten practitioners, mainly middle-aged women, met on a regular basis.

Kitchener Waterloo Site:

A month after I began participating with the Hamilton group I was still in the process of looking for a second site. I was thrilled when I received permission to take part in the activities of another Reiki collective. I contacted this group, from the Kitchener Waterloo area, through a Hamilton area website listing. In my notes I wrote:

> *I can't believe my good fortune...Although the participant observation in Hamilton is going ok, I haven't received much interest from members of this group in participating in formal interviews and I still have not located another group. I want to find a Reiki sharing group from a different lineage or style. Well*

> *lo and behold, the phone rang. The male voice asked for me, and introduced himself and said he was from Kitchener. He explained that he just received my message, that he had been away for a couple of months but was home now and wondered if I was still interested in having an interview with him. I said by all means. He then asked if I would like to attend a Reiki sharing session, on Friday afternoon; this group meets every other Friday. When I stated that yes I was interested in doing so, he said he would get permission from the group members. When I told him that I had Level 11 Reiki certification he assured me that there would be no problem with me attending. I agreed to meet him at his home in Cambridge and from there we would travel to Kitchener to join the group* (memo Wednesday Nov 7th, 2007)

The initial meeting went well. By the time I left everyone in attendance agreed to my participation in their bi-monthly sessions. Most of them also agreed to being formally interviewed. The key to entry in this group was the Reiki Master who contacted me. He was quite enthusiastic about me joining them and my transition into this group went very smoothly.

I spent twelve hours during November and December 2007 participating with this group. They met for approximately three hours every two weeks. A total of twenty-four practitioners were members but, similar to the group in Hamilton, attendance at any one session varied. As few as six and as many as thirteen practitioners were present at a single gathering. In contrast to the Hamilton group, a male practitioner hosted these sessions and four men regularly participated. As well, five older adults, three men and two women (in the 61-70 age range) attended these gatherings.

I kept a tape recorder with me and on the drive home from Reiki sessions I recorded my thoughts and then transcribed them in a word 'field notes document'. Initially, I wrote in great detail but as time went on I spent less time on writing up notes that did not glean new insights or information. The field notes contained descriptions of

the settings, the participants, my conversations with them about Reiki, and about the information that they shared in conversations with each other. These often contained details about their lives, their families, their jobs, and how they were coping with health issues. In some sessions there was very little talking and in others it was quite chatty. I also recorded my own reflections on the group meetings, recorded questions, and expressed emotions about what I had observed. Many 'a priori' understandings and some biases surfaced but through this reflexive activity I came to accept and look past the particular views of a few participants whose beliefs directly conflicted with my own. The following field note entry exemplifies this:

> *I just finished talking with [one of the practitioners]. She has this notion that people will not be committed to a practice unless they are materially invested in the activity. Individuals will not take responsibility for themselves if they create barriers around the acquisition of wealth, 'abundance' for themselves or resent 'the abundance' of others. 'Elite' attitudes concerning accessibility, affordability, and criteria for master training by some practitioners leave me angry and frustrated.* (Field note memo March 22 2008).

The participant observation proved to be invaluable to the collection of rich data. The experience provided me with a greater appreciation of the life worlds of Reiki practice groups, their dynamics, and activities (Prus 1996; Shaffir and Stebbins 1991).The following excerpts from field notes that I wrote in December 2007 exemplify how I recorded these dimensions:

> *The dynamics between the two groups are distinctly different. The first group has a more rigid approach to the practice and there is a conflicting concern with practicing Reiki in a simple and 'pristine' way while simultaneously "letting Reiki teach you". There are many references made to practicing Reiki correctly and it is common to hear Reiki masters say 'in this form of Reiki we ...' There is less tolerance for practice outside of this style and other practices are more or less considered inferior to or contaminated by superfluous techniques, although individual practitioners do bring their own personal techniques and skills to the*

> *practice; for example, teaching or counseling skills, and additional spiritual exercises such as a Course in Miracles.*

In contrast, I described the second group in this way:

> *These participants have been trained in a more eclectic form of Reiki and use a variety of techniques in conjunction with the basic components of Reiki training; for example, the use of pendulums, crystals, and additional healing techniques. There is little concern over a 'correct' way to do Reiki even though there is a set routine attached to the practice. The atmosphere is more relaxed; practitioners seem really comfortable with each other and welcoming to 'outsiders'... Participants often refer to the group as 'it's like a family'.* (Field note memo December 16, 2007)

Active participation also provided me with an intimate understanding of the healing practice, which could not have been appreciated strictly through semi-structured interviews, through a review of publications, or through analyzing websites. As participants often said "You can't learn Reiki by reading a book". Likewise, the social world of Reiki cannot be fully appreciated without delving into the life world of practice. It is difficult to articulate just how salient this is and how important it was to bracketing or attempting not to prejudge activities and rituals that were foreign to me. Had I not taken these courses and participated fully in the activity, I'm not sure that I would have allowed myself to come to a deeper appreciation of this social world.

Informal Interviews

During the course of the research, I had casual conversations with the individuals involved in the Reiki sharing groups. These often occurred immediately prior to the exchange of Reiki, as I always tried to arrive early enough to chat prior to the sessions. Sometimes these occurred afterwards. Over time, participants shared intimate details of their lives and the issues that they were struggling with.

Formal Semi-Structured Interviews

Recruitment

Participants for the semi-structured interviews were recruited through a combination of purposive and snowball sampling. I conducted internet searches of Reiki practitioners and scheduled some appointments via telephone prior to my arrival in the Atlantic region. Most of the interviews on the East coast ensued through snowball sampling; that is, some of the participants referred me to other potential informants. Similarly, in Ontario, a small number of participants were recruited for interviews through practitioner website listings. Finally, some practitioners volunteered to participate in semi-structured interviews as a direct result of my participation in the two Reiki sharing groups.

Participant Profiles

Of the fifty participants I formally interviewed, forty-eight completed a demographic questionnaire prior our conversations. Similar to other CAM studies, the people I interviewed were mainly white, middle and older aged, middle-class, well-educated women.[1] All but two had some form of post-secondary education; approximately half had university degrees and one quarter had completed postgraduate education. Overall, the age range of my participants is slightly higher than that reported in previous studies on Reiki practitioners in Canada (Kelner and Wellman 1997a). The high percentage of white well-educated women practicing Reiki is consistent with previous research and is reflective of wider CAM trends (See Adams, Easthope, and Sibritt 2003; Astin 1998; Ernst 2000; Kelner and Wellman 1997b; Millar 1997; Park

2005; Wiles and Rosenberg 2001). In contrast to most studies but similar to the findings of Andrews and Boon (2005) this research indicates that lower income is not necessarily a deterrent to CAM use or practice. Additionally, most participants in this study operated small home-based businesses that are more indicative of a "low profit industry" (Andrews 2002:344).

The participants in my study came from a mix of religious backgrounds; almost half of the participants identified themselves as Christian with Roman Catholic origins. Ten of the participants said that they belonged to an eclectic blend of religions and ten others explained that at the time of interviews they had no religious affiliations. In the questionnaire that participants completed, while some claimed to be only 'somewhat religious', the majority indicated that they were very 'spiritual'. These findings support the literature that links Reiki to spirituality (Kelner and Wellman 1997b; Voas and Bruce 2007; White and Verohef 2006).

Overall, the participants were seasoned practitioners. All but two had advanced training and thirty-five practitioners had completed mastership courses. Most had between five and nine years of experience as Reiki practitioners but ten had more than fifteen years. The majority did Reiki work part-time for pay, and only a few worked as full-time Reiki practitioners. Approximately one third of the participants practiced mainly on family and friends and one fifth of the sample regularly provided Reiki services on a volunteer basis.

More than one half of the practitioners worked in other occupations and although some were involved in health occupations/professions such as social work, addictions

counseling, nursing, medicine, occupational therapy, massage therapy, dental hygiene, public relations, and clinical psychology, the majority worked in a variety of other capacities. These included engineering, computer science, education, retail, real estate, insurance, childcare, accounting, music, art, office work, homemaking, and farming. About one third of the informants worked in other occupations/professions full-time and approximately one quarter worked part-time. Ten of the interviewees were officially retired from previous occupations.

Consistent with other research (See Sharma 1992; Low 2004), practitioners in this study were often trained in and offered more than one form of CAM therapy to clients/patients. Some health care professionals practiced Reiki as an adjunct to biomedical practices. This finding is consistent with other research studies that have examined health care professionals' adoption of CAM practices (see Tovey and Adams 2001; Hirschkorn and Bourgeault 2008). Overall, the modalities that practitioners were cross trained in included massage therapy, therapeutic touch, healing touch, tai chi, reflexology, yoga, heilpraktiker (the German equivalent to naturopathic medicine), bach flowers, and crystal therapy. For example: a family physician was trained in hypnosis, yoga, and Reiki; a public relations officer for a hospital cancer patient foundation practiced various forms of Reiki and healing touch; and a child and youth worker ran a homeopathic business and practiced Reiki. A number of practitioners had training in counseling, and in particular, in grief counseling. There is a noted affinity of Reiki to massage therapy in Canada. Massage therapists are offered elective courses in Reiki through their educational programs. Participants, who are massage therapists, explained

that they often combined Reiki therapy with other massage techniques when providing treatments.

The main information gap in the demographic questionnaire occurred in the reporting of gross family income. This happened mainly with retired seniors who did not wish to reveal this information. Age was another category that was somewhat problematic; some participants volunteered their exact age while others did not (for a summary of demographic findings see Tables 3.1a, 3.1b, and 3.1c Appendix F pp. 231-233).

The interview format provided an appropriate way to explore specific themes related to Reiki practice as well as the opportunity to enter into a dialogue with participants (May 2001). We met either in respondents' homes or at locations of their choice. Outside of home, I met with participants at a local coffee shop, a restaurant, a farm market, and a local beach. Although I intended to only conduct face to face interviews, I eventually talked with two of the participants via telephone due to scheduling and traveling issues. During the conversations we discussed a number of topics encompassing definitions and interpretations of Reiki, personal experiences with Reiki, life changes, Reiki training, practice routines, and Reiki related activities. I used an interview guide (see Appendix E pp 225-228) as a reference during the interviews but for the most part allowed the participants to direct the course of the interview and probed for clarification or expansion on significant comments.

The interviews lasted between one and two hours. I audio taped and later transcribed the conversations verbatim. I used these transcriptions in conjunction with the

voice recordings during my analysis. Following each interview I made notes of key findings and points of interest and compared these findings to previous transcripts. This helped to guide ensuing interviews. I kept hard copies of the transcripts in binders close at hand throughout the research process. These strategies provided me with an intimate understanding of the participants' interpretations, actions, and activities (Charmaz 2006).

Data Analysis

The overarching methodology I employed followed Adele Clarke's (2005) situational analysis approach. I used this as a way to visually map the elements that make up the social world of Reiki. For Clarke, the situation is the unit of analysis and is defined as "both an object confronted and an on-going process subsequent to that confrontation" (Clarke 2005: 21). For me, mapping the 'situation' was an especially helpful tool in that it provided a way to visually examine key elements and to think about relationships during the coding process.

As described by Clarke, three types of maps help the researcher in outlining the phenomenon in question: situational maps, social worlds/arenas maps, and positional maps. Situational maps provide the researcher with a visual illustration of the "human, nonhuman, discursive, and cultural elements" in the situation so that comparisons of how they relate to one another can be drawn. Social worlds/arenas maps show the "collective commitments", "relations", and "sites of action" and positional maps identify "most of the major positions taken in the data on major discursive issues" (Clarke 2005:86). A situational map *"does not tell an analytical story but rather frames that story through mapping the broader situation as a whole and all the elements in it"* (Clarke 2005:137;

my emphasis). I did not engage in all three forms of mapping but constructed both situational and social worlds/arenas maps during the research process (for an example of a situational map See Figure 3.1).

Figure 3.1 Ordered Situational Map Social World Reiki Practice

Individual Human Elements
Human Actors
Health professionals/occupations
Professionals- education/engineering
Varied Occupations- office, childcare, farming

Collective Human Actors
CRA
AURA
Reiki Branches Active membership
Small peer groups

Discursive Constructions of individual and /or collective human actors
All practitioners as 'New Age'
Practitioners as 'witches'
Practitioners as 'Quacks'

Political/ Economic Elements
Pay out of pocket
Increase in popularity
Safety
Insurance
Regulation

Temporal Elements
Invisibility of healing work
Healing
Training
Gaining Expertise
Self reconstruction

Major Issues/ debates
Reciprocity- individual
Safety
Regulation
Lack of support – family, friends
Opposition from biomedicine
Lack Public awareness
Lack of Public understanding

Non Human Elements
Reiki energy
Money
Music
Equipment
Educational materials
Reiki Symbols

Implicated /Silent Actors
Family members
Non practitioner users

Discursive Constructions of Non Human Actants
Reiki as superstition
Reiki as spiritual energy
Reiki as bio-field energy

Socio-Cultural/symbolic Elements
Self responsibility
Individualism-
Consumption
New Age

Spatial Elements
Home based practice/ hospital/ business

Related discourses
Chronic Illness/ Health/Well Being

Other Key Elements
Practitioner involvement
Psychosomatic healing
Multiple identities
Intersecting domains

Using Clarke's template, I filled in the situational elements relevant to my research enquiry. As Clarke advocates, this provided another way in which to think about the data and to consider the relationships between the various elements.

My methodology was also informed by the work of Kathy Charmaz (2006). Her grounded approach is consistent with Clarke's (2003, 2005) in that it involves the following processes: simultaneous involvement in the collection and analysis of data; a method of constantly comparing data at each stage of the analysis; the construction of codes and categories to sort and manage, and conceptualize the data; the use of memo writing to think about the categories, outline their properties, and interpret how they relate to each other as well as identify gaps in the data; and theoretical sampling, which means that themes or categories are fully developed by collecting the data pertinent to their expansion. I illustrate how I used this approach in the following section.

Coding – Open/Focused/Analytic/Memo Writing

My analysis of the interviews began with data collection and continued throughout the writing process. Once an initial coding of a transcript was complete I printed a hard copy to then manually work with the data prior to subsequent coding of the 'word document'. The analysis involved the following processes: open coding, focused coding, higher order coding, and memo writing in conjunction with the situational mapping previously described. These processes were both iterative and overlapping. The analysis began with open coding, by examining the transcripts line by line and identifying key themes and concepts (Charmaz 2006). This involved giving descriptive names to specific excerpts that illustrated particular activities or meanings in the participant

accounts. For example 'Reiki definitions', 'Reiki Training, 'Reiki Practice', 'Personal Changes', 'Volunteer Work', and 'Introduction to Reiki' were a few of the initial codes. I eventually developed over two hundred codes to capture meanings and definitions. The second process involved focused or selective coding (Charmaz 2006). Here key theme areas are outlined. For example, introduction to Reiki involved: a quest for naming and framing, a personal healing quest, a quest to facilitate healing of others, and non-specific encounters. Linkages to theoretical and conceptual findings within the literature began and this refinement (Glaser and Strauss 1967) continued until completion of the writing. Each of these key concepts were developed to contain subcategories or themes that had different activities or meanings attached to them. For instance, spiritual quest involved a search for meaning and purpose, and meaning and purpose were associated with personal growth and development, dissatisfaction with work life, and dissatisfaction with life in general.

I then searched the detailed list of codes to locate similarities and differences. This comparative coding entailed interpreting and reflecting on the meaning of the coded text. This analytic coding is illustrative of higher order coding. In conjunction with situational mapping this kind of coding drew my attention to the varying perspectives held by the participants. These analytic processes helped to uncover the different rhetoric used between and among different segments of practice, and pointed to the intersecting features, conditions, consequences, and processes involved in the social organization, practice, and use of Reiki as a healing resource. The coding process is exemplified in Table 3.2.

Table 3.2 Coding Sample

Social World Involvement ----------Higher Order Category
[single category in tree structure]
'Discovering Reiki ' Introduction to Reiki ---------- Category

1. **Quest for Naming and Framing**---------- Sub-Category
   Prior Healing Ability/Energy/Spirit Awareness

2. **Personal Healing Quest**
   Spiritual Quest----------Subsidiary Categories
   meaning and purpose
   personal growth and development
   dissatisfaction with work life
   dissatisfaction with life in general
   Emotional Crisis
   depression
   bereavement
   anxiety
   divorce
   Physical Healing Quest
   Chronic illness
   chronic pain
   fibromyalgia
   allergies
   environmental illness
   angina
   cancer
   Rehabilitation/Recovery
   sexual abuse
   alcoholism

3. **Personal Quest to Facilitate Healing of Others**
   Domains of involvement
   dying and death
   cancer
   Alzheimer's
   rehabilitation/recovery - victims of abuse, physical, sexual, alcohol/drugs
   HIV AIDS
   elder care

4. **Non Specific Encounters**
   Curiosity
   Chance
   epiphany
   synchronicity
   Being recruited
   friends
   family
   other practitioners
   Recruiting others----------bridge

Memo writing was a continuous activity that I engaged in throughout the data collection and coding phases. As I read and coded the transcripts I made memo entries about the similarities and differences that were occurring between the categories, posed questions, and reflected on what further data I needed to collect. Through coding and memo writing it became more obvious that the practice was segmented at an organizational level but at the same time had many intersecting borders where practitioners' activities crosscut health care domains, provision and use, and conventional understandings of 'lay and professional'.

Further Data Analysis Considerations

I used the field notes mainly as a reflective backdrop to the interview and document data. With respect to the document data I used content analysis (Patton 2002) as an additional way to uncover the main consistencies, inconsistencies, and meanings associated with Reiki and in particular to discover the main themes and patterns in relation to the social history of Reiki.

Admittedly, given the amount of data not just from interview transcripts but from field notes, publications, etc., I also began to think about the data in other ways, and used Robert Prus' (1996:142) approach to sorting data, specifically in relation to 'generic social processes'. The idea of "generic social processes" is not new and has been traced back to Georg Simmel who, as Prus explains, argued for a distinction between 'form' and 'content' in analysis; 'forms' are generic social processes. These provide a way to recognize similarities and differences in qualitative data and represent 'transcontextual processes' that are applicable to a wide variety of contexts. They denote 'parallel

sequences of activity across diverse contexts' and accentuate the 'emergent, interpretive' aspects of activities involved in 'accomplishing' human group life (Prus 1996:142). This provided yet another way to think about recognizing group alignments and relationships in the data. The concepts either detect or help in the delineation of social processes.

This approach proved helpful as I analyzed practitioners' involvements with the social world of Reiki. I was interested in participants' forms of involvement in Reiki and how these activities shape the way that Reiki is practiced, by whom, in what ways, for what reasons, and with what consequences. I sorted the data according to categories of involvement: getting started, sustaining and intensifying involvements (continuities) etc. There are a number of subcategories within each of these. For example, getting started encompassed seeking out this social world and/or being recruited. These categories provided an additional way to sort the data in a systematic way and to think about the relationships within the categories. Data analysis, qualitative or quantitative, is neither purely inductive nor deductive but an iterative process. Clarke and Star (2008) refer to such an approach as 'abductive'. Using a variety of techniques to help navigate this process is another form of triangulation that further validates the analysis. On a final note, although this chapter describes the research process in a straight forward way it was nothing of the sort. It was messy, confusing, and at times completely overwhelming.

[1] The profiles of those I conducted participant observation with are consistent with the participants whom I exclusively interviewed.

Reiki as a Social World: a dispersive formation

The 'Usui Method of Natural Healing' first emerged in early 20th century Japan. Since that time it has spread throughout the world and evolved into a complex and varied set of practices. Practitioners with assorted backgrounds and training carry out this work in a broad range of venues under varying legislative conditions. In this chapter my goal is to capture the complexity of this process through a social worlds lens. I track how this segmentation process has occurred and try to account for why the social world of Reiki has become such a dispersive or variegated formation. [1]

I begin with the key figures in 20th century Japan responsible for first initiating the set of practices that we now refer to as Reiki. I illustrate that even in Japan, soon after its initial development, Reiki began to be characterized by splintering as proponents developed their own unique forms of the practice. I show that this process continued as Reiki was transported to the United States. I explain how in North America the segmentation process was complicated by issues of legitimacy and authenticity. Throughout the chapter I use the language of SWT to highlight the social processes that this framework is meant to capture.

The Birth of Reiki: Japan 1922-1938

The emergence of Reiki in early 20th century Japan has been attributed to Mikao Usui (1865-1926). Although there have been conflicting depictions of his life, most accounts highlight how Usui was influenced by his Japanese culture and traditions. In developing his unique system of healing Usui brought together the philosophies, medicine, and religious practices of Japan (Petter 2007, Stiene and Stiene 2005). In

developing his system, it can be said that Usui was responsible for initiating a process of segmentation that involved fashioning something new out of existing ideas and indigenous practices in the social environment within which he lived.

Usui was born on August 15, 1865 in Taniai Japan. As a young child he studied in a Tendai monastery and became a Buddhist monk (CRA 2008; Rand 2006; Stiene and Stiene 2003, 2006). Tendai is a lay Buddhist sect that allows members to marry, have children, and work and live a non-monastic life (Stiene and Stiene 2003, 2006). Although little is known about his personal life, accounts indicate that he came from a privileged background and was well-travelled. He also married and had two children.

Usui realized his gift of healing through a 'spiritual awakening'. In the early 1920's Usui went on a retreat to Mount Kurama in Kyoto, Japan and after a twenty-one day period of fasting and meditation he experienced 'enlightenment' and discovered his ability as a healer (Epperly and Epperly 2005; Petter 2007; Rowland 2006). It was after this experience that he dedicated his life to this practice. In 1922 Usui moved his family to Tokyo and opened a healing clinic. Practitioners claim that he taught his system of healing to about two thousand people and initiated at least sixteen of his students to the level of mastery [2] (Reiki Center for the Healing Arts 2008; CRA 2008; Stiene and Stiene 2006). It is reported that following the Kanto earthquake in 1923, which killed an estimated 100,000 people, he and his students treated a number of the survivors (CRA 2008). In 1925 he opened a larger clinic in Nakano and during that year travelled and taught the method until his death from a massive stroke on March 9, 1926 (CRA 2008).

Usui is described by followers of his method as a spiritual seeker and a teacher who was knowledgeable in medicine, healing practices, and spiritual philosophies. Usui's life as a Tendai Buddhist monk, the influence of the Shinto religion (the official religion of Japan), his involvement in martial arts, and interest in medicine were all important to the development of his approach to 'natural' or 'spiritual healing' (Stiene and Stiene 2005; Petter 2007). Central to all these influences is Buddhism.

Buddhism originated in India and was founded by Gautama Siddhartha (ca.563-483B.C.), a prince who abandoned his privileged life 'to seek religious truth'. Eventually Siddhartha achieved enlightenment and became known as the 'Buddha'; a "humane man, not a god" (Schirokauer 1993:26). He spent the rest of his life teaching his philosophy to his followers (Schirokauer 1993:26). Buddhism is not theistic, meaning that there is no 'supreme intelligence' or 'creator' that directs humans; alternatively, Buddhists view "the universe as a whole, which is self creating" and believe that humans have an obligation to show 'sympathy for all beings', inanimate as well as animate (Webb 1957). They believe that all that happens is illusory because phenomena only exist 'relative to each other'. They also hold that human attachment to things is the 'source of all suffering'. To overcome attachment, Buddhists rely on four principles referred to as 'four noble truths' (Schirokauer 1993:26).

These precepts encompass the ideas that "life is suffering" and that for every action there is a moral reaction. This is in accordance with the Law of Karma which assumes that a life filled with goodness leads to reincarnation at a higher level and that a life of evil results in the opposite. Human suffering is due to "craving or desire" and in

order to overcome suffering it is necessary to practice spirituality in a disciplined way. (Schirokauer 1993:26). The spiritual exercises that guide the individual in overcoming suffering are outlined in the "eightfold path". They include: "right views, right intention, right speech, right action, right livelihood, right effort, right mindfulness, and right concentration" (Schirokauer 1993:27).

Buddhist philosophy is reflected in Usui's approach to healing and the precepts that he taught. The principles that he passed on to his students are 'spiritual' guidelines intended to lead individuals who adhere to his 'healthy living' philosophy to healing and happiness. The following excerpt sums up Usui's philosophy.

> *The true purpose of the Reiki method is to correct the heart-mind, keep the body fit, and lead a happy life using the spiritual capabilities humans are endowed with since birth.... Recite the five precepts morning and evening, and keep them in one's heart.*
>
> *Today, throughout the entire day,*
> *Do not become angry*
> *Worry about nothing*
> *Express one's gratitude*
> *Be diligent in work*
> *Be kind to others* (Reiki Australia 2008).

The description of Usui's path bears a stark resemblance to that of 'Buddha' and his life of spirituality. While Buddhism aims at freeing humans from suffering through 'intellectual, psychological, or mystical' techniques (Webb 1957:138) so too did the Usui system of healing.

Another influence on Usui was the indigenous religion called Shintoism [3] (Petter 2007). Some practitioners contend that Shintoism gave Usui's method "a unique Japanese flavour" (Stiene and Stiene 2005). Academic scholars posit that the Tendai Buddhist sect, to which practitioners claim that Usui belonged, emphasizes "ritualistic or magical means

to salvation" (Webb 1957:138), and that this is indicative of the Shinto influence on Buddhism (Lock 1980). These indigenous beliefs were reflected in Usui's reliance on the power of the Shinto gods or kami to heal disease and the use of Shinto rituals (Stiene and Stiene 2005: 13).

Shintoism is a component of Japanese folk medicine which also influenced how Usui initially developed his method (Stiene and Stiene 2005). Japanese folk medicine includes ancient Chinese remedies, moxibustion, massage techniques, and *Shinto* rituals including talismans, incantations, ceremonies, and shamanism (Lock 1980:14-15). The entire Japanese medical system of kanpo, meaning the "Chinese Method', was introduced from China by Buddhists in the 6th century as a way to ease the spread of Buddhist philosophy [4] (Lock 1980:27).

Finally, some accounts emphasize the influence of Usui's involvement in martial arts and how this influenced his approach to healing. Some practitioners claim that in the form of martial arts that Usui practiced, harmonization with ki or vital energy is accentuated. Through his disciplined practice he was able to "experience enhanced calmness, concentration, willpower, and physical fitness in daily living" (Stiene and Stiene 2005: 11). These influences are further reflected in the kinds of elements and techniques that Usui used.

Usui's method included breathing techniques, light touch and massage, symbols and mantras. These were etched within five principles of 'healthy living' previously described. Some practitioners refer to these elements as the core of the Usui system. They claim that during treatments Usui used a variety of healing techniques. These

included touching, massaging, tapping, stroking, blowing, gazing, and directing energy to diseased parts of the body (Petter 2007:25).

Usui developed a system of training that included six 'degrees' or levels. Over the course of levels six to three students learned hands on treatment, the development of energy perception, spiritual instruction, and specific healing techniques. In the second 'degree' of training students learned about distance healing and mental healing. Usui designed the first 'degree' for those he selected to become teachers (Lubec, Petter, and Rand 2006). Practitioner accounts reveal that although Usui practiced 'palm healing' or healing through touch he relied mainly on intuition with respect locating disease in the body. Usui encouraged his students to take notes, and keep journals and he provided them with a treatment handbook as well as a copy of the Meiji Emperor's poems (Petter 2003:23; Stiene and Stiene 2006). Students were required to reflect on the precepts daily and to become familiar with the Emperor's poetry. The recitation of the Emperor's poetry was a reflection of Usui's devotion to the monarch- a figure who holds an esteemed position in Japanese tradition. According to scholars, at that point in history the emperor was considered "sacred and inviolable" (Schirokauer 1993). This particular *blend* of philosophy and techniques comprised the Usui system of 'folk medicine'.

The legacy of Usui continues to live on in Japan through the students who studied and collaborated with him. The Usui Reiki Ryoho Gakkai Society [5] (The Society of the Usui Spiritual Energy Healing Method) was set up by some of Usui's students, all naval officers, shortly after his death (Stiene and Stiene 2005). According to Stiene and Stiene (2005) this society still functions in Japan today, although its membership has declined

significantly over the years. The connection to the military is explained by Stiene and Stiene (2003:119) in this way: "The military was quite powerful at the period in Japanese history…It has been suggested that Mikao was pressurized into teaching many of the naval men." It was not long after Usui initially developed his system that the first sign of internal segmentation began to appear. One of Usui's students, Chujiro Hayashi, played a key role in this process.

Hayashi was born in Tokyo on September 15, 1880, graduated from the Japan Naval School in 1902, and after retiring from the navy commenced his training with Usui in 1925. He was a medical doctor [6], a retired naval officer, and one of the last students taught by Usui before his death in 1926. Hayashi ran a Reiki clinic in Tokyo; by all accounts, the first clinic where clients paid for treatments. There are also claims that Hayashi actively promoted and taught Reiki throughout Japan (Miles 2006; Petter 2003; Stiene and Stiene 2005, 2006). While Hayashi borrowed from Usui's teachings, the form of Reiki that he taught incorporated new and unique elements.

Similar to Usui, Hayashi encouraged his students to take notes and keep journals and he provided them with a treatment handbook as well as a copy of the Meiji Emperor's poems (Petter 2003:23; Stiene and Stiene 2006). Also, like Usui he taught his method in six levels and held monthly practice seminars for beginning students (Petter 2003:15). He used Usui's techniques but also added to them.

Hayashi, similar to Usui, taught his students ways of detecting and dealing with energy imbalances but he is noted for taking a core systematic approach to sensing energy imbalance or energy tension in the body. One method that Hayashi used is called

the 'Byosen technique' (Petter 2007) or 'scanning'. Through this technique the practitioner senses the peaks and lows of 'byosen'[7] which has five levels: warmth, strong heat, pulse-like sensation, and pain. Students gain proficiency in awareness of energy blockages or imbalances through practice. Over time the practitioner learns to scan the body to locate problem areas.

Some practitioners argue that Hayashi focused more on the technique of 'hands on healing' than on spiritual development (Stein and Stein 2005; Petter 2007; King 2008). He has been criticised for trying to capture 'spiritual energy' within a medical model. Using his medical expertise he worked collaboratively with Usui and standardized hand positions to correspond to particular organs and body systems. Combinations of these positions were devised to target and treat specific diseases (Petter 2007).

In the 1930's, Hayashi opened his own school of Reiki practice called The Hayashi Reiki Kenkyu Kai (Hayashi Spiritual Energy Research Center). The details for this break with The Usui Reiki Ryoho Gakkai Society society are unclear. Some speculate that conflicts over his emphasis on the therapeutics of 'hands on healing' rather than spirituality played a part his decision to leave the group (Rivard 2007). Regardless, Hayashi taught thirteen of his students in his techniques to the level of teacher. One of these students was Hawayo Takata, a second generation Japanese American who discovered and trained in Reiki on a trip back to Japan and who ultimately introduced Reiki to North Americans. Another, Chioyoko Yamaguchi, practiced and taught her style of Reiki in Kyoto throughout her adult life. Her son Tadao Yamaguchi is promoting the family's branch of Reiki globally (Stein and Stein 2005).

Hayashi took his own life on May 11th 1940. Practitioners speculate that his concern over the military actions of his country and fear of being re-enlisted to fight in a war that he did not support precipitated this act (Petter 2007). Dr Hayashi's wife, Chie, continued his practice for some time, but eventually closed the clinic.

Hayashi was not the only Japanese student to develop and promote Usui's system. At least two other of Usui's students, Eguchi Toshihiro and Tomita Kaiji, taught natural healing methods and produced books about their respective approaches (Stiene and Stiene 2005). Like Hayashi they developed their own unique styles based on Usui's core principles and elements of practice but modified and added to them. Hence, the segmentation of the social world of Reiki began long before its introduction into North America.

The Westernization of Reiki: North America 1938-1980

Reiki was introduced to the continent by Hawayo Takata, a second generation US immigrant, whose family settled Kawai, Hawaii. Takata married a co-worker, Saichi Takata in 1917 and had two daughters. In 1930 she became a widow and in 1935, as a result of more misfortune, including the sudden death of her sister and her own failing health, Takata made her way back to Japan where she sought medical attention and was introduced to Reiki therapy. After a successful recovery, Takata began training in Reiki and within one year had advanced to the 'second degree'.

Takata returned to Hawaii in 1937. In 1938 Hayashi visited Hawaii, presented Takata with a Reiki Master certificate and assisted her in setting up a Reiki clinic. Introducing Reiki into North America presented challenges for Takata. The social

situation differed in significant ways. Although forms of 'non-cosmopolitan' or western medicine were inhibited in Japan in the early 20th century, they were never 'totally outlawed' (Lock 1980:62). Hence, Western medicine in Japan did not succeed in monopolizing the medical market to the extent that it did in Western countries. In Japan indigenous medicine systems were maintained within in a pluralistic medical market (Lock 1980). The situation for alternative healing practitioners in North America was more restrictive. In order to establish a Reiki practice in the US and avoid medical legal issues, Takata opted to become a licensed massage therapist. By the end of 1939 she completed her studies at the National College of Drugless Physicians in Chicago (Brown 1992).

Licensing required that she abide by state regulations. Holding a license for massage therapy ensured that she was not accused of practicing medicine without a license. Still, lack of public acceptance toward non conventional healing practices and the lack of credibility attached to this form of healing also created problems. To work around these difficulties, for most of her career, Takata practiced locally and in a clandestine fashion. She gave classes, mainly in private homes and adhered to a 'folk tradition' of oral teaching. She also did not permit students to take notes or to tape classes (Brown 2005; Streich 2007). More than thirty years went by before she ventured from Hawaii to the mainland of the US to give seminars on Reiki. By this time she was in her early seventies.

Former students of Takata claim that her primary motivation in teaching others to become master/teachers was to ensure that the practice did not fade into extinction.

Changing social conditions helped to make this possible. By the 1970's, the climate for alternative therapies generally began to improve. There was greater freedom of expression with respect to 'alternative' approaches to biomedicine, more public resistance toward to medical authority, and greater public exposure to Eastern healing practices, particularly in the western regions of the US and Canada. Takata gave her first class on Orcas Island off the coast of Washington in 1973 and by the mid 1970's she had also travelled to British Columbia to teach (Streich 2007).

There are conflicting claims about Takata's approach to Reiki. Some see more of Usui's influence while others recognize more of Hayashi's approach. There is general agreement, however, that Takata left her personal imprint on the practice. Takata emulated Hayashi's method in that she was very strict about using Hayashi's systematic application of hand positions during treatment (Streich 2007). More profoundly, she followed in Hayashi's footsteps with respect to his philosophy of reciprocity. Students of Takata claimed that Hayashi charged her a huge fee for her Reiki master training and instructed her to do the same (Brown 2005). Subsequently, she demanded $10,000 US from students who wished to take master training.

Where her style most resembled Usui was in her intuitive approach. Her guiding principle "was to treat cause and effect" and she used her intuition and the awareness of the energy in her hands to locate the cause (Streich 2007: 12). Former students claim that she often told them that "reiki will teach you", "reiki will guide you". Similar to Usui and Hayashi she performed energy initiation rituals and taught students the use of Reiki healing symbols.

There are subtle and not so subtle differences that distinguish Takata's style from her predecessors. First, there is her training structure. Unlike the Japanese tradition, Takata taught Reiki in three degrees rather than six. By all accounts the instruction that students received with respect to energy awareness and other healing techniques tended to be limited and inconsistent. While Takata stressed the importance of consistent practice to developing expertise in the method there were no hard and fast rules with respect to the content or pace of training (Striech (2007). Aside from the training structure, the most profound difference between Takata and the other two approaches lies in how she redefined Reiki to suit her audience and social context. This strategy served to preserve the practice.

Takata is described as a story teller who adapted what she taught and how to the situation at hand (Epperly and Epperly 2006; Rand 2006; Streich 2007). Details about the life of Usui provided by Takata to her students contain both fact and fiction. Essentially Takata reconstructed Usui's personal history to make Reiki more palatable for a largely Christian North American audience. Over the thirty-five years that she practiced Reiki, Takata maintained that Usui was a Christian minister and the headmaster of a Christian boys' school in Japan.

Takata claimed that Usui travelled to the US to study world religions and after seven years at the University of Chicago returned to Japan and joined a Buddhist monastery. She further contended that Usui studied the ancient Sanskrit Sutras of India and that it was in these works that he found "the formula for Buddha's Manual healing

System!...Written 2500 years ago!" (Brown 2005: 47). Takata's distinctly 'deist' tone concerning life force energy is captured in the following diary entry:

> *I believe there exists One Supreme Being- the Absolute Infinite- a Dynamic Force that governs the world and the universe. It is an unseen spiritual power that vibrates and all other powers fade into insignificance beside it. So thereafter, it is Absolute. This power is unfathomable, immeasurable, and being a universal life force, it is incomprehensible to man. Yet, every single living being is receiving its blessings daily, awake or asleep. Different teachers and masters call Him the Great Spirit, the Universal life Force, Life Force Energy, because when applied it vitalizes the whole system....I shall call it "Reiki" because I studied under that expression* (Takata 1982).

During the time that Takata initiated her master students she maintained her personal philosophy, yet did not impose specific religious beliefs on her students. *Maintaining religious neutrality* was then another strategy that served to enhance recruitment. For example, Takata's students came from mixed religious backgrounds and 'New Age' affiliations yet Takata did not interfere with their personal interpretations of Reiki. Whether the student's belief was in the 'Cosmos' or in the 'Divine', these convictions did not seem to preclude training; however, *most* of the early master students gravitated toward Christian understandings.

Takata left her ethnocultural imprint on Reiki practice in other ways. For instance, Confucianism has been part of the cultural fabric of Japan for centuries and central to this philosophy is the duty to respect one's parents and ancestors (Sung 2002). Japanese children learn at an early to be courteous and respect parents, teachers, and elders. Adherence to this principle is embedded in the set of precepts that she passed on to her students:

Takata's Precepts

Just for today, do not worry.
Just for today, do not anger.
Honor your parents, teachers, and elders.
Earn your living honestly.
Show gratitude to everything.

Members of the Reiki community were reportedly surprised when Usui's precepts were translated and did not match those of Takata: "Honor your parents, teachers, and elders" was substituted for "Be kind to others". The reasons for the replacement may be explained through her cultural heritage. Interestingly, this modification would not be problematic for Christians because this principle is congruent with Christian beliefs.

Takata died on December 11, 1980. Her ashes are interred at the Buddhist Church in Hilo Hawaii (Brown 2005:97). Between 1970 and 1980 she initiated twenty-two Reiki Masters; seventeen Americans and five Canadians. Practitioners acknowledge that Takata changed the practice of Reiki in explicit and subtle ways when she introduced it to North America. The strategies that Takata used served to ensure the successful import of a social world that originated in Japan. Her death marked another turning point in the differentiation process.

Differentiation in North America

After Takata's death in 1980 a leadership contest ensued between two of Takata's students. The dissention between these members precipitated the first major chasm between Reiki Masters in North America. As a result, two competing branches of Usui Reiki were formed. The Radiance Technique currently called the Radiance Technique International Association Inc. (TRTAI) was founded by Barbara Weber Ray 1982 and

The Reiki Alliance was created in 1983 by the Reiki Masters who supported Takata's grand daughter, Phyllis Furomoto as successor. The splintering that occurred was fuelled by ideological differences and played out through a quest for control over the practice and training of practitioners. This is a common condition that precipitates segmentation (see Unruh 1980; Strauss 1984).

Similar to other CAM modalities, this splintering represents divergent thrusts with respect to the scientific and spiritual dimensions of Reiki. In essence, The TRTAI interprets Reiki through *scientific* theories[8] whereas The Reiki Alliance advocates a *spiritual* approach and emphasizes the Usui method of healing. Within the TRTAI Reiki practice is described as "a scientific method" for self healing and for maintaining health (Gowland 2010). The technique is further defined as a 'cosmic' or transcendental' energy science that was "rediscovered in ancient texts by Dr. Mikao Usui" (Weber Ray 1995). According to Weber Ray, The TRTAI posits that reiki or 'light' energy is the link between science and spirit and this awareness is part of a 'New Age' of expanded knowledge.

> *Now modern science is placing increased importance on light. In humanity's New Age of expanded knowledge and consciousness, light brings together the worlds of science and spirit. Einstein's famous formula...tells you that light and matter are interchangeable. Light appears to be at the heart of all things. Just before this century, the Impressionists made an entire art form of light. The mystics have always known about it and have reminded us through the centuries that we are, in truth, Light* (Weber Ray 1983: 39).

Weber Ray claimed that she was the sole person with 'complete' knowledge of the Reiki science based system and Takata's chosen successor. Reiki Alliance members responded by staking their own claim on the 'true' form of Reiki. Like Weber Ray, they tried to

position themselves as authentic by taking advantage of Furomoto's blood relation to Takata. They linked themselves to the original roots of Reiki through lineage.

Alliance members also stressed their 'spiritual lineage'. The notion of 'spiritual lineage' implies that through ancestry the integrity of the Reiki system can best be maintained. Furomoto was voted in as leader of the Reiki Alliance by the majority of the twenty-two Reiki masters. She was originally given the title of 'Grandmaster' and later named 'Lineage Bearer' of the system:

> *Mikao Usui experienced a spiritual awakening or spiritual transmission that resulted in the creation of the system of healing we have received. What we know has been passed on to us through a series of lineage bearers who have been guardians and preservers of the integrity of the practice. Chujiro Hayashi, a successor of Mikao Usui, practiced and taught in a clinical setting in Tokyo, Japan. It was to this clinic that a young Japanese-American, Hawayo Takata, was brought in 1932... Before her death in 1980, Mrs. Takata chose as her successor her granddaughter, Phyllis Lei Furumoto* (Usui Shiki Ryoho 2010).

Another strategy the Reiki Alliance used to further differentiate the membership was with respect to the scope of Reiki in practitioners' lives. The Reiki Alliance believes that Reiki masters "live mastery" through "the pursuit of ongoing personal and spiritual growth" (The Reiki Alliance 2010). For Alliance members, spiritual growth included living according to the Reiki precepts as taught by Takata.

From the 1980's onward the ideological conflicts between the two North American Branches of Reiki played themselves out in the commercial marketplace. To establish control over the market and to protect her interests Barbara Weber Ray trademarked her approach as the Radiance Technique®, Authentic Reiki®, and Real Reiki® (The Radiance Technique International Association 2008) and published the first book on Takata's system, The Reiki Factor (1983). In these early days, The Reiki

Alliance distanced itself from such strategies. They followed Takata's more conservative approach by maintaining Takata's training fees and generated interest in Reiki through person to person contact and oral teaching methods. This, however, had the effect of creating dissention within The Reiki Alliance as not all members supported or complied with Takata's structure.

In 1983, Ethel Lombardi, was the first to distance herself from both groups. She developed her own style of Reiki, Mari-El, based on her personal beliefs which were rooted in Christianity. She taught only student and died in 1984 (Stiene and Stiene 2003:159). Around the same time, Iris Ishikuro, a Reiki Alliance member, and one of her students Arthur Robertson, lowered the training fees set by Takata and condensed the training sessions that they ran. This allowed students to move through the training process more quickly (Miles 2006). These were only the first of yet more splinter groups to emerge. A more rapid proliferation of Reiki groups then ensued.

Taking advantage of the growing interest and receptivity of CAM in North America, Robertson created a form of Reiki called Reiki Raku Ki which incorporates more New Age elements into the system. Others developed forms of Reiki that blended knowledge of the Indian Chraka (energy) system. By 1990, Reiki was very much a part of the 'spiritual marketplace' (Bowman 1999) and similar to other CAM practices the commodification of Reiki was rampant. The 1990's were an especially messy period in Reiki history. There were attempts by practitioners to both commodify and monopolize the practice. In the US, the enforcement of intellectual property rights, through trade marking, became a central strategy that entrepreneurs used to differentiate and protect

"new" training businesses and Reiki promotional products. A few examples include: Tera-Mai™, Reiki, Karuna™ Reiki and Reiki Plus ™, and Sacred flames Reiki ™.

Through this period there was much infighting between branch members. Some groups went so far as to launch lawsuits over trademark disputes. In response to the increasing proliferation of different groups, and total diffusion of what Reiki is, a bolder attempt by was made by The Reiki Alliance to regain control over the practice. In 1993, through an attempt to monopolize the Reiki market Furomoto spearheaded a campaign to trade mark the terms 'Reiki', 'Usui System', and 'Usui Shiki Ryoho'. However, by the end of 1997, largely through the lobbying efforts of other Reiki factions, this attempt proved to be unsuccessful (Petter 1998). Describing this endless differentiation, Stiene and Stiene (2003:172) write:

> *A branch is generally created in the system of Reiki when teachers change what hey have been taught. At first they may call themselves Independents Reiki Masters or they create a new, more apt, name to work under that is added to the word 'Reiki', Once this new name is passed on to a student, written on certificates, it becomes a new branch of the system of Reiki.*

From the mid-1980s onward entrepreneurs used another strategy to reinforce themselves as true 'Reiki' forms. Some travelled to Japan and used research on Usui and his life to support their claims of authenticity. Subsequently, over time, details about the history of Reiki, its forebearers, and how Reiki was originally practiced were contested and rewritten. The first practitioner to bring the Western approach to Reiki to Japan was Mieko Mitsui, a journalist, and student of Barbara Weber Ray. She went to Japan in 1985 to live and to teach the Radiance Technique. It was Mitsui who raised the first concerns over the differences in Western and Eastern Japanese approaches to Usui's method.

During the 1990's others such as Dave King from Toronto, Canada, Walter Luebeck from the UK, William Rand from the US, Frank Petter from Germany, and Bronwen and Frans Stein from Australia did research in Japan and with their discoveries have reshaped the historical details of Reiki into what is referred to by some as the "New" or "Modern History" (Ellis 2002) and by others as merely new insights into Reiki's beginnings (Rowland 2006). Petter is credited with translating Usui's memorial stone[9] and the manual that Usui gave to his students (Stiene and Stiene 2005). The writing and rewriting of history are salient to the segmentation process as subworld authenticity is rooted in the 'true' history of the Usui method.

The exact number of Reiki branches or subworlds of Reiki today are unknown. Some estimate that by 2005 over a thousand different styles had developed (Stiene and Stiene 2005). There are also an unknown number of practitioners involved, which is typical in a differentiating social world. Branches in the US and Canada mainly co-exist and function independently and collaboration between them, at the present time, remains tenuous.

Reiki in the Era of Globalization

Despite the internal wrangling, the degree of splintering, and differentiation of Reiki groups and independent teachers, Reiki continues to grow not only in North America but also around the world. Reiki has entered an era of *globalization.* Communication made easier through the internet and the ease of commercial travel have played a major part in the spread, networking, and collaboration between practitioners trained in varying schools of practice. Aside from international associations, Western

forms of Reiki have a presence in Japan and Japanese styles of Reiki have been introduced in the West.[10]

It is not easy to differentiate Japanese practices from Western forms. Advocates of Traditional Japanese branches claim that they more closely emulate their Japanese roots (Stein and Stein 2005; Petter 2007; Chrysostomou and Mellowship 2008) but practitioners of the Western traditional branch make similar claims. Despite the changes to Western practices, training from the beginning level or degree to that of Reiki master/teacher includes a set of basic elements or 'core objects': an introduction to the history of Usui Reiki, hands on treatment, energy sensing rituals, Reiki healing symbols, a distant healing technique, and training in performing initiations and teaching classes. Some observers claim that Japanese traditional training is, to date, not as differentiated as in the West but this is questionable since Western forms of Reiki also have a presence in Japan. Some of the most widely known and currently practiced forms of the Western and Japanese Reiki traditions are outlined in Table 4.1.

Globalization marks another turning point in the differentiation of Reiki. Along with the proliferation of the practice comes increasing visibility and greater external pressure for groups to establish their worth and credibility. Within a segmenting social world, along with differentiation comes an *increasing need to prove legitimacy* (Star and Strauss 1999). As Strauss (1984: 128) explained, in segmenting subworlds "the defining of different types of activities and the building of organizations for engaging in them, is often motored by a growing conviction that what "we are doing" is more legitimate" than

in other subworlds.

Table 4.1 Common Traditions and Branches of Reiki Practice

Western Branches/Forms	*Forms of Practice*	*Founder*
Western-Traditional	Usui Shiki Ryoho	H. Takata/ Phyllis Furomoto (US)
Western Non-Traditional	The Radiance Technique	B. Weber Ray (US)
	Raku Kei Reiki	A. Robertson (US)
	Usui Tibetan and Karuna	W. Rand (US)
	Usui Independent	
Western/Japanese Tradition	Gendai	H. Doi (Japan)
Japanese Tradition	Komyo	H. Inamoto-sensei (Japan)
	Jikiden	T. Yamaguchi (Japan)
	Usui Reiki Ryoho	H. Doi (Japan)

A central and evolving legitimation strategy taking place within Reiki branches encompasses the development of standards of practice. The Reiki branches highlighted in Table 4.1 have, in different ways taken steps to standardize their practices. To varying degrees, they have established codes of ethics, formalized their specific training standards, provide material resources (manuals, CD's, and/ or products) and offer certification, and continuing education opportunities. The Usui Shiki Ryoho form is the only branch that still formally advocates adherence to an oral tradition of teaching and a fee of $10,000 for third degree or mastery training. The differences with respect to average training cost, training manuals, ideological focus, and level of training of the common branches of Reiki are highlighted in Table 4.2.

In Canada, legitimizing efforts began more than a decade ago by Reiki associations and organizations. In the mid 1990's the Canadian Reiki Association (CRA)

Table 4.2 Characteristics of Common Reiki Branches/Forms of Practice

Reiki Form/Branch	Training Cost *	Material Resources	Primary Focus Advocated by Group	Levels of Training
Western Branches				
Usui Shiki Ryoho	Total $10,000 US	oral/folk	Spiritual Discipline / Healing Practice	3
Radiance Technique	Total $1,450	manuals provided	Healing Therapeutic Practice	7- 3a, 3b
Usui/Tibetan/Karuna	Total $2,100 US	manuals provided	Healing Therapeutic Practice	Basic 4 Karuna 2
Raku Kei Reiki	Total $90 US	manuals provided	Self Development Practice	4
Japanese Branches				
Usui Reiki Ryoho	Total $1,150 US	Manuals provided	Spiritual Discipline	3
Jikiden	Total $5,375	manuals provided	Healing Therapeutic Practice	4
Gendai Reiki Ho	Total $1,400	manuals provided	Spiritual Discipline/Healing Practice	4
Komyo Reiki	Total $900	manuals provided	Spiritual Discipline	4

* These amounts reflect the approximate (average) total cost to complete all levels of training. This does not include the cost of course materials. Sources: Participant Interviews and Branch Websites see Appendix B 'Reiki Branch Websites' p 214.

and the Atlantic Usui Association (AURA) developed ethical codes and training and practice standards. Schools of practice such as the Reiki Threshold in Vancouver, Soul Connection in Guelph, Ontario, and the Reiki Training Center in Alberta, have also established such guidelines. Nevertheless, in juxtaposition to formal health educational training, there is a great deal of inconsistency with respect to formal instruction, continued guidance, and/or apprenticeship within and between groups. Much is left to the creative devices of individuals and their personal commitment to practice. In some respects, this approach to learning parallels that of other CAM practices prior to embarking on formal professionalization projects (see Boone 1998; Bourgeault 2000; Cant and Sharma 1995; Coburn and Biggs 1986; Hirschkorn 2005).

Most practitioners involved in these groups use them primarily as a way to network and to build public credibility rather than a way to mobilize occupationally/ professionally. For the most part, practitioners do not hold formal memberships in Reiki associations or organizations. These amorphous features are defining characteristics of

dispersive social worlds (Strauss 1978; Unruh 1979, 1981). To add to the complexity of the situation, in recent years here have been signs that the differentiation of Reiki is beginning to occur in new ways.

Within the social world of Reiki some subworld groups or training schools in the US, Canada, the UK, and Australia offer various blends of Reiki training. In some instances Reiki branches that have produced new compilations of Reiki by mixing and matching Japanese and Western techniques. The Usui/Tibetan/Karuna branch in the US and The Reiki Threshold in Canada are but two examples. These intersections are another avenue through which segmentation happens but not the only route.

Over the past decade, particularly in the US, subworlds of practice have also begun intersecting with other social world groups in the health care arena. One example lies in the provision of continuing education credits (CEUs). For instance, Reiki sub branches in some states in the US offer CEU's to registered nurses and other health professional groups. Another emerging axis of differentiation is specialization. Bucher and Strauss (1961) pointed out that in professions, specialties become involved in unique missions. In a parallel fashion some independent Reiki practitioners work with specific population groups such as people with AIDS, Alzheimer's disease, with palliative care patients or children with autism. Others focus their skills on working with animals. Indeed, as is further illustrated in Chapter Six, independent practitioners in Canada face challenges with respect to maintaining a Reiki practice, let alone a particular Reiki specialty. However, these trends are happening in other Western countries and suggest possible alternative axes of differentiation of this social world in Canada.

Within the social organization of Reiki there are a myriad of entrepreneurs and multiple authority figures; for example branch founders, association/organization leaders and independent teachers/students, and master practitioners/practitioners. Between these groups there are many differences in how Reiki is defined and taught and little consensus over the direction that the parent social world should take. These amorphous features are characteristic of a dispersive social world (Strauss 1978; Unruh 1981).

Summary

In this chapter I tracked the origins of the Usui System and the various influences impacting its development. Segmentation is an inevitable and ongoing process in social worlds (Strauss 1984) and the Usui System of Healing is but one 'kernel' in this process. The early history served as an analytic starting point within which to specifically bring insight into the early differentiation of the practice while more broadly increasing our understanding of the varying permutations of contemporary healing work.

Looking at the social history of Reiki has provided insight into how the segmentation process of a dispersive social world happens. These include the *'formation'* or start of subworlds. This process began with the amalgamation and differentiation of the Usui system in 20th century Japan and carried over into the westernization of the system in North America in 1938. Further *differentiation* of this social world came about as subworlds split apart, and merged their practices with other healing techniques to create distinct branches of Reiki. Intricately involved were issues of legitimacy, and authenticity. In the process of substantiating claims of legitimacy and authenticity *history was written and rewritten.* These processes continue.

In looking at the development of Reiki in North America, I highlighted the relevant conditions that serve as catalysts in the formation of Reiki subworld groups and demonstrated the ways in which segmentation occurred. *Splintering influences* included intra-practice technology and skill differentiation, ethno-cultural variation, and ideological differences. Also included were extra-practice conditions encompassing medical/legal issues, and commercialism. *Extra-practice coalescing forces* were marked by a growing freedom of expression toward the practice and public use of CAM in North America in tandem with globalization. Globalization has added to the complexity and speed of segmentation. Together, these influences and social forces played a part in the adaptations, changes, and strategies that Reiki 'entrepreneurs' used to preserve, protect, and advance their interests.

In the analysis I showed how Reiki has become a confusing and complicated array of practices with few common elements. Akin to the world of computer technology (Kling and Gerson 1977) and the social worlds of senior citizens (Unruh 1981) the world of healing is complex, dynamic, and diffuse (Kling and Gerson 1977). Reiki is but one line of work or segment within the broader health care matrix. Similar to other social worlds differences in ideology or "sets of beliefs' (Strauss 1964) create tension between and within subworlds (Gerson 1983; Strauss 1984; Sanders 2007). In the case of Reiki, largely ideological chasms have driven divisions and/or irreconcilable differences within and between groups. This differs from SW accounts of dispersive worlds where segmentation is perhaps less ideologically charged and more a consequence of varied lines of activity based on multiple personal interests (Unruh 1980, 1981) or technological

innovations (Kling and Gerson 1977; 1978). Unlike social world organizations where more formal structures demand co-operation between social world participants (Star and James Griesemer 1989) collaboration between varying Reiki subworlds remains tenuous.

This account of Reiki goes beyond simply offering a demonstration of the processes that concern SW theorists. The case of Reiki makes it possible to think further about the issues that SWT raises and ways to refine the theory. For example, the direction of Reiki's most recent development suggests that additional contemporary sources contribute to the segmentation of dispersive social worlds. Increasing globalization is one generic condition of segmentation that underpins group coalescence through entrepreneurial activities that include historical research, recruitment, training, continued education, and information dissemination on a global scale.

Conclusion

The analysis of the social history has provided valuable insight into the segmentation of a dispersive social world. With so many permutations of Reiki coupled with varieties of evolving formal and informal organizational structures and ideological tensions between groups it is difficult to discern, from this analytic vantage point, what actually holds a dispersive world together? In order to answer this question it is necessary to look more closely at local level practice.

I argue that to more fully capture what is happening in dispersive SWs, such as Reiki, that it is necessary to accentuate the local level actions and interactions of individuals because they play a central role in the segmentation process and in determining the shape and direction of such worlds. Current applications of SWT tend to

fore-ground the representative voices of institutions and organizations in the maintenance of social order and/or social change and then consider how individuals are implicated within these processes. In the analyses that follow, I highlight the voices of practitioners involved in local levels of practice. Practitioner actions, interactions, and intersubjective experiences are fore-grounded while institutions and organizations implicated in the changing face of this SW serve as the backdrop. By doing so, I illustrate that internal world segmentation does not encumber the successful coalescence of an ideologically diffuse SW. In the ensuing chapter, I illustrate how coherence is possible through the concept of 'boundary objects' (Star and Griesemer 1989).

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[1] The data used in this analysis reflects historical details, frames of reference, views, and rhetorical claims of individuals and groups involved in the practice of Reiki. The 'Bibliography Primary Sources' can be found in Appendix pp. 212, 213. These data are presented through the lens of social worlds theory and reflect my personal interpretation of the social history and organization of Reiki, via this analytic frame. Indeed, there is no objective or definitive history of Reiki as each account is written from someone's perspective.

[2] Stein and Stein (2006) claim that Usui initiated twenty or twenty-one students as Reiki 'master'. Master is a contentious term amongst Reiki practitioners. Some groups claim that the term was not used by Usui and that the most advanced level of training is that of teacher and contend that it was Hawayo Takata who introduced this term. Practitioners tend to use the word freely but stipulate that master connotes the 'path of mastery'; analogous to a martial art. Part of the commitment of a Reiki teacher is to strive for mastery in the practice of Reiki.

[3] Prior to the introduction of Buddhism in the sixth century, Japan had a religion consisting of three elements: nature worship, Shinto, and Confucianism (Bryan 1924: 249). Shinto or the 'the way of the gods' is primarily a system of ancestor worship and is the traditional faith of the Japanese. In this religion "the spirits of the dead are all *kami,* beings of god-like rank and power, entitled to the reverence and devotion of the living" (Bryan 1924:251). Heaven and hell are not part of this religious belief system and morals except for 'manners', 'national customs', 'loyalty and filial piety' are unimportant (Bryan 1924:254). Bryan argues that Shinto has been "used as a motive to filial piety and national patriotism" because ancestors are considered to be living, all knowing, and prayed to for guidance, example, and counsel (Bryan 1924:251).

[4] In contemporary Japan kanpo refers to herbal medicine and is distinct from other techniques such as acupuncture, massage and moxibustion (Lock 1980).

[5] What is known about the society has been revealed through one Japanese member, Hiroshi Doi. Reiki as it is practiced within this society has three major levels and within these are six levels of proficiency. Doi Hiroshi also has his own school of Reiki called Gendai Reiki Ho; translated as The Modern Reiki Method (Rivard 2007). He has second level certification through the Usui Reiki Ryoho Gakkai Society (Stein and Stein 2003; 2006) and since 2000 has been in Master training (Rivard 2007).

[6] There is little documented about the medical knowledge of Dr Hayashi although his formal medical training would have been in Western medicine. In 1869, Japan adopted a German style of medical

education and in 1876 the government passed a regulation requiring all physicians to study Western medicine (Lock 1980:62).

[7] According to Petter (2007:23) 'byo' refers to ill, stiffness or tumor and 'sen' means gland.

[8] These scientific theories are linked to New Age ideas but nevertheless the science is based on theories of quantum physics. Such theories are widely used in the CAM arena to support notions of 'energy transfer'. For example, therapeutic touch and healing touch therapies used in nursing are framed in this way. Homeopathic medicine also relies on a similar framework.

[9] The complete translation can be found on The Reiki Threshold website: http://www.threshold.ca/reiki.

[10] Although I limit the discussion of the presence of Reiki to Japan and the West, I acknowledge that Reiki has a global presence (Melton 2001).

Coherence in a Dispersive Social World

In the previous chapter I provided insight into the social history, social organization, and heterogeneity of Reiki as a social world. In this chapter, I am interested in examining how practitioners relate to beliefs and practices connected with their work and attempt to explain how coherence is possible in an ideologically divided, dispersive social world. I argue that the answer lies in the concept of a "boundary object" (Star and Griesemer 1989). In this study, the 'energetic worldview' held by practitioners is a "boundary object" that holds a common meaning for practitioners while containing "multiple translations" (Star and Griesemer 1989) of reiki energy, Reiki practice, and objects central to Reiki practice.

Practitioners act toward 'reiki' through a commonly held 'energetic world view' which is based on the simple premise that everything that exists in nature is energy and that energy is not bounded by matter, space, and/or time. Trust in this core belief provides a foundation for entertaining varied interpretations and holding multiple truths about 'life force energy'. Similar to other forms of CAM, participants' convictions about their work were oriented in principles of science and/or ideas about spirituality. Regardless of the orientation, these meanings revolved around a core 'energetic world view'. I argue that a mix of beliefs allows for personal creativity and diversity amongst practitioners while a shared 'energetic worldview' brings coherence to their everyday work.

I begin by describing this shared belief in 'energy' and how it informs the notion of 'reiki' or 'life force energy'. I then tease apart the diverse definitions of 'reiki' and beliefs attached to Reiki practice held by participants. Next, I explore the shared

meanings that practitioners attach to healing energy and energy healing work. I then illustrate the "operational philosophy" which refers to the central ideas and procedures that practitioners use (Strauss et al. 1964). I look at how participants interpret their informal moral code, notions of self-responsibility and holistic healing. Lastly, I highlight beliefs about the procedural objects that are central to all Reiki practices. These include: touch, energy initiation or attunement rituals, and symbols and mantras. I conclude with a summary and highlight how the findings inform elements of SWT.

Shared Ideology or Energetic World View

One key feature of a social world involves the building of a shared ideology around a particular activity (Clarke 2005). Ideology refers to any "body of systematically related beliefs" that are basic to a group's way of life (Strauss et al.1964:8). Within the social world of Reiki practitioners hold a core shared ideology or 'energetic worldview'. Trust in this core belief provides the foundation for entertaining varied interpretation and holding multiple truths about 'life force' 'reiki' or 'healing energy'. In this study the 'energetic world view' held by practitioners is a boundary object. This concept is based on the premise that the form or structure of the object is common enough to be recognized by other actors yet may hold multiple "translations" (Star and Griesemer 1989). Practitioners 'translate' or interpret life force energy as 'reiki'. All Reiki related objects, meaning the ideas and concrete entities central to the practice of Reiki, oscillate around this common energetic world view or 'ideological boundary object'.

Core Shared Ideology: an 'Energetic World View'

Reiki practitioners believe in the reality of a 'life force' and trust that this 'energy' exists and functions through *matter.* For example, participants often explained that: "Everything is energy. Reiki is the energy that is all around us" (Reiki practitioner). They also claimed that "The body literally is nothing but energy, atoms, just like in a drop of water and every atom is connected to every atom through molecules" (Reiki practitioner). Practitioners believe that reiki has the potential to invoke healing by balancing the energy within and immediately around the body. Participants also claimed that the body is a medium for this energy: "The energy goes to me, through me, to you" (Reiki practitioner). "With reiki I'm just a conduit and the energy is going through me to the person or to me if I'm giving myself a treatment" (Reiki practitioner). Participants asserted that healing energy can positively impact non-humans or pets and/or inanimate objects. They told of putting this belief into action by directing healing energy to pets, food, and malfunctioning appliances or machines. In some instances, participants described this experience as a sense of presence in a situation:

> *I think because it gives me a reason to pause and think about the whole aspect of this food, this water, what do these things mean in our lives, how to treat them. And I think it's a very, very slight shift in how I respond to these things and how I look upon them.* (Reiki practitioner)

The idea of life force energy is also linked to ideas of *spatiality.* There are two dimensions that participants related to healing energy. One includes areas within and immediately around the body and the other involves all exterior places. Participants claimed that healing energy operates within the deep spaces of the physical, psychological, and spiritual dimensions of the body but that the energy is not confined to

these. According to this view the energy moves within all dimensions of *space* and can be transferred to other locations. Participants used this premise in concrete ways. For instance, they often sent 'distance' reiki to people in other geographical locations; for example, to a sick relative, a friend or someone they do not know in other regions of the country or world.

Temporality also plays a part in this world view. Participants claimed that reiki functions in all perceived dimensions of *time.* Again, this idea was regularly put into practice by participants. They worked on all sorts of health and illness issues, from the simple to the complex. Participants focused their intentions to direct the energy to situations that included the past, present, and the future. On different occasions they explained that they used this technique to heal emotional wounds incurred in the past. Sometimes they used reiki to change current patterns of behaviour, and at other times to ease anxieties about the future. Some specific examples of how distance healing was used include: *past* intergeneration issues, such as forms of violence, abuse, and/or addiction; *present* worries over finances, family members, working relationships, and end of life issues; and *future* fears such as going to the dentist tomorrow, having a job interview next week or becoming unemployed next year. Within this energetic worldview view, practitioners see reiki as an *unbounded force* that moves through matter, space, and time.

This energetic world view provides a translatable structure for reiki. Although actors within this social world recognize life force energy as 'healing energy' they assumed shifting orientations, and held fluid beliefs and views of reiki energy. This first

became apparent in their varying definitions and descriptions of reiki healing energy and Reiki healing work.

Boundary Object Translations

Reiki as Healing Energy

'Healing' was the metaphor that participants most often used to describe this energy. Rhetorically, practitioners use the idea of healing as a way to describe the balancing of energy within and around the human body or other objects but in conversations they described the features of reiki in varying ways. First and foremost, they held mixed and fluctuating beliefs and views about the nature and origin or source of this energy, and filtered their interpretations through an amalgam of ideas based in science and/or spirituality. Although all practitioners referred to reiki as 'universal life force energy' they also described it as a 'vibration'. While some claimed that this was 'electromagnetic' energy others asserted that it was 'light' energy. Still others described it as 'natural energy', 'earth energy' or 'divine energy'.

While a few participants claimed that reiki is not "supernatural in any way" (Reiki practitioner) others more adamantly claimed that "spirituality is in essence what drives the entire act of Reiki" (Reiki practitioner). Participants most heavily invested in regarding reiki healing energy as 'spirit' or 'spiritually guided' stressed that reiki was healing energy that emanated from a divine source: "Healing I think is beyond the physical and it's really a matter of the spiritual" (Reiki practitioner).

> *I mean that's ultimately, like I say the healing energy, but ultimately it's about offering that light... if I really want to feel that*

> *kind of divine presence that's what I can get from Reiki* (Reiki practitioner).

There was little agreement amongst participants when asked to explain the meaning of source. Some claimed that life force energy is a 'gift' from a sacred source such as 'God', the 'Universe', 'Divine Consciousness' and/or the 'Great Spirit'. Participants also made varying assertions about whether the energy originated from an *external source* such as 'God', a 'Higher Power', or 'Great Spirit', or an *internal source* such as 'Self' or 'Divine Consciousness'. Some practitioners shifted between interpretations. For example, some who self identified as Christian described reiki energy as a vibration or electromagnetic energy that was a gift from God and then claimed that the energy was 'the holy spirit'. In other instances, 'Light' was at times described as the 'Source' and reiki as a spectrum of healing vibrations but the meaning of 'source' was left to the audience member to interpret. In other interviews practitioners avoided attaching spiritual metaphors such as God or the Divine to the word source:

> *By light I mean the Source and I believe the Source has many vibrations coming from it and reiki is a vibration or vibrations of healing. I mean reiki is the healing aspect of all those vibrations that come from the source; those vibrations that are associated with the physical, mental, emotional* (Reiki practitioner).

Reiki Healing Energy as Sentient

In some situations, participants anthropomorphized reiki, describing it as 'intelligent' or 'sentient'. As one participant noted "I don't have to be concerned about what's in this particular part of the body or what's happening there. The energy is very smart" (Reiki practitioner). This notion aligns with a belief held by other practitioners; that they are intuitively guided by this force. In accordance with Takata's view some

practitioners claimed that "Reiki will teach you. Therefore the more you connect to the reiki the more it will teach you what you need to know when you need to know it" (Reiki practitioner). By trusting in this potential practitioners came to make sense of and gain respect for tacit knowledge.

The logic for this lies in the tendency to connect the idea of intelligence to a divine source. For instance, some participants claimed that reiki was intelligent because they believed that the energy emanated from the 'holy spirit' or from one's divine self. In contrast, other practitioners stressed that it is the body's intelligence that directs the healing energy to where it is needed and made no reference to the energy as having intelligence or agency:

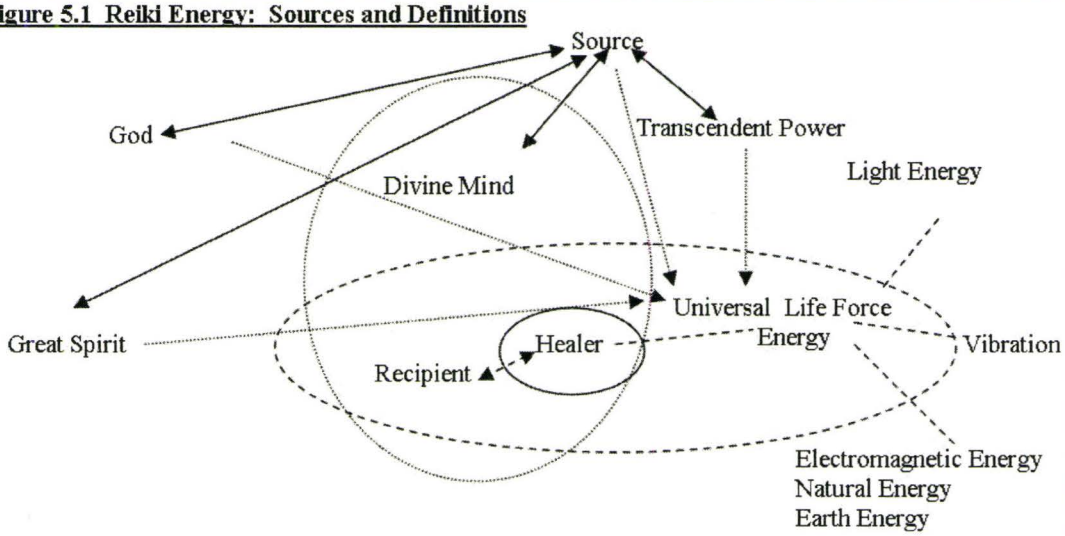
> *I am not actually effecting healing. I am not entering your body and arranging your cells in a pattern to create health. It's about them using the energy. It's about them and their own body taking use of what's around them and it heals itself. I believe very firmly in the body's personal intelligence and its ability to heal itself* (Reiki practitioner).

Another practitioner said: "The person receiving is doing the healing himself" (Reiki practitioner).

Figure 5.1 is visual depiction of the symbolic 'sources' and definitions of reiki as described by practitioners. This was inspired by Meredith McGuire's (1988) models. The sources of energy described by practitioners are illustrated with the double ended solid arrows. These include God, Great Spirit, Divine Mind, transcendent power, and universal life force energy. The words used in definitions of 'universal life force energy' and are depicted with broken lines. Light energy, vibration, electromagnetic energy, natural energy, and earth energy were all used in descriptions of reiki. The energy field

encompassing healing facilitator and recipient is represented by the circular broken line that matches 'universal life force energy'. Finally, 'Divine Mind' encompasses the 'Minds' of both recipient and healer and is illustrated by a circle with smaller broken lines.

Figure 5.1 Reiki Energy: Sources and Definitions



The illustration reinforces the idea that this healing energy is an object that is defined and symbolically interpreted in diverse ways. While some participants related reiki to a Divine Source others did not. Similarly, healing energy was defined in scientific or secular terms as well as with spiritual metaphors. Such variation is also noted in the work of other scholars who have examined beliefs associated with non conventional healing practices (Low 2004; Bishop et al. 2007). Unlike Low's 2004 study, I did not find consistent patterns amongst practitioners with respect to the source of the energy and interpretive definitions of such healing based on religious affiliations. Interpretations of reiki and its source are interpreted within the practitioners' own system of beliefs but these symbolic interpretations were used flexibly, interchangeably, and in some cases

changed over time. Practitioners often commented that "each individual will define reiki in accordance to their system of belief". Indeed, the malleability of how this energy is perceived and packaged by individuals and groups with different views and beliefs is reinforced in this comment:

> *And I've noticed that too, that every person I talk to from every creed, race, religion, ethnicity, any sort of background at all, it's all... I don't even want to say reiki because that even is the Japanese word... it's all energy healing but it might just be through their personal cultural experience, their personal religion, their personal philosophy. But it's all the same thing. It's just how we choose to clothe it that's unique* (Reiki practitioner).

Although the energy is interpreted in diverse ways, the symbolic meanings attached to this object resonate with the shared ideology or energetic world view of this social world and with practitioners' deeply assimilated personal beliefs and views. Interestingly, participants also identified with healing in ways that emphasize that the energy holds deeper and more commonly aligned meanings than the previously described definitions and orientations suggest.

In the sections that follow I illustrate that, common values which include qualities of virtue, fulfillment, and respect for tacit knowledge emerged in practitioners' descriptions of how they interpreted the energy and the practice. These underscore participants differing and at times contradictory and shifting interpretations of a healing life force. Based on shifting alignments with ideas of science or spirituality participants described the meanings that they attached to energy healing thorough 'feelings or sentiments' and/or through ideations of spirituality and spirit. While I separate these as much as possible for analysis purposes, I must stress that during both participant observation and formal interviews participants' ideas often shifted and overlapped.

Reiki Healing Energy as an Expression of 'Feeling'

The *'feeling' metaphors* commonly attached to reiki by practitioners included expressions such as harmony, balance, wholeness, connection, perfection, unconditional kindness, love, and compassion. Such idioms are common to both Eastern mystical and Western mystical traditions (see McGuire 1988) and/or are part of the current transpersonal psychology lexicon[1] (Glik 1990). They exemplify qualities of 'virtue' and 'fulfillment' that practitioners try to cultivate within themselves and desire to pass on to others through their work with reiki energy.

'Feeling' metaphors were often used by participants who held an affinity toward more psychological representations of healing energy. "Reiki [energy] is love and when you have a loving relationship it's the same as having energy. So it's not different really" (Reiki practitioner). In a similar manner another practitioner used the same metaphor: "What is love? Well it's a feeling. Well that's what healing is. It's a feeling, a very deep feeling"(Reiki practitioner). For some, the sentiment of healing was summed up as absolute fulfillment:

> *Have you ever had a moment when that moment is just absolutely right? You're sitting down, your tea cup is full, you've got an hour to spare, there's sunlight coming through the window, you're reading your favorite book. I don't know whatever it is for you but in that moment there's absolutely nothing else that matters, it's not an emotion it's a sense of perfection of the moment which is bigger than emotions themselves (*Reiki practitioner).

As this practitioner continues to point out, this ideal state is not a permanent accomplishment: "You may not be feeling joy or love or something that you can put a word on but in that moment everything is just absolutely perfect and it won't last, but it will for a while" (Reiki practitioner).

In some instances practitioners linked the feeling of 'connection' or sense of being, to the notion of 'synchronicity'. This is a concept that was introduced by psychiatrist C.G. Jung. He used this idea to relate coincidence with 'psychic' experience. The notion has become popular through transpersonal psychology and 'New Age' literature.

> *It's pretty huge. It's like synchronicity; you just have a knowing that everything is okay. It's fine. It's learning. Things just happen. And that happened before Reiki but just that part of me. I've always been spiritual so it's hard for me to define…It's just that things always seem to fall into place even when things are very difficult. It's like saying a prayer; then things happen, things change. Or wanting something and not knowing how it's going to come but it comes in some way.* (Reiki practitioner)

The idea of synchronicity provided some participants with a concept within which to make sense of their perceptions of life events in relation to their interpretations of reiki energy. The following quote exemplifies self-fulfillment through a feeling of interconnection:

> *I remember coming back from that training and just noticing more of the animals that lived around our house, for some reason the rabbits had come out that particular night when I got home. What happens usually after spending a lot of time in the reiki training or going to a distance a group healing, a reiki circle, …what I call 'Reiki events' tend to happen; where more synchronistic events tend to happen things in that you notice more things and the connection between things* (Reiki practitioner).

This feeling of 'connection' expressed though the notion of synchronicity became part of their personal biographies. They made sense of trusting in reiki through this idea.

"What I believe about reiki is that when a person is ready, a teacher will show up, that is generally true for what ever in life but we're talking about Reiki now" (Reiki practitioner). Another explained that in healing through reiki "things always seem to fall

into place even when things are very difficult (Reiki practitioner). Other practitioners attached multiple meanings to the feeling of energy healing which crosscut scientific and spiritual orientations:

> *I would call it a loving, healing vibration that allows us to move towards wholeness. So when our energy system is out of balance for whatever reason- mental, emotional, physical, spiritual- this is a loving energy, from the source, that brings us to balance* (Reiki practitioner).

Reiki Practice as Feelings of Virtue and Fulfillment

Feelings about healing also extended into ideas about reiki energy in practice. For example, some practitioners linked feelings of compassion and the desire to bond with others with the practice. This reinforces that practitioners express their belief in the virtue of Reiki through sentiments of compassion:

> *I really believe that it's a compassion thing, like when I work on people I feel so much compassion and nurturing for a perfect stranger, you know, and like why does that happen? What's connecting us?* (Reiki practitioner).

For others, fulfillment was described as a feeling of a novelty and sense of connection with others:

> *And so when someone comes to get on the table I'm in awe each and every time. Doesn't make any difference how much I've worked on it. Every time it's different and I'm in awe every time. What is the connection? Where does that come from? How does that all of a sudden surge so beautifully? And I can feel that. I'm in awe. It's opening up, waking up the feeling* (Reiki practitioner).

Participants' views and beliefs about energy and the meaning of Reiki practice were often expressed through metaphors of feeling and sentiment. While some participants used these kinds of interpretations to make sense of healing energy within their personal biographies, and in their working relations, other participants were more drawn to notions of reiki as 'spiritual' or spiritually guided energy.

Reiki Practice as Spiritual Expression

Some practitioners explicitly related their practice to spirituality. One participant, a general practitioner, summed it up in this way: "Reiki is a spiritual discipline. It requires spiritual awareness, spiritual discipline, spiritual responsibility" (Reiki practitioner). The notion of spirituality was defined by practitioners in various ways: as sense of spirit or purpose; as a sense of divine connection; a sense of being in the world; and as engagement with the spirit world. As is illustrated in the following quote, purpose was expressed as a desire for personal meaning:

> *For me spirituality is our spiritual path to find. This is a question everybody has. Why are we here? What are we supposed to do? That's the quest kind of. That's for me spirituality, to go that way and find out what kind of spiritual person you are, right? What are you supposed to do and find out about that; that you could say is where your spirit comes from right* (Reiki practitioner).

Spirituality was also perceived as the personal experience of divinity but also as the desire to help and support others. This is an expression of spiritual virtue:

> *I think more my definition of spirituality is on one side its a connection of myself to a spiritual source or a universal source but also I think the spiritual aspects of helping other people in you know just to help them in whatever ways that you can benefit other people to help them along their way through life…*

This practitioner went on to describe what he meant by supporting others:

> *But there is also being able to be there for somebody who needs support and when they're having difficulties. I volunteer at a Cancer Support Centre giving Reiki treatments and the last time I was volunteering, the person who came in for a treatment I had heard that that person's father had recently passed away, about five months ago but that person was still having problems dealing with that loss, so it wasn't just me being there for the healing aspect of giving the Reiki treatment which has a physical and emotional aspect to it as well, she needed someone to talk to and so me just being there was important for that person at that time* (Reiki practitioner).

Some practitioners defined spirituality as divine connection which involves locating the authentic self. This reflexive process involves establishing a bond with the divine, in whatever form that may take for the individual. This connection is one route to spiritual fulfillment:

> *Spirituality means connecting with the divine and the divine is not just the god source or the, you know, the all that is. It's also connecting to your own higher self which is still connected to that divine source, right?, and your spirit guide and it's learning to understand how all that's connected and empowering yourself to become the true centered person that you really are and knowing what that is and how to go about to become that* (Reiki practitioner).

Through energy healing practitioners may or may not develop or 'grow' their spirituality; that is a personal choice. Nevertheless, it was noted by these participants that Reiki "opens a door" or "opens a window' to spirituality. Some become very engaged in that process and others do not. If such a route is taken, it takes on different forms of expression, and may lead the practitioner in new directions:

> *It opened a door to spirituality. I probably had that sense before but not labeling it, but certainly going into the alternative helped because I'm a wide person. Like okay, how does this work...I guess I'm open. I'm open. I like parts of Buddhism and I like parts of Catholicism and I like parts of Judaism. But to follow them in their rigid form, no* (Reiki practitioner).

For some practitioners this connotes shedding previous beliefs and coming to a new understanding of spirituality than was previously realized:

> *Everything and everybody are connected. I used to believe, through the Catholic church that there was a personified person that had the finger that pointed yay and nay and I now believe in a loving source and it's a mystery to me* (Reiki practitioner).

Lastly, spirituality, for some took on dimensions that transcend these definitions. In some cases spirituality was defined by practitioners in terms of their experiences with

spirit or with the spirit world. Often, these incidents occurred prior to their involvements with Reiki and in most cases this began in childhood. Engagement with spirit involved a range of psychic abilities and/or gifts as 'natural healers'. In the latter, engagement with the spirit world involved experiences with 'spirit guides' and other psychic or paranormal events:

> *I have two spiritual guides that I know very, very well and have been in my life and very obvious and prevalent for a long time. One, was with me throughout my childhood and I did not tell anybody....You know. I knew then. I knew then that I was connected to something bigger and I knew that earth had something to do with it and sky had something to do with it. It wasn't necessarily a man sitting up with a stone and a set of rules. [she laughs] I knew that. I knew that then. And that kind of followed me through life* (Reiki practitioner).

These practitioners found great comfort in finding a medium that personally validated their previous experiences and/or abilities. One practitioner, a seventy-seven year old 'natural healer' with psychic abilities described personal validation in this way: "Reiki gives you the structure and makes your belief real. This is what I feel about it. It's an important thing, very important; the structure and the feeling to you that this is real. It is real" (Reiki practitioner). In these instances, spiritual fulfillment was validated through the practice of Reiki. In conjunction with these beliefs other centrally related concepts also emerged in the interviews.

Hence, the meanings that participants attached to reiki energy reflect similar values and desires. Practitioners interpret reiki energy healing as a "sense of feeling", a "sense of being", and a "sense of knowing" that is expressed through qualities of virtue, a desire for fulfillment that includes self and others, and a respect for tacit knowledge. Important then, is idea that ideology also encompasses what people value. Common

values and desires are part of the therapeutic ideology of participants. These resonate with their shared "energetic world view" and buttress shifting orientations and beliefs about reiki or healing energy.

Operational Philosophy

A characteristic of a social world, related specifically to health and healing professions, is the existence of an operational philosophy. According to Strauss et al. (1964:360) these are the "systems of ideas and procedures" that practitioners use to put their therapeutic ideologies into action. The core ideas, principles, and procedures are objects basic to Reiki. Practitioners' interpretations of these objects are derived from the meanings they attach to reiki. These in turn align with and/or oscillate around their 'energetic world view'. The central principles/ideas include an informal moral code, notions of self-responsibility and holistic healing. The core procedural objects include touch, energy initiation or attunement rituals, and symbols and mantras.

Informal Moral Code

Practitioner behavior is in part shaped through the informally established *moral codes* set out in subworlds of practice. Strauss (1993:60) describes a moral code as the "norms and rules and agreements that pertain to ethical values and issues". The Usui principles presented in Chapter Three are illustrative of an informal moral code. Some practitioners relied more heavily on the Usui principles than others yet all interpreted the Usui precepts through their personal world views. For example, one participant described how she emphasized the precepts with her clients:

> *I always give them the paper with 'Just for today I will not worry.' And I always say 'That's not easy.' 'Just for today I will not anger.' You're going to feel it,*

> *but you're not going to kill anyone. 'Just for today I will do my work with integrity.'*

The same practitioner encouraged her clients to adopt the guidelines as a way to improve life their situations:

> *And I say 'And if you haven't got a job you get up in the morning. You get dressed. Put your shoes on and you go looking for one. That's integrity.' And they're chuckling. 'Just for today I will bless all living things.' And 'Just for today I will give thanks for my many blessings.'...So even if you didn't know a thing about Reiki and you had that affirmation on your fridge and you followed it, that's living with purpose* (Reiki practitioner).

In contrast, other practitioners were less inclined to stress the principles with their clients but nevertheless trusted in them to morally and ethically guide their personal routines:

> *The other thing too is before I even do a treatment, even somebody that's not spiritual, not religious, doesn't need to believe in any of this stuff. I don't say a word. Okay, let's do a Reiki treatment. And I'll go through the process. Before we do that I will ask to myself 'Please bring in the energy, the healing for this person's highest good'* (Reiki practitioner).

Others commented that they relied on their own sense of morality and did not "bother with Usui's principles" (Reiki practitioner). In Reiki, similar to other health practices, self- responsibility is closely linked to a moral imperative.

Self-Responsibility

The informal moral imperative of the practice was often coupled with the notion of self-responsibility. Practitioners, overwhelmingly, stressed the moral responsibility of the practitioner to clients/recipients. The free will of the client, the responsibility of the practitioner to respect the client's choices, and tolerance of recipient views were expressed in the following ways:

> *Everybody has to live their life so you can't impose your will on others, you can only talk about it and if it doesn't go anywhere than its fine, just let it be. What*

> *you do is you put it out to them, let them handle it, they know, and it always works perfect, perfect* (Reiki practitioner).
>
> *I'm very much aware of keeping people completely relaxed always under their own control to choose to do what they want to do and always keeping people comfortable that way* (Reiki practitioner).
>
> *It is important not to impose how I'm feeling on the other people. And not to interfere with other people's concept of the rest of the health care that they may be receiving* (Reiki practitioner).

Self-responsibility for health is a commonly cited characteristic of holistic or CAM practices (Low 2004; Lowenberg 1989; McClean 2005; Pawluch et al. 1994) although not a feature that is unique to CAM (Pawluch et al 1994; Roy 2008; Waldram 2008). Participants repeatedly disclosed that the ultimate responsibility for health and healing lies with the individual. Practitioners made comments such as "It's our responsibility to be healthy or to be unhealthy as we see fit" "I really believe the desire to get well is underlying everything. If you don't have that desire, if you want to be a victim all your life, well you're going to be", and "I truly believe that the only person that you can change is yourself. This was considered an essential ingredient of their self healing process and a necessary prerequisite of healing facilitation work:

> *I think that the self care is essential because if I don't look after myself I'm no good to anybody else either. But I use it for my own personal.... I mean I think I'm worth looking after. So I do care for myself. As I said I do Reiki I think just about every day. When I wake up in the morning I do a short Reiki treatment on myself and before I go to bed at night, before I go to sleep at night I do a sort Reiki treatment on myself* (Reiki practitioner).

In conjunction with taking self responsibility, practitioners then foster this idea in their work with others. As one practitioner put it: "And it takes a patient letting go and seeing the big picture and accepting responsibility and changing their behavior and all

that stuff" (Reiki practitioner). Most practitioners believed that by being proactive about one's health, through Reiki, that people could feel empowered:

> *But it is very, very important to take back our power and usually after a couple of treatments I will say to the person 'Learn it. Don't trust me to give you Reiki. Learn it. Give it to yourself.' And the better they learn it, the happier I am* (Reiki practitioner).

For practitioners, Reiki practice provides a medium within which the individual may potentially put self-responsibility into action; both as a regime of self-care and as a therapy; as a way to help others as they move through the process of healing. Some participants viewed the practice as mutually beneficial: "So for me when you work with someone, when you give to someone, you give to yourself. So the motive is sharing but it's for my own healing" (Reiki practitioner). This further reinforces the notion of Reiki as a conjoined or dual practice of healing.

Through Reiki practice there is also a two-fold acknowledgement: a belief that individuals can control how they perceive and behave toward health and illness in conjunction with an acceptance that there may be little control over material outcomes (for example being cured). As one practitioner noted, there are times when clients have improved physically through integrative care but healing can have or take many forms and does not necessarily connote curing. Here the notions of support and interconnection that are described reinforce the "virtues" that participants believe in:

> *And it's very humbling for me really. A few times they got better due to the doctor, themselves, and me. And then one fellow drank antifreeze in the winter. And he was only in his 40s and he was burned on the lips and arm. He didn't get better... he was comatose when I got over there [ICU.] His family didn't know where he was. He was homeless. And the miracle was they got him down here by ambulance, put him in a nice bed with sheets, love, care, the last week, and his family, three or four of them were able to come and see him even though he*

> *couldn't see... but I said 'He knows you're here.' But the healing was that he was found after all that time and they saw him before he died. He's was never going to live. He was all burned inside.* (Reiki practitioner)

Seasoned practitioners are well aware that disease is unpredictable and often produces unpleasant and undesired results. This is made sense of through personal world views; that life is played out according to a 'divine plan', that events happen because of 'karma', that what happens is 'up to God', it is 'meant to be' or 'part of life'. These world views tend to relieve practitioners of self-blame; a noted consequence of the moral imperative of self-responsibility (McClean 2005; Minkler 1999). One practitioner said "when I first started with Reiki I thought everyone should be healed. But sometimes that is not what is best for the person. And someone much greater than us decides. And now I don't get upset when a person is not healed". This is an understanding that other practitioners also shared:

> *And it [Reiki practice] always just keeps the ego in check, which I really like because you can get caught up in 'I'm going to heal this person or that person.' It's really not up to us. You can guide, you can help, but you're not in control of any of that.* (Reiki practitioner)

Finally, the healing practice provides an *emotional anchor* in times of crisis and uncertainty and becomes a pragmatic way to perceive personal control in situations where there is a perceived loss of control or when the situation is beyond personal control. The following quotes are illustrative of this. A seventy-seven year old Reiki Master described his experience:

> *See I lost my first wife. It was, hard to believe, eleven years ago on the 25th of February. And I knew, October 22nd the year before she had a tumor...I'd work on it but it kept growing. ...And like I said we knew that it was going to be somebody's will greater than ours. And that's what happened .... They let me do everything, administer everything, keep track of everything, administer the*

> *morphine pain pump, and her medications and I did everything for three weeks. I had no sleep at times at all. But I got the energy that I needed to do that from Reiki.*

A fifty-six year old Reiki Master tells of a similar experience through Reiki:

> *So when I left that first class, my sister died ten days later, the relationship that I was in for four years ended, and I wasn't the happiest camper. So in mid July I borrowed a van, went to [a] campground and spent two weeks on my own. So I would get up early in the morning and walk and walk the beach area and just do whatever and try to find some peace with it all. I just think that through it all, I thank the universe for Reiki because I don't know if I would've gotten through that time in my life, not that it was easy, I don't mean that, that I got through it in such a healthy way that I think the Reiki helped there, as I look back as of 15 years now and as I look back I don't know that I would have been as strong, that my choices would have been as healthy... Reiki helped with just the setting aside and looking at things and getting on with life.*

An eighty-eight year old female Reiki Master with coronary artery disease expressed it in this way:

> *So every time you give a treatment you are benefiting from that energy coming through you. Also I think it affects your lifestyle. I think it soothes you so you're less anxious. When you get angry you recover and forgive and let it go much faster and so it's very good for your emotional life.*

For practitioners, the notion of self-responsibility is reinforced through the practice of Reiki and this belief buttresses their individual philosophies of practice. The notion of holistic healing is also a central principle of Reiki practice and a concept that resonates with how Reiki practitioners' value the practice.

Holistic Healing

Self Healing

Reiki is illustrative of holistic healing in practice. Reiki, similar to other CAM practices, is viewed as holistic, first and foremost because it *acts restoratively* on the whole person: "Reiki can restore the energy to the body, supporting the body with the

energy to heal itself. Reiki acts on all levels: physical, psychological and spiritual. Reiki can restore health by releasing blocked energy" (Reiki practitioner). This holistic, approach encompasses the physical/mental/ emotional and spiritual dimensions of health in what Dossey (2003:A11) refers to as the "recovery, repair, and transformation" of the person. Indeed, healing in conjunction with self transformation experiences have been described in previous studies of CAM use (see Foot-Ardah 2003; Low 2004; McGuire 1988; Pawluch et al. 2000) and in the health and illness literature more generally (Charmaz 1991). In the everyday practice of Reiki holistic care is an 'emergent process' that involves caring for and caring about self and/or others. Participants viewed Reiki as one medium within which to practice self healing and/or to facilitate the healing of others. One practitioner summed up self healing in this way:

> *I would describe Reiki as a very fundamental sort of part of who I am and at each level it's made a fundamental change in my person and who I am as an individual and I see that in my students and in my colleagues as well. There seems to be a very steady increase where with each level you go through a sort of a physical and emotional and sort of a spiritual cleansing and then you kind of, like once you start on that road there's no other path. You're just kind of there and you just keep walking. You don't know really where you're going but that's okay. So I think for me it's a very personal thing and it's a very spiritual thing.*

The Usui method is an approach to energy healing that participants use to achieve an optimal state of situated health; that is the best possible status of mind, body, and spirit within the particular life circumstances of the individual at any given moment in time. One practitioner described the commonly held view of health of Reiki practitioners in terms of lifestyle:

> *I would define heath as optimal conditions for living life to the full. Suffering is optional. Pain doesn't have to mean suffering. Pain means something is wrong.*

> *We want to reduce the amount of pain and suffering in our lives so by living properly in a holistic and healthy way. That to me is health.* (Reiki practitioner)

Typical of other forms of CAM, Reiki is also an individuated practice in that practitioners may prefer to see clients who have specific health issues; for example cancer, abuse issues, chronic pain, palliative care, etc. Regardless, practitioners view their practices as holistic because of their conviction that 'Reiki works all ways' regardless of the manifesting symptoms or issues. In the interviews participants often stressed that Reiki was useful in all aspects of health and illness. These include physical, psychological, and spiritual dimensions of both self healing and healing facilitation work. As a holistic practice, practitioners embody the practice and although they perceive discernable effects these meld together. One participant summed up each level of healing that she experienced through her practice of Reiki:

> *Reiki has become an intrinsic part of my life path itself so it's hard to separate but for example, so on a physical level, I feel like I don't, I always look within first if there's any physical issue, knowing that our emotions, how connected we are to the divine, all those have such an impact on our physical so I no longer look at the physical in isolation. It's allowed me to feel healthier from a physical perspective. Since it's been in my life I'm a healthier person all round....On an emotional level, it has helped me be much calmer; I'm sort of type A personality go, go, go and erupt easily when things don't go right and all of that was affecting my family my relationships and it is a journey and I can slip back into that now it again but the frequency and intensity of my emotions are much more regulated now and I can move to that centered place much more easily now. Mentally, I guess I feel it's kept me sharp and interested in life and excited.*

She described the spiritual aspects of healing as intrinsic to holistic healing:

> *Spiritually it's been a profound journey to my fellow human beings. I started out career wise as an environmental engineer and really looked at humanity and thought somewhat arrogantly what a stupid bunch of people [she laughs] that we are doing this to our life support system mother earth. So I came into my environmental engineering and then subsequently environmental activism with quite a sense of bitterness and anger toward my fellow human beings. So the*

> *Reiki journey has definitely helped me, not only be more compassionate toward my fellow human beings and I continue learning. So from a spiritual perspective it has been truly the most profound journey that again continuous and evolves daily; of just being more, and more, and more connected to the fabric of the universe.*

As described in the above account, practitioners' commitment to self-healing converged with a desire to facilitate the healing of others. It is at this intersection, where holistic healing is embraced in practice that Reiki becomes embodied. The meeting point between self-healing and healing facilitation is summed up in terms of commitment to both:

> *I'm committed to doing my own [self-healing] work. When does that finish, right? I don't think it does until we're done with this lifetime...For me the commitment is that I'm doing my own work and working on healing my own issues. And then as I heal, I can meet with people and say yeah, that's a lot of bravery and we can do this together. You and I can do this together. And I can say to them 'You know, I can be here for you. I can hold that for you with compassion while you move through your struggle.* (Reiki practitioner)

At this juncture the expression of Reiki as a 'conjoined practice' solidifies in the amalgam of self healing and healing facilitation work.

Healing Facilitation:

As healing facilitators, practitioners deal with the holistic needs of clients which include the physical, psychological, and spiritual aspects of healing. Practitioners hold the view that physical illness is an explicit sign of energy imbalance and that pain is a warning signal of such imbalance. Through treatment and or training this balance may be restored but in what ways and to what extent this will occur is uncertain. "So it works. Not every time, but to some degree" (Reiki practitioner). Practitioners treat a wide variety of physical problems and similar to other forms of CAM often see clients suffering from

chronic diseases and end of life issues. Practitioners also believe that physical improvements are often contingent on emotional and spiritual healing.

Emotion work figured predominantly in healing facilitation work. Practitioners worked with clients in 'releasing' pent up emotions that they believed were the cause of physical symptoms. One practitioner revealed that in her experience with clients where "there's pain there is also emotional baggage in that spot". Drawing the clients' attention to a particular emotion during Reiki treatment is perceived to be a useful technique in releasing physical discomfort:

> *I had my hand on her back... I said 'Remember about the story that you told me when you came in this afternoon about the anger and frustration that you were experiencing, if that would have anything to do with where my hand is right now'. And it wasn't 30 seconds until she said 'Oh I was so...' And she got into it, right? And I just kept my hand there and I said 'Do you think there might be a connection between the pain and your experience?' And she looked at me and she said 'It isn't there any more.' I said 'Oh, gee, that's good then'* (Reiki practitioner).

In conversations participants also came full circle in describing the importance of spirituality to the process of healing through Reiki and the importance that this holds for self–actualization: "Healing isn't just about alleviating an ailment, it's about growth; it's about becoming more fully who you are" (Reiki practitioner). While some practitioners considered spirituality to be but one 'element' of Reiki practice other described it as the core of holistic healing:

> *But there is something else I'd like to say about Reiki because I think it's really important. I think that Reiki does have a spiritual dimension as well as an emotional, physical healing. I think it really works on your spirit as well and it really helps to open up your chakras [energy centers] and if people want to, they can be in touch with spirit as well as work out their emotional stuff and their body ailments and ultimately you've got a healthier spirit aligned with your body. So if Reiki only works by trying to heal the physical dimension or even heal the*

> *emotional dimension to me that's not really enough. You have to somehow help it through to the spirit. (*Reiki practitioner)
>
> *Health okay, our physical being can be in great shape or not or anything in between but healing I think is beyond the physical and it's really a matter of the spiritual* (Reiki practitioner).

For those committed to the practice of Reiki it becomes embodied in everyday life. As one practitioner stated, Reiki is about "life integration". As a lifestyle measure, participants described Reiki as an effective tool to help and themselves and their clients reduce stress and enhance well-being. Practitioners basically believe that the holistic balancing of energy alleviates the anxieties of everyday life. Nevertheless, they described this as an ongoing process that requires consistent re-balancing:

> *Well Reiki is the balancing of mind, body and spirit. I mean you can go on a massage table and be worried and they can take the knots out of your muscles but there's peace of mind that comes with Reiki. Unfortunately you go back out into the world and with the stresses of it you're going to become unbalanced again but you've experienced something that hopefully becomes a touchstone in your life and you want to go back there to that balance* (Reiki practitioner).

Also, with respect to lifestyle, some practitioners stressed that creativity and self confidence can be enhanced through committed Reiki practice:

> *I think coming to a Reiki course, having an initiation would improve you as a mom, it would improve you as a corporate business person, it would improve you as a jailer, it'd improve you as a hangman I suppose, whatever you're inclined to do (laughing) I'm not judging* (Reiki practitioner).

In summary, holistic healing is the cornerstone of Reiki practice as all aspects of health and healing are considered important. Practitioners believe that Reiki treatment captures all dimensions of healing although the client may be more centrally focused on one or more health or illness issues. Participants were strong advocates of the notion that "We're not little pieces, separate compartments. We're all connected and what influences

or what affects one level of our being is also going to affect the other levels" (Reiki practitioner). Holistic healing is central to the conjoined practice of Reiki. As an object, holistic healing resonates with the other objects of practice. In the next section I consider the meanings that participants attached to the common tools that they use in their practices.

Procedural Objects

Three procedures central to Reiki include the use of touch in the transmission of life force energy, attunement rituals used to activate energy balancing, and the use of healing symbols and mantras to target specific aspects of healing; for example, emotional healing. Participants considered touch to be the central tool in the Reiki practice but attached different meanings and varying degrees of significance to the other objects or technologies of practice available to them.

Touch

Practitioners use touch as the central medium through which the healing energy is transferred. In a Reiki encounter, touch is used both physically though direct contact and consciously as intention. In face to face exchanges, the practice requires the use of both intentional and physical touch. The therapeutic value of touch to health and well-being is recognized in health professions literature and considered to be "a fundamental aspect of therapeutic communication" (Gleeson and Higgins 2009: 382). The salience of physical touch within the therapeutic encounter cannot be overstated. Physical touch has been reported in the literature to be of value in the alleviation of pain, reducing anxiety, providing reassurance, and in inducing feelings of security and calmness (Gleeson and

Higgins 2009). Practitioners commonly reported these reactions from clients/ patients /recipients. They often claimed that in giving a Reiki treatment there is "a tendency to calm and relax the body which creates the conditions for healing and health to occur" (Reiki practitioner). Belief in the importance of physical touch as a healing measure and as a cornerstone of the practice was often expressed by participants:

> *And I think it's in our society we don't touch any more. It's like a taboo. There have been so many losses in things like that. We went too far with it. So people aren't used to someone just touching them. And we're human. We need that connection. ...I mean that's huge and it heals so much more than what we think it does.* (Reiki practitioner)

In some cases it was a central part of their belief in and commitment to method. For example, one participant explained that a pivotal point in her career as a practitioner happened when she gave a Reiki treatment to a young man in his early thirties. He had been in a fire at a young age and had sustained severe burns to his head. She explained:

> *So he came. And he had a wig on. I didn't know it was a wig. It had a pony tail down the back and he said 'Do you do heads?' And I said 'Oh yes.' He said 'Well my head has third degree burns on it.' And he took off this wig. And I'm sitting... I had a table and it had a little round piano bench that I swivelled to get it higher or lower... that was my chair. I got such a shock when I saw the craters on his head. It looked like the moon....And he said 'no one has touched my head since my grandmother died.' And it was prophetic. So I'm so soft-hearted. And I decided 'From now on folks I'm going to continue this work if someone comes in sincerity and nothing is going to deter me.'* (Reiki practitioner)

For others, the belief in the importance of the physical touch that occurs during Reiki therapy was also reinforced through their personal experience as a recipient of touch: "I live on my own so when somebody touches me in that kind of loving way it's beautiful because I don't normally have anybody touch me like that" (Reiki practitioner).

Touch as mentioned in the previous section is not confined to direct physical contact. In cases where the recipient is not physically present touch via intention is provided by practitioners through non-local or distance healing. While some practitioners maintained that "distance healing" is akin to "prayer" other practitioners stressed that it is focusing a positive conscious intention toward another person, animal, or thing. Practitioners whose beliefs did not personally align with notion of prayer tended to rely on theories of quantum physics to make sense of the potential of healing through intention. The central principle here is that matter and energy are interchangeable. It is understood that electrons are both patterns and waves and that non-local effects may occur (Benor 1995: 234-236). These are also principles that support the idea of reiki as bio-field energy and do not preclude religious/spiritual beliefs.

Attunements or Initiation Rituals/Symbols/Mantras

In accordance with the Usui Method, practitioners believe that energy balancing is the core of method. Some practitioners claim help that rituals are performed to initiate or 'activate' energy balancing and/or to enhance this process. Attunement or initiation rituals are ceremonial processes where a Reiki master/teacher uses gestures and Reiki symbols and mantras in a prescribed way to activate the balancing of energy. These rituals are carried out during each level of training and often in between and after taking advanced training. Participants claimed that attunements open up or unblock the body's energy centers so that the process of energy balancing can begin.

> *Attunement is opening energy centers within each other's bodies…The attunement is opening and balancing those centers…And we run around and those energy centers are clogged due to circumstances, fear, our values, our beliefs, our environment. Reiki helps to open them* (Reiki practitioner).

Similar to the notion of life force energy, how attunement is framed, however, is dependent on the personal beliefs of the practitioner. For example, attunement was expressed by some participants using science metaphors:

> *In order to receive energy you need to be balanced. It's as easy as that. It's like your electrical box. If you've got too much power going to one thing you're going to turn off something else. So I think to me the Reiki attunement is more or less keeping all the switches where they need to be and opening them up in order for you to be more attuned to energies around you and to be able to channel them and to utilize them to your benefit and to other people's* (Reiki practitioner).

Alternatively, other participants used spiritual expressions to make sense of this object. In these cases practitioners believe that the initiation is a way of 'aligning' the body's vibrations with 'higher energy vibrations'. For some this emanates from an inner connection with oneself:

> *So if I invoke in whatever way I do it, same as Aboriginals do, invoke a particular energy of your divine self not mine, nobody else's, your divine self, and put it beside you, again it in my mind it acts a bit like a tuning fork and your own body sits back and realizes what vibrations it does want and it [the attunement] gives it the direction of how to get there* (Reiki practitioner).

An example of participants varying beliefs in the power of attunement involves the idea that the initiation activates an increased sensory awareness of life force energy. Participants do not hold that 'energy awareness' is exclusive to Reiki healing practice but they do contend that the initiation enhances such awareness.

> *I think certainly from reading, and from talking with those who have done other modalities, after the attunement process in Reiki there's a new level of awareness or an opening that takes place inside. They will say 'That didn't happen with my other...' You know, 'When I did the other modalities.' This is very different. And I think the senses become very acute in that attunement process* (Reiki practitioner).

As part of "growing into initiation" in Reiki practice, participants trust that there is a potential for intuitive skills and insights to increase:

> *The teacher does explain that it opens up an almost intuitive view of things, there are more intuitive insights that occur and you can more learn to listen to your inner voice and those kinds of things have been of major importance in learning Reiki for me* (Reiki practitioner).

Belief in this idea was supported in other practitioner accounts:

> *I believe that my intuition is growing. I worked on it for a long time...Sometimes the person will say 'Well how did you know that?' 'Well that's a good question. I guess the universe is just giving us some extra energy today.' But it does. It comes. There are moments when I least expect it and I think 'How lovely is that?...And I'm learning how to trust it. And so I think that again that can be passed along to the client. This isn't about fortune telling. It's just a level of awareness that rises, rises up and asks to be heard I think. So we just hear it* (Reiki practitioner).

Still, the degree to which participants described an increase in their awareness of the energy and their intuitive abilities varied and while some reported profound changes in intuition for others this was not the case. One practitioner claimed that the hand positions were developed by Dr. Hayashi "because well not everybody is intuitive." She went on to say that:

> *So to make people comfortable well you can do this and then you feel you have a routine and so on. I'm not highly intuitive but I try to remember that. Years ago when I was working on a lady who had had skin cancer down here on her legs, I guess I had gone down one side and then come up this way but then I thought 'Hmm. I think I should go back.' So that I think for me it was an example of following intuition.* (Reiki practitioner)

While the sacredness of the attunement rituals is questioned by some practitioners, all who I asked about this process acknowledged that this is a distinguishing feature of Reiki that demands respect. "My feeling is if you want to send that particular kind of energy, if you call yourself a Reiki healer, if you want people to pay you to be a Reiki healer it's absolutely vital" (Reiki practitioner). Another practitioner put it this way:

> *In order to actually tap into reiki directly, one must go through an initiatory process, now that can either be done in a ceremonial initiation or that can be done over a lifetime of diligent practice, or both, but it doesn't just happen poof, it requires some kind of direct diligent intervention* (Reiki practitioner).

Still, not all practitioners believe that attunements are absolutely necessary to the practice: "I believe there is a purpose in ritual but whether you would have to have the attunement before you could do a practice, I wave on that one" (Reiki practitioner).

Beyond the basic level of practice, practitioners are taught to use a set of Sanskrit, (ancient East Indian symbols) associated with healing. They are often visualized by practitioners and, when used, a corresponding Japanese mantra is repeated. Again, there are varied opinions and beliefs about the associated 'power' of these symbols and mantras. While some practitioners believe that the symbols hold particular power others view them as tools within which to become aware of the healing power of reiki. Convictions about the symbols complement participant beliefs about life force energy. Some trust in and stressed the value and importance of these more than others.

> *So up to a certain point once you become familiar with the sensation and getting into the right frame of mind in order to channel Reiki energy than the symbols and the mantras are not necessary, they're not really necessary and I've spoken to people who've taken who have learned Reiki a long time ago and they don't use the symbols or the mantras but they can just do Reiki and I think that's one of the goals, one of the things my teacher has said is that you are to become, you become the energy and so you don't have to focus on it as hard* (Reiki practitioner).

Overall, different practitioners and groups hold different beliefs with respect to the symbols and use them in varying degrees.[2]

Summary/Conclusion

My analysis reveals that in retaining a connection to the ideological boundary object or 'energetic world' view while holding varying interpretations of "translations" of Reiki and its centrally related objects, practitioners are able to maintain both diversity and coherence in their daily work. The shared values that participants hold about reiki reflect a common 'reality'; described as a sense of 'feeling', 'being', and 'knowing'. Participants further expressed these meanings in relation to Reiki practice in three ways: as qualities of virtue, as a desire for fulfillment that includes self and others, and as an appreciation for intuitive and tacit knowledge. These interpretations align with principles of science and/ or spirituality, resonate with their core ideology or 'energetic world view', and form the basis of a *therapeutic ideology*. Practitioners tended to treat the procedural objects, of touch, attunements and symbols/mantras in manners consistent with their personal beliefs. This means that in varying ways and degrees participants believe in the powers of the rituals, symbols, and touch. Overall, touch was the most highly valued tool used by practitioners.

The findings also indicate that practitioners link their informal moral code, based on Usui's method, to contemporary notions of self-responsibility. The emphasis on taking care of oneself and on caring for others was central to the beliefs held by most practitioners. The twofold acknowledgement that individuals can control how they perceive and behave toward health and illness but may have little control over the outcome was also commonly expressed. In other words, they did not believe that healing

necessarily connotes curing. In this way, both the practitioner and the recipient are relieved from guilt or blame if healing expectations are not met.

Participants believe that Reiki practice is empowering. This was most evident in their stories of personal suffering. They often conveyed that Reiki provides an emotional anchor in times of crisis and uncertainty, and a practical way to assume personal control in difficult times. Not surprisingly, participants believe that Reiki is a holistic practice because of their conviction that 'reiki' acts restoratively on the whole person. Typical of other CAM practices, Reiki is also an individuated practice in that practitioners are attentive to the specific aspects of health and illness of recipients/clients. These beliefs underscore energy healing work or the conjoined practice of Reiki. This approach to healing is not solely about beliefs but also about putting beliefs into action. This is more explicitly illustrated in the next chapter.

From a social world perspective, the notion of a boundary object has been especially helpful in explaining how practitioners with varying and nuanced beliefs are able to be part of same social world. The concept is, however, problematic with respect to this study. Even though group conflict and co-operation is assumed, the social worlds captured by boundary objects tend to be robustly structured, while dispersive worlds are more loosely organized and, as shown in Chapter Four, do not mandate co-operation. Based on the findings of this research objects may or may not bring about co-operation in and between social world segments. In a dispersive social world like Reiki co-operation is voluntary. It is not required or binding. Other empirical studies have pointed to similar difficulties

with the idea of cooperation between social worlds (see Adams 2004; Adams and Tovey 2001; Tovey and Adams 2001).

My analysis informs SWT by expanding on the idea of a shared ideology or "set of basic beliefs" (Strauss et al. 1964) to one that is inclusive of common beliefs and values. The therapeutic ideology of practitioners encompasses a shared energetic world view and a common set of values that buttress a diversity of beliefs and views about the central objects of practice. I suggest that such an amalgam creates a potential for the continued segmentation of dispersive social worlds. Next, I examine the conditions and consequences of putting this therapeutic ideology into action. I do so by exploring how participants manage and negotiate the issue of public acceptance through their involvements with this social world.

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[1] See Chapter One for a description.
[2] The symbols can be found on many Reiki websites.

A Continuum of Public Acceptance

In the previous chapters, I provided insight into the social history of Reiki and explored the therapeutic ideology of front-line practitioners. How practitioners confront and manage public acceptance through their involvements with the Reiki is the central focus of this chapter. The social world of Reiki is positioned within a health care matrix that is both welcoming and hostile. Over the past decade and a half, although Reiki has become more publicly visible in Canada, practitioners have faced mixed reactions toward their work and public acceptance is a central concern. In the context of this research 'public acceptance' refers to a range of social approval that practitioners experience from people outside the social world of Reiki. I reiterate that public acceptance is a *continuum* that spans from overt hostility to total receptivity.

From a social worlds perspective, participant involvements are sets of conditions and consequences or 'intersections' that connect Reiki to other worlds. Strauss (1984:137) described them as "sets of events' that are linked to, 'crosscut', and mirror social world processes. Accordingly, involvements are 'intersections' that mirror the strategies that practitioners use to gain "trustworthiness" and to carve out a "deserved place" (Strauss 1982:175) in the health service industry. Varying degrees of public awareness, opposition, and receptivity from those outside of Reiki create challenging conditions for practitioners. To manage these issues workers are engaged in maximizing, defending, and bridging strategies that crosscut practice areas. I argue that front-line practitioner involvements are an integral part of the conditions and consequences that fuel continued segmentation.

I begin by explaining why public acceptance is a concern for practitioners, I then define the parameters or fronts of Reiki practice where this cross cutting issue is being played out. Next, I highlight participants' perceptions of 'public awareness' and their responses to Reiki as a healing approach. I look at the maximizing strategies that practitioners use to promote their practices and enhance their social legitimacy. I then describe the forms of opposition they have encountered and the strategies that they employ to defend themselves and their practices. Lastly, I illustrate the bridging strategies that they are using to expand their practices within mainstream health care. I end the chapter with a summary and conclusion.

Public Acceptance

From a social worlds perspective, public acceptance is important to practitioners for two fundamental reasons: because they believe in the value or 'authenticity' of the practice and want others to appreciate its worth; and because the viability of their social world depends on others' social approval of the method and subsequent demand for the service. In the context of social worlds theory this, in part, is what constitutes social 'legitimacy'. There are varying social conditions that impact the ability of practitioners to achieve public acceptance. These include public awareness, opposition, and receptivity. In the case of Reiki, public acceptance intersects on three fronts. These include: informal Reiki practice, formal Reiki practice, and formally sanctioned Reiki practice.

Practice Fronts

In this study informal practice refers to the mutual exchange of 'reiki' between practitioners and 'significant others'; people who generally are familiar with each other such as family, friends, or acquaintances. In formal settings a practitioner usually treats clients; people they do not know, in a home based business or in the corporate sector. Formally sanctioned practice encompasses Reiki that is provided in professional health care settings. On this front, additional training or orientation is required of non health professional Reiki practitioners and health professionals who practice Reiki must act in accordance with their professional regulatory guidelines (see Figure 6.1). Across all fronts, practitioners simultaneously engage in a conjoined practice of Reiki. In other words, self healing is integral to practitioners' commitment to healing facilitation work and their intersecting involvements. [1]

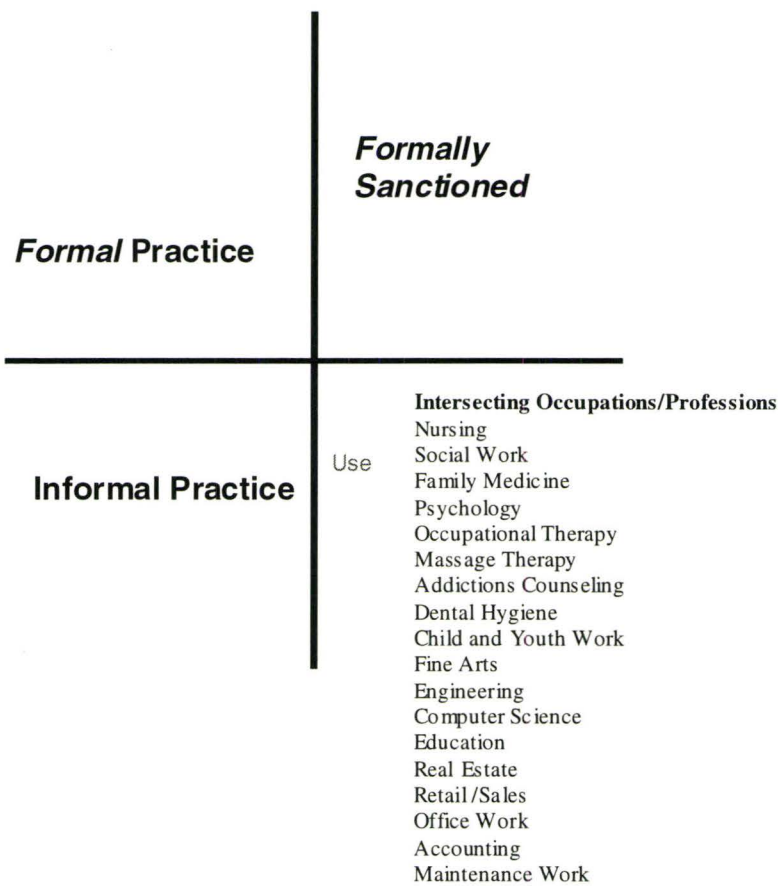
Public awareness, although important to all practitioners, is of utmost concern to those involved in formal Reiki practice. These participants are largely self-employed and work part-time in home based businesses, although some also work independently or in partnerships in the commercial sector. They face a fluctuating market and unpredictable demand for out of pocket service. In the next section I look at how participants, who are largely engaged in formal practices, confront public awareness and the strategies they use to maximize others' understanding of Reiki.

Confronting Public Awareness

Over the past decade and a half, practitioners in Canada have born witness to the growing visibility of Reiki. The reasons for this are closely connected to the growing

popularity of CAM more generally, a trend I described earlier in this dissertation. While Reiki has benefited from greater visibility, practitioners in this study are divided about just how far this awareness extends and how much people really know about Reiki. Nevertheless, until the late 1990's, particularly in Eastern Canada, Reiki remained under

Figure 6.1 Intersecting Fronts of Practice



the radar of conventional healthcare practices. Even those who became practitioners tended to practice quietly and did not advertise. "It was really foreign and people just didn't know what it was" (Reiki practitioner). After more than a decade of practicing in relative obscurity some practitioners noted a sudden shift.

> *All of a sudden it just seemed like overnight Reiki exploded and everybody you talked to either had a Reiki level one or two or they knew someone who did or they had a Reiki treatment or they'd heard of it so it was a lot easier* (Reiki practitioner).

Another commented that: "I don't think in 1992 that I could have mentioned more than one person who did Reiki that I actually knew of. Today, oh, let's see now, half my Tai Chi class are at least level one" (Reiki practitioner). Other participants claimed that "people just don't know it exists" and that the term Reiki is foreign to them: "People say 'Rike [sounds like mike] what? You're going to rike what? Raki? [sounds like rack-e] What are you talking about?' They haven't even heard of it" (Reiki practitioner).

Some practitioners stressed that even though some people have heard about Reiki the general public is not familiar enough with the practice to fully appreciate it. "There's no understanding. I would think maybe the maximum one or two percent of the population are open to the idea of Reiki" (Reiki practitioner). A number of others made similar comments:

> *In the wider community, I feel there's very little understanding of Reiki so certainly in society now I did not feel a great deal of support because the understanding of what it is really is not there yet for most people* (Reiki practitioner).
>
> *On-going, I'd say the biggest challenge really is that people really don't know what I do, they're not aware. Most of the people who come, come to me after they've exhausted everything else: 'I have something that hurts and nothing else is working'. So that is changing because people are becoming more aware, but they're aware of words not substance. So the next challenge is educating people on the substance, what really is going to happen here, what really is it that I do and how is that good for you and for me (*Reiki practitioner)?

The fragile state of public 'awareness' and 'understanding' described by participants poses a central barrier for practitioners:

> *Well I have an enormous enthusiasm for it that I don't think most people really understand. [laughs] So the appreciation I don't think is always there. And that really makes me frustrated because I feel that it's there and if only people recognized it and wanted to share it more it would be certainly wonderful.* (Reiki practitioner)

One participant aptly described the situation in terms of a love/hate relationship:

> *I find there are extremes. There's no kind of middle ground. It's either 'What's that? Are you out of your mind?' Or 'Oh my god, I love that. Do you do that?' You know? [laughs] So I've never found a middle ground. Either people who don't know anything about it or don't want to have anything to do with it, and then people who just love it* (Reiki practitioner)

While some practitioners viewed lack of awareness as a problem and a priority in terms of advancing Reiki, others, notably those who did not rely on Reiki for their livelihoods, were more willing to let things take their course. As one participant said "I don't view this as a challenge" and another noted that "And the people will come. It will materialize. If you don't get the support it is all because it's not there." While there was little consensus over the degree to which participants viewed public awareness to be a 'problem', there was an overall desire by practitioners, on all fronts of practice, to increase public awareness of Reiki. Public promotion of Reiki was a central maximizing strategy employed by participants involved in formal practice. Through this approach these practitioners crosscut other fronts of practice and interface with people external to the social world of Reiki.

Maximizing Public Awareness: Public Promotion of Reiki

Participants committed to promoting greater awareness of Reiki engaged in a variety of activities. They took part in free demonstrations and/or treatments,

presentations, advertising, writing articles for newspapers, being featured in magazine articles, and through 'word of mouth':

> *I do as many trade shows as I can. I do free treatments. I've been at the hospital a few times. I certainly talk about it wherever I am. Whatever I'm doing I manage to move it into the conversation somehow for just a moment or two. I'm currently putting up a website so that there is more information. We talked about approaching one of the churches here perhaps in the south end, and doing free Reiki healing one Sunday or a Saturday afternoon, that kind of thing.*

Another participant spoke about adopting an aggressive approach to promoting Reiki, taking advantage of every possible opportunity to initiate conversations and to offer Reiki demonstrations:

> *The first few years anybody who would slow down long enough I'd have my hands on them. After I left IBM and I had a lot of time on my hands to go and explore and talk to people, network, get my name out there. Being in the back room of the hairdresser shop with a line up of people waiting to sit down in the chair for 15 minutes. I've done talks all over the place and I've done formal presentations for a number of different massage therapy organizations. I've done presentations at hospitals. I've done one with the heart, division, whatever- cardiac, I've done some with palliative care.*

Some practitioners were involved in more prolonged projects to promote their Reiki services. Two independent practitioners paired up to increase the visibility of their practices: "[We] did a clinic for a while, on X Street". Practitioners tended to agree that the best way to promote Reiki was through demonstration. While some claimed that advertising usually did not work well others combined advertising with other strategies to attract public attention and build clientele. A former environmental engineer who moved her home based business into the commercial sector explained how she got people interested:

> *It was largely word of mouth, I did a little bit of advertising. I wrote some articles in the local paper about Reiki and about spiritual growth and so people gradually*

> *in the community came to know about my Reiki practice and it's been very gradual.* (Reiki practitioner)

Another practitioner talked about the of role advertising in creating exposure for her practice:

> *At times I'd like to have a few more clients than I do. At times it seems to slow down and then picks up again. But... and I have some advertising that I do like my brochures and things like that but then last April I guess it was, one of my clients who happens to be an editor of a health magazine called and said could she write an article. So anyway she came and then she sent a photographer to take a picture and so at least it made people aware which was great.*

Building awareness is a necessary first step in the process of public acceptance. How practitioners are opposed by others is another gauge of social approval. Outside the social world of Reiki, hostile reactions were not uncommon occurrences. These were largely based on stereotypes that serve to reinforce the idea that any engagement with this form of healing is indicative of 'deviant' behavior.

Confronting Opposition

As the literature indicates, Reiki practice and practitioners are often labeled deviant and there is a veil of social stigma that pervades this healing work (Low 2004). Developing strategies that neutralize stigma have been shown to be important not only with respect to attaining social legitimacy for CAM but also with regard to validating those who practice and use CAM. This is because facing ongoing ridicule about involvements with CAM undermines an individual's commitment to using these modalities (Low 2004). Although participants in this study did not view their involvements with Reiki as acts of deviance, nevertheless, some practitioners experienced hostile encounters with others and faced moral condemnation and /or

ridicule because of their activities. In the following section I look at the forms of stigma that practitioners encountered. These include stereotypes of healing and healing workers that serve to undermine the moral integrity, logic, and rationality of the practice and the practitioners. Participants managed social stigma through defensive strategies that include reliance on support networks, selective disclosure, and selective practice. Again these strategies crosscut all practice fronts and intersect with the 'mainstream' of biomedicine.

Social Stigma

The social world of energy healing cannot be understood in isolation to the reactions of those who constitute public opinion. Participants faced a mix of reactions from people over their involvements with Reiki. Some popular representations of energy healing practices are etched in stereotypical images of 'healers' and 'healing'. A stereotype refers to lingering, temporal, generalized, and exaggerated impressions of members of specific groups. Stereotypes are the by products of what Dewey (1957) referred to as the 'collective memories' of people that have been carried over in time and become mundane and habitual forms of thought. Habits are ways of "thinking, feeling, and acting that people invoke without reflection" (Charmaz 2002:31S). Scholars have argued that these are perpetuated, in part, because 'energy' healing practices are perceived by some segments of society to pose a threat to the social order of modern medicine and traditional religions (McGuire 1988). The social stigma attached to CAM use and practice is part of the discourse of 'alternative healing' in CAM literature (Ernst 2008). In this study, stereotypes were the central instruments of stigmatization used to discredit the practice and the practitioners.

Stereotypes are implicit in the discourse; that is in talk, text, and imagery of competing social world segments. These constructions tend to over emphasize the risk that such practices and practitioners pose in everyday life. Hence, stereotypes undermine the credibility of practitioners and the legitimacy/authenticity of the practice in ways that are pervasive, insidious, and evade accountability. I am not arguing that there are no risks linked to energy healing work or that all practitioners are equally competent and/or scrupulous. Rather, I wish to emphasize that stereotyping is one of the implicit yet salient barriers that impede the social legitimation/authentication of practitioners in this social world.

In this study, practitioners generally experienced social stigma in demoralizing face to face encounters and more pervasively through institutionalized discourse. In the following sections I illustrate how these stereotypes undermine healing and healers, and imply that practitioners, mainly women, are a threat to social order because of their 'irrational' and 'taboo' approaches.

Stereotypes: Heretics, Devils, and Witches

In some instances practitioners confronted overt hostility as a consequence of their activities. Moral condemnation was the primary instrument used in these encounters. For example, a Roman Catholic nun spoke of the opposition of some members of her faith community to her practice of Reiki. This participant explained that she had already "rocked the boat" by changing her career from a religious educator to that of a massage therapist. She said "now besides being looked askance at for doing massage by most of the clerical religious people, when I started Reiki they sent my name

to the pope to get me to stop because it was considered New Age." She also emphasized that touch was "pretty much taboo" and energy work was considered by some in her community to be associated with evil:

> *So, then one of our sisters decided to send my name to the pope. She really was very afraid of Reiki. She thought it was like from the dark side of spirits. So I gave her a little book to read. It didn't help her; anyway, she sent my name at least three times. She's dead now. But I was never sent for a free trip over there and now the pope that she sent it to is dead. So she never did hear back from Rome.*

Gullibility was also linked to moral condemnation. One participant told of an incident where friends of hers chided her for being involved in the practice: "When I talk about Reiki some of them kind of, get this gloomy kind of look, and they say it's a sect, you know, I heard it's a sect and they take your money". Another commented that "You know, some people think this is a cult or they laugh or say humbug and I feel badly this way about it". Other practitioners also described experiences where outsiders berated them for their involvement in Reiki, based on notions that the practice was heretical:

> *And at work I had a real quick, fast lesson...because I was a manager of the program at that time so I could decide what people were going to do in terms of some of continuing education. So I decided, I actually brought [name]] in to do an in-service and give people samples of reiki. And I was just like so enthused about this. Well, I had one of the counselors come to me and he was quite adamant that this was devil's work.*

Some practitioners' talked about how friends, relatives and acquaintances often referred to Reiki practice as "Voodoo" or "witchcraft".[2] In some of the interviews comments such as "and we're not witches" would slip into practitioners' descriptions of the practice. Although these participants did not consider Reiki practice to be witchcraft,

they were cognizant of how others might judge their involvement in this healing work. In some instances these kinds of concerns were lasting remnants of early experiences:

> *And I wasn't very old when I heard them talking about Crazy [name]. Now Crazy [name] was married to my mother's uncle [name] ...but she was what they call a healer or a psychic or a witch; that's what they called her and this came to my ears and I said 'I don't dare say a word about this.'*

Another, whose grandmother had been a 'healer', expressed it in this way:

That's the one I guess hang up I have with any of the energy modalities is that people aren't too familiar with what you're doing. I'm always kind of afraid of being thought of like a witch!

Stereotypes: Flakey, Illogical, and Irrational- (knowledge and logic)

In tandem with the imagery of witches, gender was often linked to the stereotypical notions of healing and healers. Some practitioners claimed that others viewed their involvements with Reiki as "flakey" and "illogical". One practitioner explained that he was kind of surprised that both he and his wife became Reiki masters because they were both "very logical".

Alternatively, other participants claimed that main deterrent to public receptivity entailed the need for scientific validation. In these accounts, reference to knowledge that was based on 'rational' rather than tacit understanding was emphasized:

> *I think the lack of scientific proof is holding it back from a lot of mainstream acceptance and other than a lot of actual science I think the only way that that would change was if there was actual research into it performed in a strictly logical way.* (Reiki practitioner)

Others emphasized that the idea of energy healing seems incredulous to many people. One practitioner put it this way:

> *A lot of people when they hear the word say 'What's that?' And when I tell them what it is, they laugh. Because they don't believe that anything can be done by*

> *just putting my hands on their head or their shoulders or whatever* (Reiki practitioner).

Defending Identity and Practice

Investing in Support Networks

A central way in which stigma is managed is through support networks or social circles known as 'Reiki shares' or 'Reiki circles'. Most of the women and some men that I interviewed belonged to these kinds of groups. The specific reasons that participants are involved in these groups vary. Sometimes participants used the groups as a way to socialize with other practitioners, some came primarily to receive treatment, and others used the sessions as an opportunity to practice energy work skills and/or to discuss ideas and concerns related to practice.

> *We invite... it is open to everybody, not only the people that is Reiki or healing touch or whatever. It's open to anybody. And what we do is that we place some tables at home and we ask people just to gather around and give each other a treatment so people will receive and give (Reiki practitioner).*
>
> *Well for me I really look to them because I find them not only a help to me because I always feel so good after a session but it's a learning session. It's a teaching session, a learning session for all of us (Reiki practitioner).*

In some instances these were very stable and tightly knit groups consisting of just a few members who held longstanding relationships with each other. One participant in a circle of four stressed the salience of her group: "But I want to say about my Reiki group that's so supportive. And there's a lovely spirit there and it's my greatest support" (Reiki practitioner). Another commented that "I still have sessions with [name; her Reiki master/teacher] I exchange with [name] and we are constantly challenging each other and helping each other to grow and really loving helping each other to love ourselves". Even in more recently formed sharing groups, participants expressed similar sentiments: As

one participant noted: "It's like a second family over there when we get together" (Reiki practitioner). Other practitioners were part of larger support groups which often became established when training in the practice began:

> *And even the people that I went through, I took Reiki with, it becomes your extended family, right ...And it's nice to have that group of people that you can call, and they may know other people too so it really extends out. You know, the nice thing is that I consider them all my family. I know many practitioners on the island.*

Similar to the homeopathic medicine principle of 'likes attract likes", a number of practitioners expressed the importance of relating to people with similar interests in Reiki, although these pursuits were far from uniform amongst practitioners:

> *The Reiki group was really amazing that time because it gave me an actual support group of people with like interests or very close similar types of interests, if nothing else general New Age spirituality type interests which is all the same. So it gave me a lot of validity towards what I was working with, something that actually had some support behind it and it gave me something also that helped keep me in line.*

A common thread that runs through the accounts is the idea of having a network of support:

> *I do have a lot of good close friends who are very supportive and we do healing exchanges with each other, and just when we need someone to just vent with or just, need to talk about something. But yeah, I have a really good support system. I'm very, very pleased with it. This kind of work sometimes you just need someone to talk to. Something comes up and bothers you, you have to care about maintaining the confidentiality but you can still do that and be able to get it off your chest* (Reiki practitioner).

Open communication is another central feature of these groups that practitioners value:

> *One of the biggest benefits is the fact that there's a networking group. I mean you can get in touch with any of the people that are in the organization that are members; even other people... like I find that Reiki is such a... you can't pin it down to like 'if you do this, this is what's going to happen.'...And sometimes people will, respond in ways that you don't really expect or don't understand but*

> *somebody else might have had a similar experience that they can help you out on that* (Reiki practitioner).

Selective Disclosure

Disclosure is a noted strategy of stigma management (Goffman 1963). Similar to past studies of stigmatization, participants learned when to speak about their involvements and when it was best to remain quiet (Low 2004). Some practitioners explained that currently they could be much more open about their involvements with Reiki. As one participant explained, people no longer looked at her like she was a "three headed green purple eyed monster" when she explained Reiki to them. Still, others were more cautious:

> *But I never push it. I've never really talked about it much...Once people see, once they talk to somebody and find out that this was good there seems to be a big change then. But it's not something you talk about with new people coming in. Usually if people are into alternatives or if somebody mentions something I generally take the opportunity to talk about it* (Reiki practitioner).

Another stated: "I don't spend a lot of time trying to talk people into it."

Others commented on the importance of knowing when and how to talk about Reiki. The ability to be able to explain value of Reiki in language that 'outsiders' can understand poses a challenge:

> *I got an e-mail about a week ago that [three Reiki Masters] were going to start doing a Masters healing like once a month, start advertising, you know, 'Come for a treatment' and the advantage of having three Masters work on you, that type of thing. But people don't know what that means if they haven't had Reiki treatments. They think 'Oh this is voodoo stuff. I'm not going there.' Right? So it scares them to death. So it's a fine line of knowing how to put it out there or what to say* (Reiki practitioner).

Similarly other practitioners also commented on the difficulty of articulating what Reiki is about in language that does not immediately arouse skepticism.

> *The biggest obstacle is getting people to understand what Reiki is about and the benefit of it because it's almost like that door just automatically closes as soon as you start talking about channeling in that life force energy; well then the door is closed* (Reiki practitioner).

Practitioners tend to be cautious about what they reveal to whom. Participants often claimed that to understand Reiki "you have to experience it" and that in trying to explain Reiki through language it just becomes "gobble(y) goop" (Reiki practitioner).

> *I can try all I want to put words around it [Reiki] yet I believe that it has to be experienced. It's like saying the word honey and a person who has never had honey would still see it as a word but not the experience of what honey tastes like. So I think that it is something that has to be experienced but trying to put words, I can attempt to do that yet it will always fall short* (Reiki practitioner).

One practitioner expressed his frustration with explaining Reiki practice to others.

> *In terms of an ability to heal and this type of work whether its Reiki or any kind of energy work we're in the business of seeing miracles everyday and we don't have the ability to communicate that often to people outside, or else we do it in such a flamboyant, flowery way that people go, oh my god, you're on drugs.*

Another practitioner revealed that physicians have a difficult time revealing to others that they practice Reiki. "I personally know some doctors here that I work closely with that have Reiki…They won't say it". Indeed, medical associations have been instrumental in controlling the behavior of health practitioners (McGuire 1988) and in perpetuating the stigma attached to Reiki practice and practitioners (see Ernst 2008).

Selective Practice

In some instances practitioners were not only quiet about their involvements with Reiki but were selective about where, when, and with whom they carried out their work. On informal and formal fronts this situation has notably improved over time. In the early

1990's, practitioners more often than not had to work around opposition. As one practitioner noted:

> *I was of course extremely enthusiastic about it when I finished my level and I wanted to do as much Reiki as I could but nobody was open to it. And everybody thought I was a freak and I thought I was a freak which just made it worse, like you know, this sounds very strange and bizarre. So I gave up on people and I worked only on animals.*

This practitioner is now practicing part-time in a home based business. She claimed that many people in her local community know about and are willing to try Reiki. She has been able to build a small clientele and is happy with the response to her work. On the formally sanctioned front, selective practice took on other dimensions.

A family physician with Reiki master training who took part in this study revealed that the opposition that he received from the medical association over his interest in holistic healing jeopardized his career in family medicine:

> *I get a little tired making people sick and keeping them sick with conventional medical practice. But they demand it and it's required...I've been disciplined and told to stop healing which I did because my wife insisted on it because I had a young family. This was back in the early '90s.*

This doctor rarely gave Reiki therapy to his patients. "I do tend to refer most of my patients out for Reiki... actually I ask someone if he's interested and if he is I refer him to friends". Since the time of his reprimand this participant restricted his involvements in the social world of Reiki to informal practice "So I do it with my friends or in my off time or in my spare time or in my holiday time...I am not active in the Reiki community as such except in our own little way. We do that for ourselves." This participant's comments reinforce the idea that the divides between biomedicine and healing therapies such as Reiki run deep. His account further suggests that there is little interest on the part

of the medical profession to sanction the practice: "And any quick fix that comes along, the medical profession will embrace it. Steal it. Okay? I can't see them stealing the Reiki because it's too hard to prove and it takes too much discipline to do".

This was a problem not only for this medical professional but also for other allied health care professionals. In formally sanctioned practices, health care workers felt restricted in offering Reiki to clients because it is not 'acknowledged' as a treatment. A retired psychologist explained her situation:

> *I was doing chronic pain in a physiotherapy clinic, not as my full time job but as my extra job, and I introduced Reiki to many of those people and included it as part of my work with helping them to manage. But I had to be careful because it wasn't really a recognized way of doing chronic pain management with some of the companies I was working with. So I would explain to the clients what Reiki was but I would kind of include it in progressive and other relaxation sessions. So we would do some relaxation and then I would ask them if they would like me to do Reiki with them. And some of them loved it and wanted only that. And some of them, I knew I couldn't even broach the subject, so it really depended who the person was.*

Similarly, a registered nurse, trained as a Reiki master, explained that she restricted her practice of Reiki when at work in her local hospital. She refrained from treating patients and only provided quick "spot treatments" to co-workers who were feeling unwell:

> *People at work, there are always the ones that are totally skeptical. I think I told you that I used it at work when there are people who have headaches or a sore this or that or whatever. If I've got a few minutes to do it, it's certainly not going to do any harm and there's certainly always the potential for something good to happen. I don't have enough time to really do a full treatment or anything like that. Even anything more than five minutes I can't really do at work because it's not really appropriate.*

Participants explained that they knew of no formal policies concerning the practice of Reiki in hospitals. Based on my data of Reiki practice on formally sanctioned fronts, it appears that the practice, in many respects, remains under the radar of acute care

practitioners. The opposition to the formally sanctioned practice of Reiki is embedded, in part, through a lack of recognition of the treatment and formal guidelines within which to provide the therapy. This is more deeply rooted in opposition from professional bodies over the legitimacy of the practice and the place of holistic healing in mainstream health care practices (McGuire 1989; Kelner et al. 2004a, 2004b). Still, public acceptance is not totally about opposition to Reiki. It also is about receptivity. In the next section I look at where Reiki practice is embraced in 'mainstream' health care and by whom.

Encountering Receptivity

Reiki tends to be more familiar to health care providers in the areas of rehabilitation, chronic illness, and palliative care. It is in these situations that practitioners on all fronts of practice experienced receptivity for their work. Practitioners garner respect and feel a deep sense of appreciation and personal satisfaction for their work with people who are 'open' to trying Reiki treatments and/or are interested in taking Reiki training. Practitioners often talked about the ways in which they felt intrinsically rewarded for providing this service:

> *I wanted to volunteer my time after retirement to some charitable organization or hospital or whatever and whenever they had open houses I never had time to go there,...and I'm happy with the work. I just love it. It gives me the time that I want for myself and also time for others.* (Reiki practitioner)
>
> *I think that it's just a wonderful thing to be able to do and I love seeing when I've done Reiki on somebody and they've come to me and they're looking totally stressed out and life is miserable and they leave there and sometimes they don't even think that anything happened, but ten years have dropped off their face* (Reiki practitioner).

During interviews, participants told of the many instances where they felt pride in their work, where the practice was welcomed, and they were treated with respect: "After

treatments they often say 'I don't know what you did but I'm pain free." (Interview 42 p10). An addictions counselor/Reiki practitioner who worked in a facility for women suffering from substance as well as physical and sexual abuse also stressed her positive response to therapy from vulnerable clients:

> *They love it because like we have to have a list now for the whole month because we used to put out a list and they would want to sign up. The same ones were signing up and there was a real competition and that so we have to put it up for the whole month and let everybody have a chance to at least put their name down once.*

Another central strategy that participants used to expand their practices and create public awareness encompasses bridging strategies. These too crosscut all fronts of Reiki practice.

Bridging Social Worlds

Educating Others

Practitioners agreed that education has to take place on a variety of levels in order to achieve public acceptance. Although educating might be viewed as a maximizing strategy, I consider it to be a bridging technique because educating others was not solely related to promoting a Reiki business. On a more basic level, it was about acting on their therapeutic ideology. Front-line workers used any and every opportunity to introduce people to energy healing work. In unobtrusive ways they went about educating and training 'receptive' significant others, members of the general public, and health care professionals about benefits of Reiki practice. They did this informally, formally, and through formally sanctioned practice. These kinds of involvements intersected the social

worlds of CAM and biomedicine practices. The most fundamental way that practitioners used this strategy was through their own healing work.

> *But that's my mission is to demystify it, to treat, to show by example what this is, to precept through my personal example of my life and through my actual healing work and then to empower those to the gifts that lay inside them.* (Reiki practitioner)

Another central way that practitioners introduced Reiki to others was through workplace opportunities.

Workplace Opportunities

One of main ways that health professionals are being educated about Reiki is through the direct negotiations of formal practitioners with front-line managers in health facilities. One participant talked about how Reiki had been introduced to staff in two local area hospitals close to where she lived. In one instance, the practitioner offered treatments to her co-workers:

> *One of the girls in our organization works at the hospital in mental health. She had been off for a month on vacation and had come back. She was sitting around the table at a meeting and just said 'Oh my god. Everybody is so burned out. She woke up that night and just said 'Okay it's time.' Here's my schedule. And she told me she was going to do it. And it's happening. And so she had all these clinically trained people asking for Reiki, asking can I have more*? (Reiki practitioner)

She went on to explain that another practitioner's presentation of Reiki to breast cancer survivors prompted the coordinator of an oncology support program to have Reiki offered as an option for patients and families:

> *And, you know, it had to fly by the coordinator in the hospital and she got the go ahead and I think she had eleven or thirteen women that night who were just amazed and the feedback from the coordinator was 'I need to know how to get this in the hospital. I would like to have something set up.*

All participants were strong advocates of the practice and were active in educating within their respective milieus. For example, a social worker who was trained as a Reiki master explained that "professionally, I recently did a twenty minute in-service on Reiki at work so that worked out good. In roads are being made very slowly". A retired psychologist explained that she introduced Reiki into "pain management programs". Another practitioner with 2nd Degree training, who is also a dental hygienist, explained how she introduced Reiki in her place of employment. One of the dentists that she worked for was "very open" to the idea. This created an opportunity make clients aware of the practice:

> *So she had a couple of sessions and really, really loved it and started speaking to patients about it and said to them 'Well [name] does this'...I had read in our notes that Reiki can help people with anesthetic to alleviate that horrible feeling of being frozen for so long. And so I have worked on a couple of people. It actually made them more comfortable leaving the office...and I've had very positive feedback from everybody.*

Sometimes practitioners personally negotiated entry into hospital settings. One practitioner, also a massage therapist, explained how her request to volunteer Reiki to patients in an oncology care program at a local hospital was well received. She viewed the receptivity of both nurse managers and physicians to be important dimensions in gaining entry in these domains. Notably, having credentials as a licensed massage therapist helped her to obtain access but the overall receptiveness of the gatekeepers also played a part in this process:

> *The head nurse that I spoke to in the area she was wonderful. She was so excited to have somebody there because I also would also offer the Reiki services and massage. And you know, two of the primary physicians there, two are from Pakistan and one is from somewhere in Europe where these things are used readily every day in the medical community. So it was really nice. My first day*

> *there they were coming down 'Hi, it's nice to have you here.' And I'm like 'It's nice to be here but it's a little strange to me. Thank you.' [laughs] You know? So the reception was really good.*

This suggests that ethnicity plays a part in how well Reiki is received in formally sanctioned work fronts.

Training Others

The participants with mastership training often taught Reiki to others. They did this in conjunction with offering treatments to clients or other recipients. These practitioners considered teaching Reiki to be a way to empower others to take responsibility for their own health, to begin or enhance their healing journeys, and as a way to 'pay it forward'; that is, to inspire the recipients of training to take an active part in the healing facilitation of others. That is not to say that all clients who receive treatments take Reiki training. Some practitioners had a number of clients who took this route and others did not. Overall, most practitioners agreed that people take Reiki training at a point in time when they are open to the potential benefits that practicing Reiki offers and are receptive to the shared ideology or 'energetic world view' held by practitioners:

> *So when we start working with people and introducing them to energies and different ways of looking at the world or situations, then I find that their interest increases; and then they ask 'You know, I've been thinking about taking Reiki. Would you teach me?' Or 'Do you have a course coming up because I really think that that's something I need to do?' And so it's usually a slow process, right? And to me when they start asking about it then they're becoming ready enough to understand it and to fully grab hold of it. I always tell them 'Wait until you know you're really ready because you really want to get the full benefit of it, the full understanding of it, the full impact that it has for you'* (Reiki practitioner).

As the above quote indicates, sometimes students begin their Reiki journeys as treatment recipients. This is consistent with the findings of other studies (see Low 2004; Sointu 2006c). In formal practice, Reiki Master/Teachers trained people to practice informally, with their families and friends. They trained some to become formal practitioners and they also trained health professionals to practice Reiki as a complement to their formally sanctioned health practices; in other words, to treat clients and/or patients as a complement to CAM or bio-medical practice. Some participants trained individuals from a variety of health care professions.

> *I've had several physicians as students, tons of nurses, tons of registered massage therapists, and actually, a lot of physiotherapists too. In fact one of my master initiates was a physiotherapist. Having said that, in general, I'd say the acceptance is fairly good in terms of allowing it. It's really in the nature of well, it's not going to do any harm. If it makes people happy, let them, and that's really where it's at. That's from the actual medical staff.* (Reiki practitioner)

Reciprocally, some formally sanctioned health practitioners became Reiki masters and subsequently became part of the Reiki training network. For example, a few practitioners on the formal front of practice received their initial training in Reiki from a health care professional. One participant said "My first Reiki teacher the one I did first and second degree with, is a physician". The massage therapists and the nurse that participated in this study are part of this kind of network.

Lastly, a few practitioners were also engaged in negotiations with health professional associations and non health professional associations to offer Reiki as a way to obtain professional continuing education credits. One massage therapist explained how she and her husband, who is involved in formal practice as a Reiki teacher, were involved in this activity.

> *We're trying to get the Reiki courses approved for CEU'S radiology technicians and the nurses and maybe even the physiotherapists and Respiratory technicians just because there are a lot of people who are interested. A lot of teachers too have approached me saying that they're interested.*

Regulated CAM practitioners, such as massage therapists hold a unique position with respect to Reiki. As credible health care professionals they maneuver more freely between the worlds of CAM and biomedicine. They are able to offer Reiki therapy to clients and patients because their professional bodies recognize Reiki within their scope of practice.

Participation in Volunteer Work

All participants in my study provided Reiki on a voluntary basis at one time or another and some volunteered Reiki services on a regular basis. They carried out this work in all sorts of situations but most often they gravitated toward places where the most vulnerable and disadvantaged (medically speaking) were located. These included hospices, oncology and/or palliative care units or facilities, and HIV AIDS programs. In these spaces, Reiki is more familiar to both patients/clients and staff. One example was provided by an East Coast practitioner who was involved in oncology fund raising work. She explained that at the hospital where she was employed Reiki was already part of everyday care provided on wards:

> *So when they call me I am at work here. You can see that I am in the hospital so my nurse friends call me and they say okay, 'I am too busy to do a Reiki to this person on this level' and I say 'Yes, okay.' So I close my office for a half an hour and I go do the treatment; maybe on day surgery or with old people and then I come back to work. So this is paradise for me.*

Aside from offering the therapy to patients, this participant viewed volunteer work as another opportunity to expose and educate staff about Reiki, to get an insider view of the

workings of a hospital organization, and to negotiate internally rather than trying to access entry from the outside:

> *So I am in a position right now...I have contact with a lot of patients, privileged information, a lot of doctors and nurses. And at the same time because I do good work I am recognized so they're open more. And I am being transparent. I tell them today I have my director of communication foundation hat. Okay, now I am the practitioner or the Reiki Master. And I can say also that sometimes some employees come here you know, some other people, they come in my office right there. I close the door. I do a Reiki. Then I volunteer. So for me it's like it's integrated. I am not necessarily paid for this but I know that by doing this I am helping the work I do right now.*

Most often, however, participants volunteered in community based programs:

> *Well I do Reiki at the X Center once a week. In the afternoon I usually do three to four people. And one of these women is in palliative care at the moment and asked that I visit her and do Reiki whenever I could.* (Reiki practitioner)

> *It's very, very gratifying...especially when we go to [name], it's a cancer support group...and the person tells you I won't have long to live anymore and you give them Reiki and they are just so grateful for anything that you can help them* (Reiki practitioner).

> *I go to the [name] nursing home every Friday afternoon but I don't give this client a full body treatment. It started out because she had a dreadful ulcer on her shin which was very persistent but although it didn't cure up her ulcer, she wants Reiki. It made her feel better and she said the pain went for a couple of days.* [after the treatment] (Reiki practitioner)

Through sustained commitment to volunteering more patients and families have been exposed to Reiki and are requesting such services:

> *And then I started offering treatments at the AIDS Coalition and at first it was so slow, you know, and then people signed and they didn't come but I was in the city anyway so I wasn't bothered. I don't give up easily, you know, and that's probably why things got better because I stayed with it. I was just ready to quit at one point but then all of a sudden, you know, some people became regulars coming for treatments because they enjoyed it so much and now it's... another lady is coming with me and joins me in giving treatments so we are two there now so that if one is sick or not there.* (Reiki practitioner)

Once engaged in Reiki, some practitioners were recruited to take part in established volunteer programs. As one practitioner said: "[Name] gave Reiki there already and couldn't do it anymore and asked me if I would be able to take her spot over". For participants who did not hold joint CAM and or health professional licenses in conjunction with Reiki training, volunteering within the regulated public system involved engaging in hospital based volunteer programs:

> *I do volunteer work which adds to the, things that I do. I go down to [place name] That's for cancer patients. And I go to the Hospital site. There's a 'program there. And cancer patients and their families can go there and receive 20 minute treatments.* (Reiki practitioner)

Association Membership

To gain entry into biomedical settings participants involved in formal practice were required to become members of established Reiki organizations. For example, membership in AURA was a required step in being recognized as a Reiki practitioner in an oncology based volunteer program in Nova Scotia. In this instance hospital gatekeepers relied on the credentials as set out by the Atlantic Association. As one practitioner explained:

> *To be a volunteer there are criteria set by our Reiki Association and I think it's either level two or level three and of course you'd have to have the time to do it and the desire to do it. And if you were accepted that way then the hospital asks you to come in for some interviews as a volunteer, one of their volunteers. And then we had to go through a whole afternoon workshop down at the hospital. So there were things leading up to being accepted.*

The importance of legitimacy, through publicly recognized credentials, was most noted by practitioners who were members of Reiki associations and organizations: "I think it

makes you more credible. I think when people know that you belong to the association that you're really serious about your work" (Reiki practitioner).

> *I am being very, very honest here. I use it [CRA membership] to advertise on the web. And here I have a good credibility. It has provided me students on a regular basis. So this means for me that people need this in order to make a discernment on who is good and who is not.* (Reiki practitioner)
>
> *Being part of the organization is good too because it shows that you have belief in what Reiki can do and it's not just some neat cool thing that you learned how to do. No, it's serious and it does have actual benefits so you if you belong, join an organization like AURA it shows that you take your work seriously and that you do follow guidelines, regulations, and that you're very responsible about what it is that you want to do.* (Reiki practitioner)

Some participants suggested that association membership helped build legitimacy because of the material resources and continuing education opportunities that they offered: "Then of course when you have the association membership you have more credibility, right? And so joining the [International Association of Reiki Professionals] IARP will also give us resources to new training techniques and brings us an opportunity to attend workshops" (Reiki practitioner). For other practitioners joining associations offered support and networking and training credentials:

> *But it's nice to have that background, something that you can call a name and have a nice little certificate because people need to see certificates. And the support system, you know, that you have people that work together and AURA has Reiki exchanges and then the retreat and that sort of thing so it's a nice community to be in* (Reiki practitioner).

I do not want to overstate the importance of joining a Reiki association or organization. Most of the participants who belonged to these groups saw them first and foremost as a support network and secondarily as a way to increase social legitimacy. The majority of participants did not belong to these groups and some were opposed to them:

> *I don't need the guise of an association or the guise of someone there standardizing things because that word worries me just slightly because standardizing can also mean limiting sometimes and it all has to be like this. Nothing is one way* (Reiki practitioner).

Practitioners are well aware of the implications of standardization and the challenges that taking this route poses for them. Although marginalized within the hierarchy of biomedicine, formal practitioners currently maintain greater control and flexibility over their work than most regulated health care professionals.

Referral Networks

Another way that practitioners in formal practice collaborated with each other was through the creation of referral networks. In my experience with the Reiki sharing groups I found that practitioners sometimes referred their clients and/ or students to other CAM practitioners, health care professionals or energy workers. One participant summed up his collaborative efforts in the following way:

> *I like to refer to a naturopathic doctor, that's my main referral, but also to other people also a life coach, things like that. So I had one prime example of a guy who came with cancer and he was quite emaciated when I saw him and I used to know him and it shocked me. He had some money saved and he could take some time off 5 months or 6 months off of work so I referred him. He came to me, he went to a naturopathic doctor and he went to a life coach and because I kind of facilitated it I got feed back from all of it...and I saw where everybody was benefiting and helping this man get where he was going to, and now he's back to work. He's cancer free and his big dream is to save for a sailboat to sail around the world and he's part way into that now. He went from cancer to a better life than he had before.*

Some participants said that physicians sometimes referred patients from their practices to them. Nevertheless, as previously uncovered, practitioners in formally sanctioned practices are more inclined to use referral networks as a defensive strategy than a bridging technique.

Summary/Conclusion:

I began this chapter with two premises: first, that public acceptance is a range of social approval that practitioners experience from 'outsiders' and second, that they experience this continuum in three ways: informally, formally, and through formally sanctioned practice. While legitimacy is usually linked to biomedical scrutiny in the CAM literature, my analysis shows that social legitimacy for Reiki practitioners is more indicative of public acceptance. The findings also indicate that varying degrees of public awareness, opposition, and receptivity from members of other social world segments create challenging conditions as well as opportunities for practitioners. To manage and negotiate the continuum of public acceptance Reiki workers participated in maximizing, defending, and bridging strategies. I argued that front-line practitioner involvements are an integral part of the conditions and consequences that fuel continued segmentation.

With respect to opposition, the analysis indicates that social stigma pervades Reiki practice and is based on stereotypes that largely implicate women. Stereotypes permeated all working boundaries. Intentional or not, this labeling tends to perpetuate the stigmatization of those involved with this social world. Paradoxically, such notions may or may not be internalized by advocates or non-advocates of Reiki practice. Similar to a study of CAM use and practice by Sointu (2006), my research suggests that practitioners feel empowered by Reiki. The intrinsic rewards that participants reaped from their involvements tended to counter the opposition that they endured. Overall, through their involvements, participants chip away at dispelling pervasive myths and misconceptions about Reiki. In sharp contrast, practitioners also experienced receptivity for their work.

In these instances, practitioners took advantage of opportunities to increase public awareness and expand their activities on all fronts.

Educating others was the central way that practitioners bridged other social worlds. Through this strategy, practitioners' involvements intersected in a variety of ways with a myriad of actors outside the world of Reiki. Importantly, the findings suggest that opposition to Reiki is only part of the story of what is happening on practice fronts.

My findings also indicate that through their bridging activities participants were active in providing a service largely to medically compromised people. This finding diverges from what is reported in current literature; that people involved with Reiki are mainly middle-class women on quest for well-being (Kelner and Wellman 1997a). While not inaccurate, this tends to trivialize the practice and those engaged in it. Reiki practitioners focus on optimizing health and well-being but this is part of their therapeutic ideology, part of the approach to treatment. Essentially, the experience of Reiki practice cannot be divorced from how suffering is constructed in daily life.

This analysis informs SWT by providing insights into the intersecting processes of a dispersive world. Exploration into the specific strategies that practitioners use to manage and negotiate within this arena provides an opportunity to gain a deeper understanding of the "conditions and consequences" (Strauss 1984) occurring within a segmenting world such as Reiki. Strauss (1984) contended that in tracing these "intersections" other SW processes come into view. While public acceptance was the focal point of practitioner involvements, social legitimacy became the central cross cutting process.

My analysis expands the concept of social legitimacy by highlighting how practitioners tend to resist the standardization of their world rather than using standardization, which is a noted subprocess of legitimation, as a strategy for attaining social legitimacy. Alternatively, members have focused their attention on the more immediate and base level issue of public acceptance rather than taking the route of formally sanctioned regulation through professionalization. Practitioners are actively engaged in experientially demonstrating the potential benefits of Reiki. Achieving social legitimacy in this way is more subtle, quiet, and less politically charged but not less active.

Where and how practitioners carry out their work has major implications for the kind of status that the practice and they as practitioners, can achieve. For example, health professionals who crossed established conventional boundaries, for the most part, did so with caution. In addition to the social stigma that all practitioners faced, health care professionals with Reiki training confronted varying degrees of restriction through their regulatory bodies. Additionally, although the absence of institutional policies do not necessarily prevent treating patients, this 'non-recognition' can impact the transparent use of the therapy with patients/clients. Even though participants are expanding the boundaries of the practice through this route these inroads do little to improve their economic livelihoods or to change their marginal place within biomedical care settings. Regardless, although issues of social acceptance tend to be rhetorically polarized over ideological differences, in practice, these boundaries are not impervious.

What the future holds for the practice and the practitioners remain tenuous. On the one hand, although I think it is unlikely that energy healing will suddenly disappear, the staying power of the translation of "reiki" is less certain. While the practice is gaining greater exposure and some inroads have been made with respect to public acceptance, practitioners hold a precarious position within the health care matrix. Currently, it appears that Reiki practitioners have greater autonomy and flexibility over their work than health care professionals who have to comply with professional standards and scopes of practice. How long Reiki practitioners can retain this kind of control is questionable due to the specific directions within which the practice is moving. If the practice continues its expansion into integrative medicine, those without health professional training will likely have a more difficult time carving out a legitimate place on formally sanctioned fronts. In formally sanctioned practice, health care professionals, with perhaps the exception of massage therapists, also face major obstacles with respect to the transparent practice of Reiki. Not surprisingly, Reiki is most welcomed in mainstream spaces where cutting edge biomedical acute care tends not to tread. Although these selective domains welcome volunteers it remains to be seen if Reiki can eventually emerge as a 'legitimate' practice within mainstream biomedical care. Finally, while local practitioners' involvements do little to change the marginal position of Reiki practice within the current healthcare hierarchy, these intersections nevertheless challenge conventional notions of 'acceptable' healing practices in both subtle and explicit ways.

[1] While I wish to stress the importance of Reiki as a 'twin' or 'conjoined practice' it is beyond the scope of this dissertation to explore the self healing processes and transformative effects of Reiki reported by participants.

[2] I am referring solely to situations where witchcraft and voodoo were aversive to participants' significant others. I do not wish to imply that the religious practice of witchcraft was repugnant to all participants.

CONCLUSION

In this dissertation I used SWT to examine the history, development, and practice of Reiki. I drew on the growing body of documentary material generated by those involved in this social world as well as data produced through participant observation with two Reiki groups. Further, I conducted intensive interviews in Ontario and Atlantic Canada with fifty practitioners. In what follows, I synthesize the findings of my research, discuss my contributions, and lastly consider limitations and possible areas for future research.

Synthesis of Research Findings

I began by showing that Reiki is a heterogeneous, loosely organized, and dispersive social world. The ongoing differentiation and internal segmentation that characterizes Reiki began in Japan shortly after the practice was first developed. The pattern continued after Reiki was introduced into North America in 1938 and evolved even further through the 1980's. Much of the initial internal differentiation was due to conflicting ideologies and competing interests of Reiki entrepreneurs. The emergence after the 1960's of a social climate conducive to CAM practices, more generally, coupled with the new possibilities for growth that globalization made possible, played a part in fueling this segmentation process. Consequently, Reiki has splintered into separate subworlds and even smaller group segments. These factions include an assorted array of Reiki traditions, schools of practice, associations, and styles of practice. According to Strauss, the continued segmentation of any social world is inevitable (Strauss 1984). A variety of conditions, reciprocal consequences, and actions of individuals may increase

the potential for continued segmentation. Through the unique sets of events that transpired, particularly since 1980, Reiki has segmented more rapidly, resulting in a configuration that is more dispersive, complex, and less stable than many social worlds presented in current sociological research.

In looking at the social history and organizational structure of Reiki I have also attempted to account for the heterogeneity of the Reiki world. While heterogeneity amongst practitioners is not unique to CAM practices or many other social worlds of medicine, practitioner diversity typically is either overlooked in scholars' descriptions of CAM or problematized as part of professionalization projects. For example, although the diffuseness of the organizational structure of Reiki has been alluded to in previous research, the practice itself has been dismissed in part because as a group Reiki practitioners did not appear to be unified or have any desire create a standardized professional service and to negotiate with the state over professional status (Kelner and Wellman 2004 b).

Based on my data, the same is largely still true today. To date, representative Reiki groups in Canada have not seriously considered such negotiations. Still, this world is segmenting in alternative ways. Notably, the diffuseness and heterogeneity has been compounded through the contemporary phenomenon of globalization. With Reiki being trans-nationally mobile, the potential for continued segmentation through information technology and travel opens a new spectrum for even more culturally diverse forms of activity. But this is but one aspect of the social world of Reiki.

In the face of this diversity, there is also coherence. What brings coherence to a social world is a shared ideology around a central activity. In this social world practitioners hold a shared therapeutic ideology based on an 'energetic world view'. This is built on the simple premise that everything that exists in nature is energy and that energy is not bounded by matter, space, and/or time. Trust in this core belief provides a foundation for entertaining varied interpretations and holding multiple truths about this 'life force' or 'healing' or 'reiki' energy.

'Reiki energy' is interpreted by practitioners in varying ways but despite its different translations, participants hold common values that buttress their individual beliefs about this object. These include qualities of virtue, fulfillment, and respect for tacit knowledge. In part, it is these values that underscore nuances in beliefs and interpretations of 'healing energy', and the core procedures and technologies common to all Reiki segments or branches or styles of practice. This appreciation also reinforces the more commonly held convictions of practitioners encompassing self responsibility for health and holistic healing.

An important insight of this research relates to this shared 'therapeutic ideology'. It was through this finding that I realized internal world segmentation does not encumber the successful coalescence of a dispersive social world. Although holding an energetic world view can be seen as broadly aligning with contemporary thinking, the notion of 'life force energy', however, sparks a great deal of controversy. This one idea is the most potent ideological premise that polarizes the debates and the divides between and

amongst CAM practitioners, between CAM groups and biomedicine groups, and between and amongst biomedicine practitioners.

These conflicts are far from new but are nonetheless continuing; particularly in debates over what constitutes conventionally acceptable forms of treatment, who is able to decide what is socially legitimate, who gets to practice a particular therapy, and to what lengths a therapy is transformed through these interactions. These issues have formed the core of sociological research on CAM practices. A few examples include chiropractic medicine (Coburn and Biggs 1986), midwifery (Bourgeault 1996; 2000); naturopathy (Boon 1998); homeopathy (Sharma1992); and herbal medicine (Hirschkorn 2005). One important thread that is apparent in much of this research is that in order to gain some semblance of legitimacy and social status within the paradigm of biomedicine, groups seem to have to divorce themselves from the 'life force' principle. Along with the increasing visibility of Reiki amongst the general public comes greater pressure to prove social legitimacy.

Interestingly, the majority of participants were personally interested in social approval but were largely resistant to the traditional routes of legitimacy to prove the worth of their method. Although the practitioners I interviewed were not actively pursuing 'professionalization projects' this does not mean that they are passive about achieving social acceptance. As Coburn and Biggs (1986) have argued, professionalization is only one way to gain social legitimacy; legitimacy vis-à-vis clients is also critical for the success and sustainability of some CAM practices (in their case, chiropractic). While 'official' legitimacy is tied to medical scrutiny and state recognition,

social legitimacy for Reiki practitioners is more indicative of public acceptance which embraces legitimacy encountered on informal, formal, and formally sanctioned fronts of everyday practice. Drawing upon Strauss' (1984:137) concept of *intersections* which he used to refer to "sets of events" that are linked to, "crosscut", and mirror social world processes," I show how involvements are "intersections" that reflect the strategies that practitioners use to gain "trustworthiness" and to carve out a "deserved place" (Strauss 1982:175) in the health service industry.

I discovered that practitioners experienced varying degrees of opposition and receptivity as they carried out their work in informal, formal, and formally sanctioned practices. Importantly, practitioners active in formal practices are the most publicly visible and face the greatest obstacles with respect to carving out a living based solely on the practice of Reiki. They confront fluctuating markets and unpredictability with respect to the demand for their services. Most train in other modalities and hold other full-time or part-time employment but would prefer to devote all their time to Reiki. Participants on this front of practice were the most active in confronting a lack of public awareness through promotional activities. While they used a variety of strategies to attract attention to the practice they typically educated others directly and experientially through demonstration.

With respect to opposition, one important finding relates to how the social stigma that pervades Reiki practice is based on stereotypes. In an era of increased freedom of expression, with respect to forms of healing, energy workers no longer have to worry about being 'burned at the stake' for participating in energy healing, but nevertheless they

are constrained by reactions of people and groups who discredit both the practice and those engaged in it. These stereotypes permeated all working boundaries. Intentional or not, this labeling tends to perpetuate the stigmatization of those involved with this social world. Still, these notions may or may not be internalized by advocates or non-advocates of Reiki practice.

There was little evidence in my study to support the idea that practitioners felt anything but empowered by Reiki, a finding similar to Sointu's (2006) study involving CAM users and practitioners. The intrinsic rewards that participants reap from their involvements seem to counter the opposition that they endure. Overall, through their involvements, participants chip away at dispelling pervasive myths and misconceptions about Reiki. In contrast, practitioners also experienced receptivity for their work. In these instances, practitioners took advantage of opportunities to increase public awareness and expand their activities on all fronts.

Educating others, mainly through demonstration, was also the central way that practitioners bridged other social worlds. Through this strategy, practitioners' involvements with Reiki intersected in a variety of ways with a myriad of actors outside the world of Reiki: with significant others, clients, acquaintances, co-workers, bosses, work site managers; institutional policies (or lack thereof), and formal regulatory bodies.

Participants bridging activities suggest that opposition to Reiki is only part of the story of what is happening on practice fronts. For example, within formally sanctioned practices, Reiki may not necessarily be prohibitive to bio-medically trained health care professionals or other CAM practitioners. Although the issues of social acceptance tend

to be rhetorically polarized, previous studies have shown that in actuality there is a great deal of heterogeneity within and between health practice groups with respect to ideology (Bourgeault 2000, Bucher 1962; Hirschkorn 2005; Pawluch 1983, 1996; Sharma 1992; Strauss et al. 1964). Regulatory bodies mandate the 'representative' ideology of professional groups and homogenize professional practice through the standardization of content and scopes of practice. This does not mean that all health professionals share the same beliefs about other mainstream health practices. The CAM movement is, in part, fueled by 'holistically' minded health professionals fully trained in biomedicine. Health professionals in this study exemplify this kind of heterogeneity.

My findings also indicate that through their bridging activities participants were active in providing a service largely to medically compromised people. For example, my data suggest that while there is a mainstream demand for the therapy it is often generated by vulnerable populations; for example, through people in palliative care, those living with stigmatizing conditions such as HIV AIDS, the elderly in nursing homes, women in abusive situations, or those struggling with mental health issues and relationship problems. This finding diverges from what is reported in current literature; that people involved with Reiki are mainly middle-class women on a quest for well-being (Kelner and Wellman 1997b). While not inaccurate, this depiction tends to trivialize the practice and those engaged in it. Reiki practitioners focus on optimizing health and well-being but this is part of their therapeutic ideology, part of the approach to treatment. Essentially, the experience of Reiki practice cannot be divorced from how suffering is generally constructed in daily life.

Where and how practitioners carry out their work has major implications for the kind of status that the practice and they as practitioners, can achieve. For example, health professionals who crossed established conventional boundaries, for the most part, did so with caution. In addition to the social stigma that all practitioners faced, health care professionals with Reiki training confronted varying degrees of restriction through their regulatory bodies. Additionally, although the absence of institutional policies did not necessarily prevent treating patients, this 'non-recognition' can impact the transparent use of the therapy with patients/clients.

While participants are expanding the boundaries of the practice through this route, these inroads do little to improve their economic livelihoods or to change their marginal place within biomedical care settings. Despite the challenges, an important lesson in this analysis is that despite rhetorical divisions over social legitimacy, in practice, these boundaries are not impervious. Overall, CAM practices such as Reiki are interfacing with mainstream healthcare in ways that are overlooked in current scholarship. The complexity, diversity, coherence, and value that social worlds such as Reiki hold for practitioners tend to be under acknowledged in current CAM scholarship. Similar to other forms of care-giving, the contributions that these practitioners make go largely unnoticed and are in many respects under-rated.

Contributions

Sociology of CAM

This research is unique in the sociology of CAM because it provides an in depth look at the practice of Reiki 'energy healing'. The study makes the following original

contributions. My research provides a novel sociological analysis of the processes and interactions that form, shape, and direct a contemporary healing practice. The analysis documents the heterogeneity of Reiki practice and its loose organizational structure. I illustrated the shared ideology and diverse interpretation that practitioners hold about their work. Finally, I highlighted a continuum of public approval for energy healing and the strategies that participants used to manage and negotiate public acceptance in ways that interface with but, at least for the present, remain under the radar of biomedical scrutiny.

The complexity, heterogeneity, and multilayered nature of holistic healing methods, as they are practiced and used in everyday life, are not easily captured within current theories of CAM; as indeed are 'mainstream' healing modalities more generally. The tendency is to rely on dichotomous approaches which frame either the practice or use of CAM. As a twin or conjoined practice Reiki encompasses practice and use and resides in the multilayered crevices of both.

I found that Reiki practitioners chose to make a commitment to both self healing and to the healing facilitation of others. While other researchers have noted that those who are CAM users are also practitioners (Low 2004; Sointu 2006), most of the time one or the other is eclipsed in analyses. This poses not only a methodological problem in conducting studies of CAM (are they practitioners or users?) but also creates ontological (what we know) and epistemological (how we know what we know) dilemmas. How can we study realities that are in practice holistic when our approach to studying the empirical world is one based on dualistic thinking (practice or use)? I am not suggesting that the

idea of 'conjoined practice' solves this problem but it at least affords greater acknowledgement of the practice and use of Reiki as being 'embodied' or one in the same for practitioners. This is a necessary first step in advancing our theories and understanding of the meaning of holism in practice. In other words, practitioners do not divorce their method and experience of self healing practices from their practice of energy work with others. My analysis attempted to explore the issues, tensions, and consequences linked to and encompassing the practice and use of CAM in a way that, theoretically, through the use of SWT, does not conflict with the holistic tenets of CAM. Although this kind of focus is lacking in current sociological theories of CAM, the insights garnered from confronting this dichotomy extend beyond the sociology of CAM literature.

Social Worlds Theory

This study contributes to SWT by accentuating the importance of social actors (individuals) in the shaping of dispersive social worlds. My analysis demonstrates why it is important for social world theorists, in their efforts to understand social worlds and how they work, to foreground the activities, practices, and lived work experiences of social actors. It is at the level of acting individuals that the processes social world theorists are interested in exploring take shape and are brought into being. The experience and interactions of practitioners at local levels are an important entry point into social world processes that affect contemporary social change. I argued throughout this dissertation that in the study of dispersive social worlds, such as Reiki, it is necessary to accentuate the local level actions and interactions of individuals engaged in and

experiencing such worlds. By doing so, I illustrated that internal world segmentation does not necessarily encumber the successful coalescence of an ideologically diffuse social world. I maintain that it is through interactional strategies that the continued segmentation of a dispersive social world occurs; to the extent that a shared ideology contributes to the social coherence of a diffuse social world.

While sophisticated applications of social worlds and arenas theory are well suited to the study of established organizational groups, recent conceptual developments, such as in the area of social world arenas, are not as applicable to less formally organized, dispersive social worlds; particularly the social worlds of CAM practices. Many CAM practices have loose organizational structures, porous borders, and intersect in ways that are not easily captured through current theories. There may be few or many representative voices but in either case the majority of practitioners tend not to hold affiliations with formal organizations or associations. In these situations, the experience and interactions of individuals at local levels figure more predominantly in local processes that cultivate social change. Still, the social worlds toolbox of sensitizing concepts continues to offer a fruitful and innovative way to capture what is happening in dispersive social worlds.

Segmentation

The social history of Reiki offers an example of the adaptations, changes, and strategies that Reiki 'entrepreneurs' used to preserve, protect and advance their practice interests. More broadly, it is illustrative of how segmentation processes in the diffuse social worlds of CAM operate. The social history also informs this theory by identifying

additional contemporary phenomena that contribute to the segmentation of dispersive social worlds. Increasing globalization is one "generic source" or "general condition" of segmentation (Strauss 1984) that underpins group coalescence through entrepreneurial activities that include historical research, recruitment, training, continued education, and information dissemination on a global scale. Globalization is also a source of segmentation that adds to the complexity and speed of segmentation.

Looking at the conditions that propel and shape a social world are a necessary part of understanding how individuals are putting pragmatism into action and reciprocally contribute to the expansion and shape of an activity. The viability of dispersive social worlds is contingent on individuals' involvements in them.

Boundary Objects

While the notion of a boundary object has been especially helpful in explaining how practitioners with both disparate and nuanced beliefs are able to remain part of the same social world, the use of the concept is problematic to the overall analysis of Reiki practice. In the dispersive social world of Reiki, actors are voluntary participants who may or may not choose to come together in co-operative ways. Whereas boundary objects highlight the standardization and homogenization of "knowledge" and or "ways of knowing" (Star and Griesemer 1989), the core object in this particular social world brings out the differentiation and heterogeneity of knowledge and or ways of knowing amongst individuals and groups. Even though group conflict and co-operation is assumed, the social worlds captured by boundary objects assume group conflict and co-operation and tend to be robustly structured, while dispersive worlds are more loosely organized and

do not mandate cooperation. In a world such as Reiki, objects may or may not bring about co-operation in and between segments. Cooperation is voluntary. It is not required or binding. Other empirical studies have pointed to similar difficulties with the idea of cooperation between social worlds within and beyond CAM (Adams 2004; Adams and Tovey 2001; Tovey and Adams 2001; Tuunainen 2005).

My analysis further informs SWT by accentuating that the therapeutic ideology of practitioners is made up of a shared world view, and common values that buttress varying beliefs. In the case of Reiki, it is the participants' therapeutic ideology that brings coherence to a dispersive social world. Theoretically, coherence reciprocally creates a potential for the creation of new intersections and hence, continued segmentation (Strauss 1984; Star and Griesemer 1989).

Intersection

This analysis informs SWT by providing insights into the intersecting processes of a dispersive world. Focusing on the action and interactions of individual members helps to uncover otherwise overlooked processes characteristic of this world. Exploration into the specific strategies that constitute member involvements affords an opportunity to gain a deeper understanding of the "conditions and consequences" (Strauss 1984) taking place in a segmenting world such as Reiki. Strauss (1984) argued that in tracing these sets of events or "intersections" other cross cutting social world processes come into view. In this analysis, while public acceptance or the range of social approval that practitioners experience from people outside the social world of Reiki was the focal point of practitioner involvements, social legitimacy or the strategies that practitioners use to

establish public acceptance emerged as the central cross cutting process. Social legitimacy strategies, as it turned out, had less to do with confronting medical associations or the state, than with establishing face to face credibility with those encountered in everyday practice.

My analysis therefore fills out the concept of social legitimacy, first of all, by accentuating the actions and interactions of front-line practitioners involved in this arena. Secondly, it highlights how members are, for the most part, resisting the standardization of their social world rather than using standardization as a strategy for attaining social legitimacy. Indeed, standardization seems to be an anathema to client-centered Reiki practice. Members' attention was focused on the more immediate and ground level issue of public acceptance rather than taking the route of formally sanctioned regulation through professionalization. The analysis also shows that practitioners were actively engaged in experientially demonstrating the potential benefits of Reiki. Achieving social legitimacy in this way is more subtle, quiet, and less politically charged but not less active.

Limitations and Promising Areas for Future Research

While this study has provided much insight into the understudied social world of Reiki, it is important to consider the limitations of my enquiry. First of all, my sample was not ethnically diverse and men were under represented. Similar to other studies in this field, my research participants involved mainly well educated, white women. While many were receptive to participating in this research, finding enough men and ethnically diverse practitioners to participate was problematic despite seeking out participants in

both Eastern and Central Canada. The extent to which this may have biased some of my key findings remains unclear.

My research is also limited with respect to the location of participants. While I interviewed practitioners in both Atlantic and Central Canada across a range of urban and rural settings, my sample did not include practitioners from Western Canada- a hotbed of Reiki practice. This decision was largely due to my strong preference for face-to-face, in-depth interviews with participants which would have been impossible in Western Canada due to financial and time constraints. This remains an unexplored area suitable for future research. Moreover, despite having two different practice locations, I refrained from undertaking a comparative analysis at this point in time. While comparative research would increase our understanding of CAM, I chose instead to focus my attention on laying the much needed ground work of the commonalities of Reiki practice in preparation for future comparative research.

While the features and processes highlighted in this study are transferable to social worlds within and beyond Reiki, transferability should be limited to communities that share the diffuse and dispersive characteristics of Reiki. For example, similar to Reiki, computer gaming is a dispersive world influenced by gender (Fine 2002). It is possible that the social world of computer gaming shares features and processes that are more common with the social world of Reiki than does say chiropractic medicine, even though Reiki and chiropractic medicine both are forms of CAM.

This study, despite its insights, also raises many questions and thereby opens up varied possibilities for future research. In keeping the focus on the individual's

experience of CAM, a future analysis might consider exploring the socialization process of becoming a CAM practitioner. An examination of this process could illustrate how people shift from using the practice as a self healing method to becoming a healing facilitator of the practice or vice versa. This would further expand upon the concept of conjoined practice introduced here.

With respect to intersectional analyses, an area that has largely been ignored in CAM research is how gender is implicated in the social worlds of CAM. While my study uncovered how stereotypes tend to be more closely linked to women, another interesting area of exploration could involve exploring how men experience their involvements in the gendered social worlds of CAM. A related line of inquiry might consider how divisions of labor are shaped through CAM and the implications that this holds for men and women, and for CAM practices. Another direction could entail how aging creates and constrains opportunities for engagement in the social worlds of CAM. Many of the implications that such involvements hold for seniors are yet to be explored.

Comparative research is another area that warrants further attention. More specifically, a comparative analysis of the transformative changes that people undergo through trajectories of 'healing' and the transformations experienced through trajectories of 'illness' would expand our knowledge in this area. While literature exists on both, to date no comparisons of these trajectories have been undertaken. Another possible direction could involve a comparative analysis of the use of Reiki in hospitals in Canada. This might encompass a mixed methods approach designed to capture quantitatively the extent of use of Reiki in hospitals in Canada and to qualitatively compare and contrast

the central issues that offering Reiki to patients poses for front line workers, patients, and managers within and across sites. Such a study could build on this research which is grounded in SWT.

My suggested directions for future research encourage examining the features and processes that shape communities of healing practices. These remain understudied and under theorized areas in the sociology of CAM. Overall, this kind of research is important because it can provide specific insights into the complexity of the social worlds of CAM and augment our overall understanding of health and healing in contemporary life. Such enquiries are much more than academic exercises but important sources of information for individuals and groups involved in health care provision, as well as for those who consume such services. Eventually, this includes everyone!

BIBLIOGRAPHY

Adams, Jon. 2001. Direct Integrative Practice, Time Constraints and Reactive Strategy, an Examination of GP Therapists' Perceptions of Their Complementary Medicine. *Journal of Management in Medicine* 15 (4):312–323.

Adams, Jon. 2004. "Demarkating the Medical/Nonmedical Border: occupational boundary-work within the GP's accounts of their integrative practices." Pp. 140-157 in *The Mainstreaming of Complementary and Alternative Medicine: studies in social context*, edited by P. Tovey, G. Easthope, & J. Adams. London, New York: Routledge Taylor & Francis Group.

Adams, Jon and Philip. Tovey. 2001. Nurses' Use of Professional Distancing in the Appropriation of CAM: A Text Analysis. *Complementary Therapies in Medicine* 9 (3):136–140.

Adams, Jon, Gary Easthope, and David Sibbrit. 2003. "Exploring the Relationship Between Women's Health and Use of Complementary and Alternative Medicine." *Complementary Therapies in Medicine* 11:156-158.

Adler, Patricia and Peter Adler. 1987. *Membership Roles in Field Research.* California: Sage Publications Inc.

Albanese, Catherine L. 2000. The Aura of Wellness: Subtle-Energy Healing and New Age Religion. *Religion and American Culture* 10 (1):29-55.

Allen, Davina. 2009. "From Boundary Concept to Boundary Object: The Practice and Politics of Care Pathway Development." *Social Science & Medicine* 69 (3):354-361.

Andrews, Gavin J. 2002. Private Complementary Medicine and Older People: service use and user empowerment. *Ageing and Society*. 3 (22):343-368.

Andrews, Gavin. J. and Heather. Boon 2005. CAM in Canada: Places, Practices, Research. *Complementary Therapies in Clinical Practice.* 11:21-27.

Annandale, Ellen and Judith. Clark 2000. Gender, Postmodernism and Health. Pp. 51-66 in *Health, Medicine and Society: Key Theories, Future Agendas*, edited by S. J. Williams, J. Gabe, and M. Calnan. London and New York: Routledge.

Armstrong, Pat and Hugh. Armstrong. 2003. *Wasting Away: The Undermining of Canadian Health Care*. Don Mills, Ontario: Oxford University Press.

Armstrong, Pat. 2002. The Context for Health Care Reform in Canada. Pp. 11-48 in *Exposing Privatization: Women and Health Care Reform in Canada*, edited by Pat Armstrong, Carol Amaratunga, Jocelyne Bernier, Karen Grant, Ann Pederson, Kay Wilson. Aurora: Garamond Press.

Astin, John A. 1998. Why Patients Use Alternative Medicine: results of a national study. *Journal of the American Medical Association* 279 (19):1548-1553.

Atkinson, Paul. 1997. Anselm Strauss an Appreciation. *Sociology of Health and Illness.* 19 (3):367-372.

Atlantic Usui Reiki Association. (A.U.R.A.). 2007. Retrieved September 7, 2008. (http://www.atlanticusuireiki.ca).

Baer, Hans A. 2008. The Emergence of Integrative Medicine in Australia: the growing interest of biomedicine and nursing in complementary medicine in a southern developed society. *Medical Anthropology Quarterly.* 22(1):52-66.

Baer, Hans A., John Hays, Nicole McClendon, Neil McMoldrick. and Raffella Vespucci. 1998. The Holistic Health Movement in the San Franscisco Bay Area: some preliminary observations. *Social Science & Medicine.* 47(10):1495-1501.

Barnes, Patricia., M. Eve Powell-Griner, Kim McFann, and Richard L. Nahin. 2004. Complementary and Alternative Medicine Use Among Adults: United States, 2002. *Seminars in Integrative Medicine.* 2:54-71.

Barnett, Libby and Maggie Chambers. 1996. *Reiki energy medicine: bringing healing touch into home, hospital and hospice.* Rochester, VT: Healing Arts Press.

Becker, Howard S. 1984. *Art Worlds.* Berkley: University of California Press.

Benor, Daniel J. 1995. Spiritual Healing: a unifying influence in complementary therapies. *Complementary Therapies in Medicine.* 3:234-238.

Benoit, Cecilia. 1991. *Midwives in Passage.* St John's Newfoundland Institute of Social and Economic Research.

Bishop, Felicity, Lucy Yardley, and George T. Lewith. 2007. A Systematic Review of Beliefs Involved in the Use of Complementary and Alternative Medicine. *Journal of Health Psychology.* 12 (6):851–867.

Blaxter, Mildred. 2004. *Health: key concepts.* Cambridge: Polity Press.

Blumer, Herbert. 1969. Symbolic Interactionism: Perspective and Method. Englewood Cliffs: Prentice Hall Inc.

Bodeker, Gerard, Fredi Kronenberg, and Gemma Burford. 2007. "Policy and Public Health Perspectives on Traditional, Complementary and Alternative Medicine: an overview" Pp. 9-38 in *Traditional, Complementary and Alternative Medicine: policy and public health perspectives,* edited by Gerard Bodeker and Gemma Burford London: Imperial College Press.

Boon, Heather. 1998. Canadian Naturopathic Practitioners: holistic and scientific world views. *Social Science & Medicine.* 46 (9):1213-25.

Boon, Heather, Merrijoy Kelner, Beverly Wellman, and Sandy Welsh. 2004. "Responses of Established Healthcare to the Professionalization of Complementary and Alternative Medicine in Ontario." *Social Science and Medicine.* 59 (5):915-930.

Boon, Heather S, Folashade Olatunde, and Suzanna M. Zick. 2007. Trends in Complementary/Alternative Medicine Use by Breast Cancer Survivors: comparing survey data from 1998 and 2005. *BMC Women's Health.* 7 (4):1-7.

Boon, Heather, Moira Stewart, Mary Ann Kennard, Ross Gray, Carol Sawka, and Judith B. Brown. 2000. Use of Complementary/Alternative Medicine by Breast Cancer Survivors in Ontario: prevalence and perceptions. *Journal of Clinical Oncology.* 18:2515–2521.

Boon, Heather, Marja Verhoef, Dennis O'Hara, Barb Finflay, and Nadine Majid. 2004. "Integrative Healthcare: Arriving at a Working Definition." *Alternative Therapies in Health and Medicine* 10 (5):48-56.

Bourgeault, Ivy Lynn. 1996. "Delivering Midwifery: an examination of the process and outcome of the incorporation of midwifery in Ontario" Ph.D. dissertation, Department of Community Health, University of Toronto.

Bourgeault, Ivy Lynn. 2000. Delivering the `New' Canadian Midwifery: the impact on midwifery of integration into the Ontario health care system. *Sociology of Health & Illness.* 22 (2):172-196.

Bourgeault, Ivy Lynn and Kristine Hirschkorn. 2008. "CAM Integration in Interprofessional Context: nursing, midwifery and medicine in Canada." Pp. 11-32 in *International Perspectives on CAM in Nursing*, edited by Jon Adams and Philip Tovey.

Bowman, Marion. 1999. Healing in the Spirtual Marketplace: consumers, courses and credentialism. *Social Compass.* 46:181-189.

Broom, Alex. 2009. "I'd forgotten about me in all of this: discourses of self-healing, positivity and vulnerability in cancer patients' experiences of complementary and alternative medicine." *Journal of Sociology.* 45 (1):71-87.

Brown, J., E. Cooper, L. Frankton, M. Steeves Wall, J. Gillis-Ring, W. Barter, A. McCabe and C. Fernandez. 2007."Complementary and Alternative Therapies: survey of knowledge and attitudes of health professionals at a tertiary pediatric/women's care facility." *Complementary Therapies in Clinical Practice* 13 (3):194-200.

Bryan, J. Ingram. 1924. *Japan From Within: An Inquiry Into the Political, Industrial, Commercial, Financial, Agricultural, Armamental and Educational Conditions of Modern Japan.* London: T. Fisher Unwin Ltd.

Bucher, Rue. 1962. Pathology: a study of social movements within a profession. *Social Problems.* 10:40-51.

Bucher, Rue. and Anselm. Strauss. 1961. Professions in Process. *The American Journal of Sociology.* 66 (4):325-334.

Bury, Michael. C. 1997. *Health and Illness in a Changing Society.* London. Routledge.

Canadian Reiki Association (CRA). 2003. "What is the Usui System of Natural Healing?" Retrieved September 10, 2008. (http://www.reiki.ca/faqs.htm#1).

Cant, Sarah. L. and Ursula Sharma. 1995. "The Reluctant Profession – Homoeopathy and the Search for Legitimacy." *Work, Employment & Society* 9 (4):743-762.

------. 1999. *A New Medical Pluralism?: doctors, patients, and the state.* London: UCL Press Limited.

------. 2000. Alternative Health Practices and Systems. Pp. 426-439 in *Handbook of Social Studies in Health and Medicine*, edited by GL Albrecht, R Fitzpatrick, S Scrimshaw. Thousand Oaks, California: Sage.

Canter, Peter H. 2008. "Vitalism and Other Pseudoscience in Alternative Medicine: the retreat from science." Pp. 152-161 in *Healing Hype or Harm: a critical analysis of complementary or alternative medicine,* edited by Edzard Ernst. UK: Societas.

Charlton, Bruce. G. 2008. "Healing But Not Curing: alternative medical therapies as valid new age spiritual healing practices." Pp. 68-77 in *Healing Hype or Harm: a critical analysis of complementary or alternative medicine,* edited by Edzard Ernst. UK: Societas.

Charmaz, Kathy. 1991.*Good Days, Bad Days: The Self in Chronic Illness and in Time.* New Brunswick, NJ: Rutgers U. P.

------.2002. The Self as Habit: the reconstruction of self in chronic illness. *The Occupational Therapy Journal of Research.* 22:31S-41S.

------. 2006. *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis.* London: Sage Publications.

Chu, Dennis. A. 2004. Tai Chi, Qi Gong, and Reiki. *Physical Medicine and Rehabilitation Clinics in North America.*15:773-781.

Clarke, Adele E. 1990. "A Social Worlds Research Adventure: The Case of Reproductive Science." Pp. 15-42 in *Theories of Science in Society* , edited by S. E. Cozzens and T. F. Gieryn. Bloomington: Indiana University Press.

------. 1991. "Social World/Arena's Theory as Organizational Theory." Pp. 119-158 in *Social Organization and Social Process: Essays in Honor of Anselm Strauss*, edited by David R. Maines. New York: Aldine De Gruyter.

------. 1998. *Disciplining Reproduction: Modernity, American Life Sciences, and the Problems of Sex.* Berkeley, CA: University of California Press.

------. 2003. Situational Analyses: Grounded Theory Mapping After the Postmodern Turn. *Symbolic Interaction.* 26 (4):553–576.

------. 2005. *Situational Analyses: Grounded Theory After the Postmodern Turn.* Thousand Oaks, California: Sage Publications Inc.

Clarke, Adele. E. and Theresa Montini. 1993. The Many Faces of RU486: tales of situated knowledges and technological contestations. *Science Technology Human Values.* 18:42-78.

Clarke, Adele E. and Monica J. Casper 1996. From Simple Technology to Complex Arena: Classification of Pap Smears, 1917-1990. *Medical Anthropology Quarterly.* 10 (4):601-623.

Clarke, Adele. E. and Susan Leigh. Star. 2008. "The Social Worlds Framework: a theory methods package." Pp:113-138 in *The Handbook of Science and Technology Studies,* edited by E.J Hackett, O Amsterdamska, M Lynch, and J Wajcman. Cambridge, Massachusetts: The MIT Press.

Coburn, David. 1994. "Professionalization and Proletarianization: Medicine, Nursing, and Chiropractic in Historical Perspective," *Labour/Le Travail,* 34:139-62.

------. 2001. "Health, Health care, and Neoliberalism." Pp. 45-65 in *Unhealthy Times Political Economy Perspectives on Health and Care*, edited by Armstrong P. H. Armstrong, and D.Coburn. Ontario: Oxford University Press.

Coburn, David and C. Leslie. Biggs. 1986. Limits to Medical Dominance: the case of chiropractic. *Social Science and Medicine.* 22:1035-1046.

Coburn, David, George M. Torrance, and Joseph M. Kaufert. 1983. Medical Dominance in Canada in Historical Perspective: the rise and fall of medicine. *International Journal of Health Service.* 13 (3):407-432.

Conrad, Peter. and Michael. Bury. 1997. Anselm Strauss and the Sociological Study of Chronic Illness: a reflection and appreciation. *Sociology of Health and Illness.* 19 (3):373-376.

Coulter, Ian. 2004. "Integration and Paradigm Clash." Pp. 103-122 in *The Mainstreaming of Complementary and Alternative Medicine: studies in social context*, edited by P. Tovey, G. Easthope, & J. Adams. London, New York: Routledge Taylor & Francis Group.

Coulter, Ian and Evan Willis. 2004. The Rise and Rise of Complementary and Alternative Medicine: a sociological perspective. MJA. 180:587-589.

------. 2007."Explaining the Growth of Complementary and Alternative Medicine." *Health Sociology Review.* 16 (3-4):214-225.

Crawford Stephen, Wayne Leaver, and Sandra Mahoney. 2006. Using Reiki to Decrease Memory and Behavior Problems in Mild Cognitive Impairment and Mild Alzheimer's Disease. *The Journal of Alternative and Complementary Medicine.* 12(9):911- 913.

Crellin, John, Raoul Anderson, and James Connor. 1997. *Alternative Health Care in Canada: Nineteenth and Twentieth Century Perspectives.* Toronto, Ontario:

de Bruyn, Theodore . 2002. A Summary of National Data on Complementary and Alternative Health Care- current status and future development: a discussion paper. Ottawa: Health Canada.

Dewy, John. 1957. *Human Nature and Conduct: an introduction to social psychology.* New York: The Modern Library. (original work published in 1922).

Di Nucci, Ellen. M. 2005. Energy Healing: a complementary treatment for orthopedic and other conditions. *Orthopedic Nursing.* 24 (4):259-269.

Dossey, Barbara. M. 1997. "Complementary and Alternative Therapies For Our Aging Society." *Journal of Gerontological Nursing* 23(9):45-51.

Eisenbenberg, David, Roger Davis, Susan Ettner, Scott Appel, Sonja Wilkey, Maria Van Rompay, and Ronald Kessler. 1998. Trends in Alternative Medicine Use in the United States, 1990-1997: results of a follow-up national survey. *Journal of the American Medical Association.* 280:1569-75.

Engebretson Joan. 1996a. Urban Healers: an experiential description of American Healing Touch Groups. Qualitative Health Research. 6(4):526-541.

------. 1996b. Comparison of Nurses and Alternative Healers. *Journal of Nursing Scholarship.* 28(2):95-100.

Ernst, Edzard. 2008. *Healing, Hype or Harm: a critical analysis of complementary or alternative medicine.* Exeter: Societas.

Ernst, Edzard and Adrian White. 2000. The BBC survey of complementary use in the UK. *Complementary Therapies in Medicine.* 8:32-6.

Esmail, Nadeem. 2007. "Complementary and Alternative Medicine in Canada: trends in use and public attitudes, 1997-2006." *Fraser Institute.* 87:1-53.

Fadlon, Judith. 2004. "Meridians, Chakras and Psycho-Neuro-Immunology: The Dematerializing Body and the Domestication of Alternative Medicine." *Body & Society* 10 (4):69-86.

Foltz, Tanice G. 1994. *Kahuna Healer: Learning to See with Ki.* New York & London: Garland Publishing Inc.

Foote-Ardah, Carrie E. 2003. The Meaning of Complementary and Alternative Medicine Practices Among People with HIV in the United States: strategies for managing everyday life. *Sociology of Health and Illness.* 25 (5):481-500.

Freidson, Eliot. 1970. *Profession of Medicine: a study of the sociology of applied knowledge.* Chicago: University of Chicago Press.

Furnham, Adrian. 2007. Are Modern Health Worries, Personality and Attitudes to Science Associated With the Use of Complementary and Alternative Medicine? *British Journal of Health Psychology.* 12:229–243.

Furnham Adrian, and Charles Vincent. 1995. Value differences in Orthodox and Complementary Medicine Patients. *Complementary Therapies in Medicine.* 3:65-69.

------. 2000."Reasons for Using CAM." Pp.61-78 in *Complementary and Alternative Medicine: challenge and change*, edited by Merrijoy Kelner, Beverly Wellman, Bernice Pescosolido, and Mike Saks. Amsterdam, The Netherlands: Harwood Academic Publishers.

Gabe, Jonathon. and Michael. Calnan. 2000. Health Care and Consumption. Pp. 255-73 in *Health, Medicine and Society: Key Theories, Future Agendas*, edited by Simon J. Williams, Jonathon Gabe, and Michael Calnan. London and New York: Routledge.

Garrett, Catherine. 2001. Transcendental Meditation, Reiki and Yoga: suffering, ritual and self-transformation. *Journal of Contemporary Religion.* 16 (3):329-342.

Gerson, Elihu 1983. "Scientific Work and Social Worlds. *Knowledge.* 4:357-377.

Gilberti, Theresa. 2004. The Re-Emergence of an Ancient Healing Art in Modern Times. *Home Health Care Management and Practice.* 16 (6):480-486.

Gillett, James, Dorothy Pawluch, and Roy Cain. 2002. How People with HIV/AIDS Manage and Assess their Use of Complementary Therapies: a qualitative analysis. *Journal of the Association of Nurses in AIDS Care* 13:17-27.

Gilmour, Joan M., Merrijoy Kelner, and Beverly Wellman 2002. Opening the Door to Complementary and Alternative Medicine: self-regulation in Ontario. *Law Policy.* 24(2):150-174.

Glaser, Barney G. and Anselm Strauss 1967. *The Discovery of Grounded Theory: strategies for qualitative research.* Chicago: Aldine publishing company.

Gleeson, M. and A. Higgins. 2009. Touch in Mental Health Nursing: An Exploratory Study of Nurses' Views and Perceptions. *Journal of Psychiatric and Mental Health Nursing.* 16:382–389.

Glik, Deborah C. 1986. Psychosocial Wellbeing Among Spiritual Healing Participants. *Social Science and Medicine.* 22 (5):579-586.

------. 1988. Symbolic Ritual and Social Dynamics of Spiritual Healing. *Social Science and Medicine.* 27(11): 1197-1206.

------. 1990. The Re-definition of the Situation: the social construction of spiritual healing experiences. *Sociology of Health and Illness.* 12 (2):151-168.

Goffman, Erving. 1963. *Stigma: notes on the management of spoiled identity.* New York: Simon and Schuster.

Goldner, Melinda. 2004. The Dynamic Interplay Between Western Medicine and the Complementary and Alternative Medicine Movement: how activists perceive a range of responses from physicians and hospitals. *Sociology of Health & Illness.* 26 (6):710-736.

Goldstein, Michael. S. 2000. The Growing Acceptance of Complementary and Alternative Medicine. Pp. 284-97 in *Handbook of Medical Sociology*, edited by C. Bird, P. Conrad, and A.M. Fremont. Upper Saddle River, NJ: Prentice Hall.

------. 2002. The Emerging Socioeconomic and Political Support for Alternative Medicine in the United States. *The Annals of The American Academy of Political and Social Science.* 583:44-63.

Goldstein, Michael S., Dennis T. Jaffe, Carol Sutherland, and Josie Wilson. 1987. Holistic Physicians: implications for the study of the medical profession. *Journal of Health and Social Behavior.* 28 (2):103-119.

Heelas, Paul. 2007. 'The Holistic Milieu and Spirituality: reflections on Voas and Bruce." Pp. 63-80 in *A Sociology of Spirituality,* edited by Kieran Flanagan and Peter Jupp. Hampshire England: Ashgate Publishing Company.

Heelas, Paul and Linda Woodhead. 2005. *The Spiritual Revolution: why religion is giving way to spirituality.* Oxford: Blackwell.

Hewitt, John. P.1994. *Self and Society: a symbolic interactionist social psychology sixth edition.* Boston: Allyn and Bacon.

Hirschkorn, Kristine . 2005. "The Regulation and Professionalization of Herbal Medicine." Ph.D. dissertation, Department of Sociology, McMaster University.

Hirschkorn, Kristine and Ivy Lynn Bourgeault. 2008. Structural Constraints and Opportunities for CAM Use and Referral by Physicians, Nurses, and Midwives. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine.* 12 (2):193-213.

Hirschkorn, Kristine, Robert Andersen, and Ivy Lynn Bourgeault. 2009. Canadian Family Physicians and Complementary/Alternative Medicine: the role of practice setting, medical training, and province of practice. *Canadian Review of Sociology*. 46 (2): 143-159.

Hodges, R. D. and A. M. Schofield. 1995. Is Spiritual Healing a Valid and Effective Therapy? *Journal of the Royal Society of Medicine.* 88:203-207.

Hollenberg, Daniel. 2006. "Uncharted Ground: patterns of professional interaction among complementary/alternative and biomedical practitioners in integrative health care settings." *Social Science & Medicine* 62(3):731-744.

Illich, Ivan. 1976. *Limits to Medicine-Medical Nemesis: The Expropriation of Health.* Toronto & London: McClelland and Steward, in association with Calder and Boyars.

Johnson, Terence.1972. *Professions and Power*. London: MacMillan Press Ltd.

Jonas, Wayne B. 2002. Policy, the Public, and Priorities in Alternative Medicine Research. *The Annals of the American Academy.* 583:29-43.

Kaptchuk, Ted J. and David M. Eisenberg. 2001. Varieties of Healing 2: A Taxonomy of Unconventional Healing Practices. *Annals of Internal Medicine.* 135:196-204.

Kelner, Merrijoy 2005. "The Status of CAM: Where are we now? How I became interested in CAM and how it changed my life." Keynote Speech for ACHRN Conference, University of Nottingham, June 29, Nottingham, England.

Kelner, Merrijoy, and Beverly Wellman. 1997a. Health Care and Consumer Choice: medical and alternative therapies. *Social Science & Medicine.* 45:203-12.

------. 1997b. Who Seeks Alternative Health Care? A profile of users of five modes of treatment. *The Journal of Alternative and Complementary Medicine* 3: 127-40.

------.2003. "Complementary and Alternative Medicine: How do We Know it Works?" *Healthcare Papers*. 3 (5):10-28.

Kelner, Merrijoy, Heather Boon, Beverly Wellman, and Sandra Welsh. 2002. Complementary and Alternative Groups Contemplate the Need for Effectiveness, Safety and Cost-effectiveness Research. *Complementary Therapies in Medicine.* 10 (4): 235-239.

Kelner, Merrijoy, Beverly Wellman, Heather Boon, and Sandra Welsh. 2004a. Responses of Established Healthcare to the Professionalization of Complementary and Alternative Medicine in Ontario. *Social Science and Medicine*. 59: 915-930.

------. 2004b. The Role of the State in the Social Inclusion of Complementary and Alternative Medicine. *Complementary Therapies in Medicine.* 12 (2-3):79-89.

------. 2006. "How far can complementary and alternative medicine go? The case of chiropractic and homeopathy." *Social Science & Medicine* 63(10):2617-2627.

Kitai, Eliezer, Shlomo Vinker, Abraham Sandiuk, Ofer Hornik, Charna Zeltcer, and Anat Gaver. 1998. Use of Complementary and Alternative Medicine Among Primary Care Patients. *Family Practice.* 15: 411-4.

Klassen, Pamela. 2005. Ritual Appropriation and Appropriate Ritual: Christian Healing and Adaptations of Asian Religions. *History and Anthropology.* 16 (3):377-391.

Kling, Rob. and Elihu Gerson. 1977. The Social Dynamics of Technical Innovation in the Computing World Symbolic Interaction. *Symbolic Interaction.* 1 (1):132-146.

------. 1978. "Patterns of Segmentation and Intersection in the Computing World" *Symbolic Interaction.* 1 (2):24-43.

Kolstad, A., T. Risberg, Y. Bremnes, T. Wilsgaard, H. Holte, O. Klepp, O. Mella, E. Wist. 2004. Use of Complementary and Alternative Therapies: a national multicentre study among health professionals in Norway. *Support Care Cancer.* 12 (5):312-318.

Larson, Magali S. 1977. *The Rise of Professionalism: a sociological analysis*. Berkley. University of California Press.

Law, John and Vicky Singleton. 2005. "Object Lessons." *Organization.* 12 (3):331-355. (www.csa.com).

Levin, Jeffey, and Coreil Jeannine. 1986. New Age Healing in the US. *Social Science and Medicine.* 23(9):889-897.

Light, David. 2000. The Medical Profession and Organization Change: From Professional Dominance to Countervailing Power. Pp. 201-16 in *Handbook of Medical Sociology*, edited by C. Bird, P. Conrad, A.M. Fremont. Upper Saddle River, N.J.:Prentice Hall.

Lock, Margaret. 1980. *East Asian Medicine in Urban Japan: Varieties of Medical Experience.* Berkeley: University of California Press.

Low, Jacqueline. 2004. *Using Alternative Therapies: a qualitative analysis.* Toronto: Canadian Scholars Press Inc.

------. 2005. "Avoiding the Other: a technique of stigma management among people who use alternative therapies." Pp. 273-285. in *Doing Ethnography: studying everyday life,* edited by Dorothy Pawluch, William Shaffir and Charlene Miall.Toronto: Canadian Scholars Press.

Lowenberg, June. S. 1989. *Caring and Responsibility: the crossroads between holistic practice and traditional medicine.* University of Pennsylvania Press, Philadelphia.

MacDonald, Keith. 1995. *The Sociology of the Professions.* London: Sage Publications.

MacLennan, Alastair H., D.H. Wilson, and Anne W. Taylor. 1996. Prevalence and Cost of Alternative Medicine in Australia. *Lancet.* 347:569-73.

MacNevin, Audrey. 2003. "Remaining Audible to the Self: Women and Holistic Health." *Atlantis.* 27 (2):16-23.

Maines, David. 1991. *Social Organization and Social Process: essays in honor of Anselm Strauss.* New York. Aldine De Gruyter.

Mansour, Ahlam, Gail Laing , Leis Anne, Judy Nurse and Alana Denilkewich 1998. The Experience of Reiki: Five Middle- Aged Women in the Midwest. *Alternative and Complementary Therapies.* 4(3):211-217.

Mansour, Ahlam A, Marion Beuche, Gail Laing, Anne Leis, and Judy Nurse. 1999. A Study to Test the Effectiveness of Placebo Reiki Standardization Procedures Developed for a Planned Reiki Efficacy Study. *Journal of Alternative and Complementary Medicine.* 5(2):153-64.

Marie, Jenny. 2008. "For Science, Love and Money: The Social Worlds of Poultry and Rabbit Breeding in Britain, 1900-1940." *Social Studies of Science* 38(6):919-936.

May, Tim. 2001. *Social Research: Issues, Methods, and Process.* Third Edition. Buchingham: Open University Press.

McClean, Stuart. 2005. The Illness Is Part of the Person': Discourses of Blame, Individual Responsibility and Individuation at a Centre for Spiritual Healing in the North of England. *Sociology of Health and Illness.* 27 (5):628-648.

McGuire, Meredith. 1983. Words of Power: Personal Empowerment and healing. *Culture Medicine and Psychiatry.* 7:221-240.

------. 1987. Ritual, Symbolism and Healing. *Social Compass.* 4:365-379.

------. 1988. *Ritual Healing in Suburban America.* London: Rutgers University Press.

Mead, George H. 1934. *Mind, Self, and Society.* Chicago: University of Chicago Press.

Melton, J. G. 2001. "Reiki: The International Spread of a New Age Healing Movement." Pp. 73-93 in *New Age Religion and Globalization,* edited by M. Rothstein Aarhus, Danimarca: Aarhus University Press.

Miall, Charlene E. and Andrew D Miall. 2002. "The Exxon Factor: The Roles of Corporate and Academic Science in the Emergence and Legitimation of a New Global Model of Sequence Stratigraphy." *The Sociological Quarterly.* 43(2):307-334.

Micozzi, Marc S. 2006. *Fundamentals of Complementary and Alternative Medicine Third Edition.* St. Louis: Saunders Elsevier.

Millar, Wayne J. 1997. Use of Alternative Health Care Practitioners by Canadians. *Canadian Journal of Public Health* 88:155–158.

------. 2001. "Patterns of Use- Alternative Health Care Practitioners." *Health Reports Statistics Canada.* 13 1:9-21.

Mills, Donald. L. 1966. *Study of Chiropractors, Osteopaths and Naturopaths in Canada.* Ottawa: Queen's Printer.

Minkler, Meredith. 1999. Personal Responsibility for Health? A Review of the Arguments and the Evidence at Century's End. *Health Education and Behaviour* 26:121-40.

Morse, Janice M. and Lyn Richards. 2002. *Read Me First for a User's Guide to Qualitative Methods.* Thousand Oaks: Sage Publications Ltd.

NCCAM (National Center for Complementary and Alternative Medicine). 2008. Reiki: an introduction. (http://nccam.nih.gov/health/reiki/)

Oerton, Sarah. 2004. "Bodywork Boundaries: Power, Politics and Professionalism in Therapeutic Massage." *Gender, Work and Organization* 11(5):544-565.

Olson, Karen, John Hanson, and Mary Michaud.2003. A Phase II Trial of Reiki for the Management of Pain in Advanced Cancer Patients. *Journal of Pain and Symptom Management.* 26(5):990-7.

Park, Jungwee 2005. "Use of Alternative Healthcare" *Health Reports*: 16 (2). Statistics Canada.

Parkin, Frank. 1979. *Marxism and Class Theory: A Bourgeois Critique.* London: Tavistock.

Patton, Michael Quinn. 2002. *Qualitative Research and Evaluative Methods 3rd Edition.* Thousand Oaks: Sage Publications.

Pawluch, Dorothy. 1983. Transitions in Pediatrics: A Segmental Analysis. *Social Problems.* 30 (4): 449- 465.

------. 1996. *The New Pediatrics: A Profession in Transition,* New York: Aldine de Gruyter.

Pawluch, Dorothy, Roy Cain, and James Gillett. 1994. Ideology and Alternative Therapy Use Among People Living with HIV /AIDS. *Health and Canadian Society*: 2(1) 1994: 63-83.

------. 2000. Lay Constructions of HIV and Complementary Therapy Use. *Social Science and Medicine*. 51:251–64.

Prus, Robert. (1996). *Symbolic Interaction and Ethnographic Research.* Albany: State University of New York Press.

Rubik, B., A. J. Brooks, and G. E. Swartz. 2006. In Vitro Effect of Reiki Treatment on Bacterial Cultures: role of experimental context and practitioner well-being. *Alternative and Complementary Medicine.* 12(1):7-13.

Saks, Mike. 2000. "Professionalization, Politics and CAM." Pp 223-238 in *Complementary and Alternative Medicine: challenge and change*, edited by M., Kelner, B. Wellman, B. Pescosolido, and M Saks. Amsterdam: Harwood Academic Publishers.

------. 2001. "Alternative Medicine and the Health Care Division of Labour: Present Trends and Future Prospects." *Current Sociology.* 49 (3):119–134.

------. 2003. *Orthodox and Alternative Medicine: Politics, Professionalization and Health Care.* New York: Continuum.

Sanders, Carrie. B. 2007. "Is anyone there?: collapse of information and communication technologies in the social worlds of police, fire and emergency medical services." Ph.D. dissertation, Department of Sociology, McMaster University.

Schneirov, Matthew and Jonathon Geczik. 2002. Alternative Health and the Challenges of Institutionalization. *Health.* 6 (2):201-220.

Schirokauer, Conrad. 1993. *A Brief History of Japanese Civilization.* Fort Worth: Harcourt Brace Jovanovich.

Shaffir, William B and Robert Stebbins. 1991. *Experiencing Fieldwork: an inside view of qualitative research.* Newbury Park: Sage Publications.

Shankar, Kamala, and Lucy P. Liao. 2004. Traditional Systems of Medicine. *Physical Medicine and Rehabilitation Clinics of North America* 15:725–747.

Sharma, Ursula. 1992. *Complementary Medicine Today: Practitioners and Patients.* London: Routledge.

------. 2000. "Medical Pluralism and the Future of CAM" Pp. 211-222 in *Complementary and Alternative Medicine: Challenge and Change.* Amsterdam, edited by, M. Kelner, B. Wellman, B Pescosolido, and M. Saks. The Netherlands: Harwood Academic.

Sharma, Ursula and Paula Black. 2001. Look Good, Feel Better: Beauty Therapy as Emotional Labour. *Sociology.*35 (4):913-931.

Shibutani, Tamotsu. 1978. "Reference Groups as Perspectives." Pp. 108-115 in *Symbolic Interaction: a reader in social psychology,* 3rd ed., edited by J.G Manis and B.N. Meltzer. Boston: Allyn and Bacon Inc.

Shiflett, S. C., S. Nayak, C. Bid, P. Miles, S. Agostinelli. 2002. The Effect of Reiki Treatment on Functional Recovery in Patients in Poststroke Rehabilitation: a pilot study. *The Journal of Alternative and Complementary Medicine.* 8(6):755-763.

Shuval, Judith 2006. "Nurses in Alternative Health Care: integrating medical paradigms." *Social Science & Medicine.* 63(7):1784-1795.

Siahpush, Mohammad. 1998. Postmodern Values, Dissatisfaction with Conventional Medicine and Popularity of Alternative Therapies. *Journal of Sociology.* 34(1): 58–70.

------. 1999. "A Critical Review of the Sociology of Alternative Medicine: research on users, practitioners, and the orthodoxy." *Health and Place.* 4 (2):159-178.

Sointu, Eeva. 2005. The Rise of an Ideal: tracing changing discourses of wellbeing. *The Sociological Review.* 255-274.

------. 2006a. Healing Bodies, Feeling Bodies: Embodiment and Alternative and Complementary Health Practices. *Social Theory and Health.* 4:203-220.

------. 2006b. Recognition and the Creation of Wellbeing. *Sociology.* 40(3): 493-510.

------. 2006c. The Search for Wellbeing in Alternative and Complementary Health Practices. *Sociology of Health and Illness.* 28: 330-349.

Star, Susan Leigh. 1997. 'Anselm Strauss: An Appreciation'. *Sociological Research Online.* 2 (1). (http://www.socresonline.org.uk/2/1/1.html)

Star, Susan Leigh and James Griesemer.1989. 'Institutional Ecology, Translations and Boundary Objects: Amateurs and Professionals in Berkeley's Museum of Vertebrate Zoology, 1907-39'. *Social Studies of Science.* 19:387-420.

Star, Susan Leigh and Strauss Anselm. 1999. Layers of Silence, Arenas of Voice: The Ecology of Visible and Invisible Work. *Computer Supported Cooperative Work.* 8:9-30.

Strauss, Anselm. L. 1978. A Social World Perspective. Pp. 119-128 in *Studies In Symbolic Interaction: An Annual Compilation of Research Vol.1*, edited by N. K. Denzin. Connecticut: JAI Press Inc.

------. 1982. Social Worlds And Legitimation Processes. Pp. 171-190. *Studies in Symbolic Interaction: a research annual volume 4*, edited by N. K. Denzin. Connecticut: JAI Press Inc.

------. 1984. Social Worlds and Their Segmentation Processes. Pp. 123-139 in *Studies in Symbolic Interaction: a research annual volume 5*, edited by N. K. Denzin. Connecticut: JAI Press Inc.

------. 1991. *Creating Sociological Awareness: Collective Images and Symbolic Representations.* New Brunswick: Transaction Publishers.

------. 1993. *Continual Permutations of Action.* Hawthorne, New York. Aldine de Gruyter.

------. 1997. Mirrors *and Masks: the search for identity*. New Brunswick, N.J.: Transaction Publishers. (original work published in 1959).

Strauss, Leonard Schatzman, Rue Bucher, Danuta Ehrlich, and Melvin Sabshin. 1964. *Psychiatric Ideologies and Institutions*. New York: Free Press.

Sung, Kyu-taik. 2002. "Filial Piety: The East Asian Ideal of Parent Care in Changing Times." *Southwest Journal on Aging*. 17 (1-2):23-29.

Tataryn, Douglas J. 2002. "Paradigms of Health and Disease: a framework for classifying and understanding alternative and complementary therapies". *The Journal of Alternative and Complementary Medicine*. 8(6): 877- 892.

Testerman, John K., Kelly R. Morton, Rachel A. Mason, and Ann M. Ronan. 2004. "Patient Motivations for Using Complementary and Alternative Medicine." *Complementary Health Practice Review*. 9 (2):81-92.

The Canadian Reiki Association. 2003. About Reiki FAQs: What is the Usui System of Natural Healing? Retrieved April 10, 2008. (http://www.reiki.ca/faqs.htm#2).

Thompson, Craig J. 2003. Natural Health Discourses and the Therapeutic Production of Consumer Resistance. *Sociological Quarterly*. 44(1):81-107.

Thomas, Kate J., J.P. Nicholl, and Pat Coleman 2001. Use and Expenditure on Complementary Medicine in England: a population based survey. *Complementary Therapies in Medicine*. 9: 2-11.

Timmermans, Stefan and Valerie Leiter. 2000. The Redemption of Thalidomide: standardizing the risk of birth defects. *Social Studies of Science*. 30(1):41-70.

Timmermans, Stefan and Marc. Berg. 2003. *The Gold Standard: the challenge of evidence based medicine and standardization in health care*. Philadelphia: Temple University Press.

Tindle, Hilary A., Roger B. Davis, Russell S. Phillips, David M. Eisenberg. 2005. Trends in the Use of Complementary and Alternative Medicine by US Adults: 1997-2002. *Alternative Therapies in Health and Medicine*. 11(1) 1-42.

Tovey, Philip and Jon Adams. 2001. Primary Care as Intersecting Social Worlds. *Social Science & Medicine*. 52: 695–706.

------. 2002. Towards a Sociology of CAM and Nursing. *Complementary Therapies in Nursing and Midwifery* 8 (1):12-16.

------.2003. Nostalgic and Nostophobic Referencing and the Authentication of Nurses' Use of Complementary Therapies. *Social Science and Medicine.* 56 (7):1469-1480.

Tovey, Philip, Gary Easthope, and Jon Adams. 2004. *Mainstreaming Complementary and Alternative Medicine: Studies in Social Context.* London: Routledge

Tsang, K.L., L. E. Carlson, and K. Olson. 2007. Pilot Crossover Trial of Reiki Versus Rest for Treating Cancer Related Fatigue. *Integrative Cancer Therapy.* 6(1): 25-35.

Turner, Bryan S. 1995. *Medical Power and Social Knowledge.* London: Sage.

Tuunainen, Juha. 2005. When Disciplinary Worlds Collide: The Organizational Ecology of Disciplines in a University Department. *Symbolic Interaction.* 28 (2): 205-228.

Unruh, David. R. 1979. Characteristics and Types of Participation in Social Worlds. *Symbolic Interaction.* 2: 115-129.

Unruh, David. R. 1980. The Nature of Social Worlds. *Pacific Sociological Review.* 23 (3):271-296.

------. 1981. "Social Worlds of Older Americans." Ph.D. dissertation, Department of Sociology, University of California.

Verhoef, Marja and Lloyd Sutherland. 1995. Alternative Medicine and General Practitioners: Opinions and Behaviour. *Canadian Family Physician.* 41: 1005-11.

Verhoef, Marja J., Heather Boon and Donatus R. Mutasingwa. 2006. The Scope of Naturopathic Medicine in Canada: an emerging profession. *Social Science and Medicine.* 63 (2):409-417.

Vincent, Charles and Adrian Furnham. 1996. "Why Do Patients Turn to Complementary Medicine? An empirical study." *British Journal of Clinical Psychology.* 35:37-48.

Voas, David and Steven Bruce. 2007. "The Spiritual Revolution: another false dawn for the sacred." Pp. 41-63. in A *Sociology of Spirituality.* Editors Kieran Flanagan and Peter Jupp. Hampshire, England: Ashgate Publishing Company.

Waldram, James B. 2008. "Aboriginal Healing in Canada: Studies in Therapeutic Meaning and Practice." *The Aboriginal Healing Foundation Research Series.*

Wardell, Diane and Joan Engebretson. 2001. Biological Correlates of Reiki Touch

Healing. *Journal of Advanced Nursing*, 33:439-445.

Wardell, D., D. H. Rintala, Z. Duan, and G. Tan.2006. A Pilot Study of Healing Touch and Progressive Relaxation for Chronic Neuropathic Pain in Persons With Spinal Cord Injury. Journal of Holistic Nursing. 24(4): 231-240.

Wardwell, Walter. 1994. Alternative Medicine in the United States. Social Science and Medicine. 38 (8):1061-1068.

Webb, Herschel. 1957. *An Introduction to Japan 2nd edition.* New York: Columbia University Press.

Wetzel, Wendy. 1989. Reiki Healing: A Physiological Perspective. *Journal of Holistic Nursing*. 7(1):47-54.

White, Margaret and Marja Verohef. 2006. Cancer as Part of the Journey: the role of spirituality in the decision to decline conventional prostate cancer treatment and to use complementary and alternative medicine. *Integrative Cancer Therapies.* 5 (2): 117-122

Wiener, Carolyn. 1981. *The Politics of Alcoholism.* New Brunswick, N J: Transaction.

Wiles, J., and M.W. Rosenberg. 2001. Gentle Caring Experience: seeking alternative health care in Canada. *Health & Place.* 7:209-24.

Winnick, Terri A. 2005. "From Quackery to "Complementary" Medicine: The American Medical Profession Confronts Alternative Therapies." *Social Problems.* 52(1):38-121.

Witz, Anne. 1992. *Professions and Patriachy.* London: Routledge

York, Michael. 1995. *The Emerging Network: a sociology of the New Age and Neo-Pagan movements.* Lanham, Maryland: Rowman and Littlefield Publication Inc.

Zollman, Catherine and Andrew Vickers. 1999. ABC of complementary medicine: users and practitioners of complementary medicine. *BMJ.* 319: 836-8.

APPENDIX A

Bibliography Primary Source Documents

Atlantic Usui Reiki Association. (AURA). 2007. What is Usui Reiki? Retrieved April 6 2008. (http://www.atlanticusuireiki.ca).

Brown, F. *Living Reiki: Takata's Teachings.* 1992. LifeRythm: Mendocino Ca.

Chrysostomou, A. and D. Mellowship. 2008. What Are The Different Forms Of Forms of Reiki? The Healing Company. (http://www.thehealingco.com/About%20Reiki%202.htm).

Ellis, R. 2002. *Reiki and the Seven Chrakas: your essential guide.* London: Vermilion.

Epperly B.G. and K.G Epperly. 2005. *Reiki Healing Touch and the Way of Jesus.* Kelowna: Northstone Publishing.

Gowland, D. 2010. The First Degree of the Official Programs of The Radiance Technique ® Authentic Reiki®. Retrieved March 10. 2010. (http://www.holisticmedicineorillia.com/1st_degree_on_yellow.pdf).

Hall, M. 2001. *Practical Reiki.* London: Harper Collins Publishers.

Lubec, W. F. A. Petter and W. Rand. 2006. *The Spirit of Reiki: the complete handbook of the reiki system.* Twin lakes Wi: Lotus Press.

Miles, P. 2006. *Reiki a Comprehensive Guide.* New York: The Penguin Group.

Mitchell, P.D. 1985. *The Usui System of Natural Healing.* revised edition for The Reiki Alliance. Coeur d'Alene: Idaho.

Mitchell, P.D. 1996. "The Usui System of Reiki Healing: a description of the modality/therapy." Reiki Alliance Website. Retrieved September 10, 2008. (http://www.reikialliance.com/engarticle.htm).

Petter, F.A.1998. The Future of Reiki in Japan. Retrieved April 7, 2008. (http://www.reikidharma.com/en/reiki/article/en_article_future.html).

Petter, F.A. 2007. *The Original Reiki Handbook of Dr. Mikao Usui.* Twin lakes Wi: LotusPress.

Petter F.A. 2003. *The Hayashi Reiki Manual.* Twin lakes Wi: Lotus Press.

Rivard. R. 2008. Threshold Reiki website. Retrieved September 10, 2008. (http://webpages.charter.net/lrsmith/dilemma.htm).

Rowland, A. Z. *Intuitive Reiki For Our Times: essential techniques for enhancing your practice.* Rochester, Vermont: Healing Arts Press.

Steine, B.and F. Steine. 2006. A-Z of Reiki Pocketbook: everything about Reiki. Winchester UK. O Books.

Steine, B., and F. Steine. 2005. *The Japanese Art of Reiki: a practical guide to self healing.* Winchester UK: O Books.

Steine, B. and F. Steine. 2003. *The Reiki Sourcebook.* Winchester UK. O Books.

Streich, M. 2007. "How Hawayo Takata Practiced and Taught Reiki." *Reiki News Magazine.* Spring 6 (1) pp 10-16.

Takata, H. 1985. The Usui System of Natural Healing: From Hawayo Takata's Early Diary. (Taken from the book "Reiki, a Memorial to Takata Sensei", compiled by Mrs. Alice Takata Furumoto, 1982). Edited by Mitchell P.D. 1985. Idaho: The Reiki Alliance.

The Canadian Reiki Association. 2008. What is the History of Usui Reiki? Retrieved April 10, 2008. (http://www.reiki.ca/faqs.htm#2).

The International Center for Reiki Training 2008. Retrieved April 7, 2008. (http://iarp.org/articles).

The Reiki Alliance. 2010. How to Become a Student. Retrieved April 7, 2008. (http://www.reikialliance.com/usui-shiki-ryoho/how-to-become-a-student)

Ray, B. W. 1983. The Reiki Factor. First Edition. New York: Exposition press.

Ray, B. W. 1995. Historical Perspectives on The Radiance Technique®, Authentic Reiki®, Real Reiki®, TRT®. Retrieved April 6, 2008. (http://www.trtia.org/histpers.html).

Reiki Center for the Healing Arts. 2008. Dr Mikao Usui. Retrieved April 1, 2008. (http://reikifranbrown.com/usui.htm).

Usui Shiki Ryoho. 2010. Spiritual Lineage. Retrieved November 10, 2009. (http://www.usuireiki-ogm.com/spiritual_lineage.html)

APPENDIX B

Reiki Branch Websites

Reiki Organizations/Associations

Atlantic Usui Reiki Association. (AURA)
http://www.atlanticusuireiki.ca

The Canadian Reiki Association (CRA)
http://www.reiki.ca/faq.htm

Reiki Alliance.
http://www.reikialliance.com/english.html

Reiki Australia.
http://www.reikiaustralia.com.au/Page/Consultation

The Australian Reiki Connection
http://www.australianreikiconnection.com.au/AboutReiki/?p=history

The Healing Space. Nova Scotia, Canada.
http://www.jikiden-reiki.ca/

The International Association of Reiki
http://www.wisechoices.com/intassocreiki.html

International Association of Reiki Professionals
http:/ www.iarp.org

The Radiance Technique International Association
http://www.trtia.org/index.html

The Reiki Alliance
http://www.reikialliance.com/eng_about.html

The Reiki Association. UK. 2008. Retrieved September 10, 2008.
http://www.reikiassociation.org.uk/5.html

The Reiki Threshold. Vancouver.
http://www.threshold.ca/reiki/home.html

UK Reiki Regulatory Working Group
http://www.reikiregulation.org.uk/

Usui Reiki Ryoho
http://www.usuireiki-ogm.com/what_is_reiki.html

Reiki Training Center Websites

The International Center for Reiki Training. William Rand. US
http://www.reiki.org/AboutICRT/AboutICRT.html

The John Harvey Gray Center For Reiki Healing. US.
http://learnreiki.org.

Reiki Center for the Healing Arts. Fran Brown. US.
http://reikifranbrown.com/bio.htm

The Center for Advanced Energy Therapeutics. Mega R. Mease. US.
http://www.reikiinfoline.com/

The Gainesville Center for Reiki Training. Terry Rogers. US.
http://www.angelfire.com/me/achello/center.html

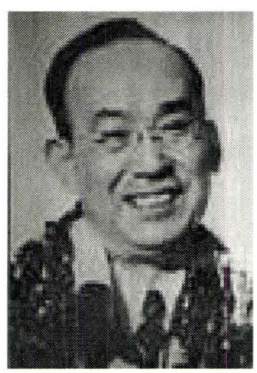
Southwestern Usui Reiki Ryoho Association. Founder Adonea. US.
http://www.angelfire.com/az/SpiritMatters/contents.html

International House of Reiki. Founders: Bronwen and Frans Steine. Australia.
http://www.reiki.

APPENDIX C

Key Historical Figures

Mikao Usui (1865-1926)



Dr. Chujiro Hayashi (1880-1940)

Hawayo Takata (1900-1980)

Image Sources:

Mikao Usui - http://www.google.ca/images?hl=en&source=imghp&q=Mikao+Usui&btnG=Search+Images
Chujiro Hayashi
http://www.google.ca/images?hl=en&gbv=2&tbs=isch%3A1&sa=1&q=C.+Hayashi+and+Reiki
Hawayo Takata
http://www.google.ca/images?hl=en&gbv=2&tbs=isch%3A1&sa=1&q=Hawayo+Takata+and+Reiki&btnG=Search&a

APPENDIX D
Acronyms

AURA- Atlantic Usui Reiki Association

CAM- Complementary and Alternative Medicine

CRA- Canadian Reiki Association

NCCAM- The National Center for Complementary and Alternative Medicine (US)

SW- social world

SSW- subsocial world

SWT – social worlds theory

Appendix E
Ethics Documents

Consent Semi-structured Interviews

A Study of Reiki: dimensions of lay practice

Principal Investigator: Yvonne LeBlanc PhD Student
Department of Sociology
McMaster University
Hamilton, Ontario, Canada
(905) 525-9140 Ext. 27414

Supervisor Ivy Lynn Bourgeault, Ph.D.
Associate Professor
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Canada Research Chair in Comparative Health Labour Policy
McMaster University
1280 Main Street West
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The purpose of this study is to gain a better understanding of Reiki practice.
Prior to the interview you will be asked to read and sign this consent form and to then fill out a short demographic questionnaire, with questions like your age and education. We are going to talk about things like how you define Reiki and Reiki practice, your experience of Reiki training, issues that are of concern to you as a lay practitioner, and your views on the future of Reiki practice. It is anticipated that the interview will probably take 1 ½ to 2 hours of your time. With your permission I would also like to audio-tape the meeting.
Please be aware that:

- You do not need to answer questions that make you uncomfortable or that you do not want to answer. Your participation in this interview is voluntary and you can decide to stop the interview at any time. If you decide to stop participating, there will be no consequences to you. Upon withdrawal information will be destroyed or used as per your request.
- There are no known harms associated with this study and this research will not benefit you directly. The study is a necessary step toward a better understanding of the multifaceted issues facing Reiki practice in Canada.
- There is no financial compensation for participation in this research.
- Your privacy will be respected. In describing this experience your true identity will not be revealed (pseudonyms will be used). Even though I will be taking precautions to safeguard your identity, there is a possibility (because of your contact with other Reiki practitioners) that published information might make you identifiable to other Reiki practitioners. The audio tapes, transcriptions, and any written notes will be safely stored in a locked cabinet during the course of the research and destroyed at the end of the study unless you indicate otherwise.
- You may obtain information about the results of the study by contacting me, the researcher. If you are interested in the findings, I will provide you with a copy once the research has been completed. Finally, please feel free to contact me at any time, now or in the future, if there are any questions and/or concerns.

If you have questions or require more information please contact Yvonne Le Blanc at
Home (905) 648-6233
Mc Master University Sociology Department 905 525-9140 Ext. 27414
e-mail: leblanyl@mcmaster.ca

This study has been reviewed and approved by the McMaster Research Ethics Board. If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact:

McMaster Research Ethics Board Secretariat
Telephone: (905) 525-9140 ext. 23142
c/o Office of Research Services
E-mail : ethicsoffice@mcmaster.ca

CONSENT

I have read the information presented in the information letter about a study being conducted by Yvonne LeBlanc of McMaster University. I have had the opportunity to ask questions about my involvement in this study, and to receive any additional details I wanted to know about the study. I understand that I may withdraw from the study at any time, if I choose to do so, and I agree to participate in this study. I have been given a copy of this form.

Name of Participant

In my opinion, the person who has signed above is agreeing to participate in this study voluntarily, and understands the nature of the study and the consequences of participation in it.

Signature of Researcher

Date _____

Invitation for Participant Observation

Principal Investigator: Yvonne LeBlanc PhD Student
Department of Sociology
McMaster University
Hamilton, Ontario, Canada
Office (905) 525-9140 Ext. 27414
e-mail:leblanyl@mcmaster.ca

Supervisor Ivy Lynn Bourgeault, Ph.D.
Associate Professor
Department of Sociology & Health, Aging and Society
Canada Research Chair in Comparative Health Labour Policy
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Hamilton Ontario, Canada L8S 4M4
Office Phone 905 525-9140 Ext. 23832
email: bourgea@mcmaster.ca

I am a registered nurse and a PhD student studying sociology at McMaster University. To complete the research requirements of my program I am doing a study on Reiki practice. My purpose is to gain a better appreciation of what Reiki and Reiki sharing mean to you and how you, as Reiki practitioners, learn and develop your skills. I have Level 1 Reiki training and if there are no objections from members of the group I will participate with you in Reiki sharing. I plan to attend these sessions on a regular basis for approximately four to five months.

With your permission, I will record and use the information gathered during these meetings in my thesis and in articles that I intend to submit for publication. This can be done (today /this evening) or at a later date, which ever you prefer. I also wish to assure you that none of the information collected about you during these meetings will be published without your prior written consent. You should also be aware that you are under no obligation to allow my participation and if my presence now or in the future makes you uncomfortable I will withdraw from the gatherings. You can tell me directly or tell the group leader. At that time any collected information will be dealt with as per your request.

While there are no known harms or benefits associated with this research, I anticipate that active participation in these sessions will result in a mutually beneficial exchange. I wish to assure you that I will take measures to ensure the privacy of the group. For example, in describing this experience your true identity will not be revealed (pseudonyms will be used) and any notes that I write about these meetings will be safely stored in a locked file cabinet and destroyed at the end of the project (or dealt with as per your request). As these are group sessions, I cannot absolutely ensure that what occurs during these gatherings remains confidential, as this depends on all members of the group. Even though I will be taking precautions to safeguard your identity, there is a possibility that published information might make you identifiable to other group members.

The research results will be available upon request. If you are interested in the findings, let me know and I will provide you with a copy once the research has been completed. Finally, please feel free to contact me at any time, now or in the future, if you have any questions and/or concerns.

You should also know that this study has been reviewed and approved by the McMaster Research Ethics Board. If you have concerns or questions about your rights as a participant or about the way the study is conducted, you may contact:

McMaster Research Ethics Board Secretariat
Telephone: (905) 525-9140 ext. 23142
c/o Office of Research Services
E-mail: ethicsoffice@mcmaster.ca

Yvonne LeBlanc will participate in Reiki Sharing Sessions
I give consent [ ] I do not give consent [ ]
Indicate
Date _____ Signature Host [ ] Participant [ ] _____

CONSENT TO PUBLISH FINDINGS

I have read the information presented in the information letter about a study being conducted by Yvonne LeBlanc of McMaster University. I have had the opportunity to ask questions about my involvement in this study, and to receive any additional details I wanted to know about the study.

I understand that the release of this information is voluntary and that I can withdraw my permission at any time prior to publication; without consequence. I also understand that should this occur, I can determine what will be done with any collected information.

I am aware that any written notes will be safely stored in a locked cabinet during the course of the research and destroyed at the end of the study unless otherwise indicated.

I understand that there are no know harms or benefits associated with this research and that there is no financial compensation for participation in this research.

I am aware that there is always the possibility that research participants will be able to guess the identities of individuals in written or oral presentations of the research.

I understand that unless I want to reveal my true identity, I will not be identified in any written work or presentations; pseudonyms will be used.

[ ] Reveal my true identity [ ] Do not reveal my true identity

I agree that Yvonne LeBlanc can use information she obtained while participating in Reiki sharing sessions as well as from informal conversations with me in her written research reports. I also agree to the publishing of these results.

Signature of Participant

In my opinion, the person who has signed above is agreeing to participate in this study voluntarily, and understands the nature of the study and the consequences of participation in it.

Signature of Researcher

Date _____

Letter to Reiki Sharing Participants

As a social science researcher, interested in complementary and alternative health practices, I wish to gain a better understanding of Reiki, interpretations of Reiki, how the practice is learned, and how practitioners develop their skills. If there are no objections from group members I will participate with you in your Reiki sharing sessions and to fulfill McMaster University PhD requirements I will record and use the information gathered during these meetings in my dissertation.

You are under no obligation to allow my participation and if my presence now or in the future makes you uncomfortable I will withdraw from the sessions. At that time any collected information will be dealt with as per your request. There are no known harms or benefits associated with this research and none of the information collected during these gatherings will be published without your prior written consent.

I wish to assure you that I will take measures to ensure the privacy of the group. For example in describing this experience your true identity will not be revealed (pseudonyms will be used) and any notes that I write about these meetings will be safely stored and destroyed at the end of the project. As these are group sessions, I cannot absolutely ensure that what occurs during these gatherings remains confidential, as this depends on all members of the group. Even though I will be taking precautions to safeguard your identity, there is a possibility that published information might make you identifiable to other group members.

Research results will be available upon request. If you are interested in the findings, let me know and I will provide you with a copy once the research has been completed. Finally, please feel free to contact me at any time, now or in the future, if you have any questions and/or concerns.

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Comparative Health Professions and Policy Research Office
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1280 main Street West
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PhD Advisor : Ivy Lynn Bourgeault, Ph.D.
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Canada Research Chair in Comparative Health Labour Policy
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Hamilton Ontario, Canada L8S 4M4
Office Phone 905 525-9140 Ext. 23832
e-mail: bourgea@mcmaster.ca

Date _____

Telephone Recruitment Scripts

Participant Observation

Phase 1:
My name is ...I am a registered nurse, and I have Level 1 Reiki certification. I am also completing a PhD in sociology at McMaster University. My research interests are in gender, health, and complementary and alternative health practices, and for my doctoral research I am doing a study on the Lay practice of Reiki. The purpose of my research is to gain a better understanding of what Reiki means, how it is learned, and how lay practitioners develop their skills. In order to accomplish this, over the next four to five months, I hope to actively participate in your Reiki sharing sessions. So, I am phoning to ask your permission to attend the gatherings that you host. Do you think that this is possible?

If no, "I realize that you are busy, thank you for taking the time to talk with me today, today."

If yes,
That's great.

I just want you to know that...
This research has been approved by the McMaster University Ethics Board and with your permission to join the group I will post a letter of information and consent form for you and the other members. This letter outlines my research goals, and describes things like, what I will do to ensure the privacy of the group, and what I intend to do with the information that I gather. I want to stress that no information will be published without an individual's written consent. The letter also points out that the members are under no obligation to allow my participation. If my presence, at any time, makes anyone uncomfortable I will withdraw from the sessions and any information that I have collected will be dealt with according to the members' wishes.

Before I attend any sessions *I will ask that you discuss what I hope to do with the group and to find out if they are ok with this. I'll drop off some copies of the information letter for members to read. If you are comfortable with their response then I will ask that you sign a consent form allowing me to conduct my research at your house/center.*

I just want you to know that at the first meeting I will introduce myself, talk about my research and answer any questions/concerns that anyone has. I will make it clear that if anyone (including you) wants me to leave at any time I will do so without any consequences to anyone. I will contact each individual to get written consent (or not) to use the observations that I have made of him/her during the sessions and will explain that this can occur at this time or at a later session and that the timing can be different for different individuals. Each time a new member joins the group I will take them aside and will explain all of this to them.

There is one last thing I want to pass by you. I hope that some of the practitioners attending this session will eventually be interested in participating in a one on one interview with me. If you have no objections, I will personally ask for volunteers if anyone is interested in being interviewed. I also hope that you will consider being interviewed as well.

Semi Structured interviews: My name is …I am a registered nurse, and have level 1 Reiki certification, I am also completing a PhD in sociology at McMaster University. My primary research interests are in gender, health, and complementary and alternative medicine and for my doctoral research I am examining the lay practice of Reiki. The purpose of the study is to gain a better understanding of Reiki practice. I am interested in exploring how you decided to become a practitioner, the details of your training, Reiki issues and activities that are of interest to you, and your views on the future of Reiki practice. To explore these things, I would like to conduct an in person interview with you at a mutually convenient time and place.

I anticipate that the interview will probably take 1 to 2 hours of your time and with your permission I will audiotape our meeting.
Therefore, I am wondering if you might consider participating in this research…
If no, thank you for your time, today.
If yes,
I will send you a letter that explains the study as well as a demographic questionnaire and a list of the kinds of questions that I would like to ask you about. I'll give you some time to think about this and if it is ok with you I will phone you on…

I just want you to know that…
This research has been approved by the McMaster University Ethics Board and just before the interview I will ask you to fill out a short demographic questionnaire. This will take less than five minutes, and then I will ask you to read and sign a written consent form. This outlines the purpose of this study and highlights the measures that I will take to ensure group privacy. The consent also emphasizes that your participation is strictly volunteer and that you can withdraw from the interview art any time without penalty, and that any collected information will be dealt with as per your request.
Would you like me to read the consent form to you now?
Do you have any other questions?
Can set up an appointment then…

Interview Guide

SECTION 1: Becoming a Reiki practitioner: Personal Identity/Transformations

Definitions and interpretations
Reiki/ Lineage

1. What is Reiki?
2. If there was one word to describe Reiki practice, what it is that you do, what would it be?
3. What makes it unique?
4. How is Reiki important in your life?
5. Can you tell me about your Reiki lineage? How does this lineage differ from the others? How committed are you to this particular lineage?
6. Can you define what you do? Is there a term that best describes this?

Related concepts
Probes

- How would you define spirituality?
- How would you describe your spiritual commitment?
- How would you define well-being?
- How would you define health?

Life Trajectory
1. Can you tell me about how you got involved in Reiki?
Probes:

- Can you describe the events that led up to you seeking out Reiki?
- What if anything to did know about Reiki Training?
- Tell me about how you were introduced to Reiki
- What was going on your life at the time?
- What was that first experience like?
- Who is anyone influenced your decision to become a practitioner?
- Tell me about how he or she influenced you....

Reiki commitment to training
Student-Teacher Interpersonal Relationship

1. How did you find your teacher?
2. Can you describe your first meeting with your teacher was like?
3. Can you describe your relationship with your teacher?
4. How has this changed

Level 1 Training

1. Can you tell me in detail about your level 1 experience?

Level 11 Training

1. Can you tell me about your decision to take level 2 training
2. Can you describe for me in detail your level to experience? How was this experience different from your level 1 experience?

Level 111 Training

3. Can you tell me about your decision to take level 3 training

4. Can you describe for me in detail your level to experience? How was this experience different from your level 2 experience?

Probes:

- Can you tell me about your thoughts and feelings during the days of the training?
- Can you describe the attunement for me
- Can you describe to me how you felt before and after the sessions... what happened in between
- What positive changes occurred in your life?
- What negative changes occurred in your life?
- Can you tell me about the kind of support that you received?
- Can you describe any lack of support during that time?
- Can you tell me about any relationship changes that occurred during this time/ afterward
- As you look back on it now are there any other events that standout in your mind?
- Can you describe the most important lessons you learned during this time?

Do you have any concerns about being a Reiki practitioner?

Closing

1. How have you grown as a person since taking level...?
2. Is there anything I should think I should know to understand your experience with Reiki better?
3. Is there anything else you would like to add?
4. Is there anything you'd like to ask me?

* Some questions borrowed from Charmaz (2006: 30-31).

SECTION 11: Reiki Practice

A) Reiki Practice: Occupational/Personal Development

Definitions and interpretations:

2. What is a Reiki Circle or sharing session?
3. What do you prefer to call these meetings? Why?

Skill Enhancement Activities:

1. Can you tell me in detail about your personal practice of Reiki?

Probes

- Can you tell me what practicing Reiki means to you?
- How often do you to Reiki on yourself? For how long?
- Can you describe in detail what is involved in your self treatment routine?
- Do you find it difficult to devote time for this?
- Can you tell me about the personal rewards?
- Can you tell me about the challenges involved
- Is your family supportive of this practice? Is there anyone who isn't supportive? Can you tell me more about that?

2. How do you think this enhances your skills as a Reiki practitioner?

Probes

- How important is your personal routine to developing your skills? Can you describe the ways
- How important is your personal routine to being an effective practitioner? Can you tell me more about this?

3. Can you tell me in detail about your involvement in Reiki sharing sessions?

Probes

- How did you get involved? How did you decide which group to attend? Do you go to more than one group? How long it attending these sessions?

- Can you tell me more about your involvement in the group?
- How important is the group to you personally?
- In what ways has your participation in this group helped you in your practice?
- In what ways has your participation in this group impacted on your daily life?
- Has this participation been a hindrance to you in any way?
- How have you grown as a person by being involved in this group?
- Have you encountered any difficulties because of your participation in the group? Within the group? Outside of the group?

4. Are there any other activities like conferences, workshops that you have been involved in? Can you tell me about these?

Support
1. Can you tell me about the ways in which I feel supported by this group? Are there any ways in which you don't feel supported? Can you tell me more about that?

Net-working
1. How do you stay in touch with people? How important is it to do so?
Probes
- How do you get your information about Reiki?
- Do you belong to any other any other kinds of groups; blogs; Chat rooms? Can you tell me more

B) Reiki Practice: Occupation Advancement
1. Can you tell me about any further Reiki related activities that you are involved in like associations or organizations, that sort of thing?

Probes
- Can you tell me about the organization?
- How long have you been a member?
- How often do you meet and
- Where do you generally meet?
- How are you involved? How much time to devote to associated activities?
- How is being a member of the organization an advantage to you:
  a) personally
  b) in your practice
- Are there any disadvantages?

2. What are your immediate goals?
- What you hope to accomplish?
- In what ways will you go about accomplishing these?
- Are you involved in any committees for conferences, workshops? Can you tell more?

3. What are your future goals?
- Where do you see yourself in terms of your Reiki practice in five years from now?

4. Where do you see your Reiki practice headed?
Definitions
What is a lay practitioner?
What is a Reiki Professional?
- Can you define what a Reiki professional is?
- Do you consider yourself to be a Reiki professional?

- Is a Reiki professional different from a healthcare professional, please explain…

Regulation and licensing:

- How do you feel about the regulation and licensing of your practice?
- What you think are the major obstacles related to this?
- How interested are you in having Reiki become part of the public health care system?
- You think you have place in the system? What would that look like?
- What role do you think the government should play in this?
- How do you think other groups [i.e. medical community] are encouraging/discouraging the practice of Reiki?

Closing Interview:

1. Is there anything else you would like to add?
2. Is there anything further that you would like to ask me?

APPENDIX F
Demographic Questionnaire

1. Please specify place of residence
[ ] Nova Scotia [ ]New Brunswick [ ] Ontario

2. Please check the age bracket that applies
(*must be 19 yrs of age or older)
[ ] 20 or under [ ] 21-30 [ ] 31-40 [ ] 41-50 [ ] 51-60 [ ] 61-70 [ ] 71-80 [ ] 81 or over

3. Gender
[ ] M [ ] F

4. What is your highest level of education (*Check highest level completed.*)
[ ] Elementary school [ ] Some high school [ ] High school diploma
[ ] Technical/Community College [ ] Some university [ ] University degree
[ ] Post graduate training

5. What was your combined family income from all sources last year?
[ ] Below $20,000 [ ] $21,000 to $40,000 [ ] $41,000 to $60,000
[ ] $61,000 to 80,000 [ ] Above $81,000

6. What is your religion, if any? [religion types borrowed from Canadian census data Hamilton, Ontario 2001)
[ ] Roman Catholic [ ] Ukrainian Catholic [ ] United [ ] Anglican [ ] Baptist
[ ] Lutheran [ ] Muslim [ ] Pentecostal [ ] Christian reformed church [ ] Jewish
[ ] Buddhist [ ] Hindu [ ] Sikh [ ] Orthodox – Greek [ ] Orthodox – Ukrainian
[ ] Orthodox – Serbian [ ] Mennonite [ ] Jehovah Witness [ ] Mormon- Latter Day Saint [ ] Salvation Army
[ ] Methodist [ ] Adventist [ ] Aboriginal Spirituality
[ ] New Age [ ] Pagan [ ] Atheist/Agnostic [ ] No religion
[ ] Other (specify) _____

7. I consider myself to be _____ religious:
[ ] very [ ] moderately [ ] somewhat [ ] not at all

8. I consider myself to be _____ spiritual:
[ ] very [ ] moderately [ ] somewhat [ ] not at all

9. To which cultural or ethnic group do you feel you belong?
[ ] Aboriginal [ ] African [ ] American
[ ] British (English, Irish, Scottish or Welsh)
[ ] Canadian (other multiple origins such as Canadian Scottish)
[ ] Eastern European (Polish, Ukrainian, Czechoslovakian, Hungarian etc.)
[ ] Scandinavian (Norwegian, Swedish, Finnish, Danish, Icelandic)
[ ] French (includes Quebecois) [ ] Greek [ ] Italian [ ] Jewish
[ ] Middle East [ ] Oriental (Chinese, Japanese, Vietnamese, Filipino etc.)
[ ] Other European (German, Swiss, Austrian, Belgian, Dutch, Spanish)
[ ] Pakistani or East Indian [ ] Portuguese [ ] West Indian (Caribbean) [ ] Other _____

10. What is your Reiki employment status?
[ ] Working full time for pay [ ] Working part-time for pay

[ ] Working as volunteer
Specify hours per week devoted to volunteering as Reiki practitioner _____

11.
Employment other than Reiki practice: (*Check only one*)
[ ] Working full time [ ] Working part-time (includes seasonal work)
[ ] Going to school and not working [ ] A homemaker (not paid)
[ ] Unemployed [ ] Laid off [ ] Retired [ ] Self-employed
[ ] Unable to work because you are disabled

12. I have been a Reiki practitioner for
[ ] 6 months or less [ ] between 7 and 12 months [ ] between 13 months and 18 months [ ] between 19 and 24 months [ ] greater than 2 years but less than five years [ ] 5 years or longer (specify number of years) _____

13. Please specify Reiki style (lineage)

_____

14. Acquired Reiki level
[ ] Level 1 [ ] Level 2 [ ] Level 3 [ ] Level 4

15. Cost of Training: Please Specify *(If applicable)*
Level one _____ Level 2 _____ Level 3 _____ Level 4 _____

16. I belong to a Reiki Association/Organization
[ ] yes [ ] no
if yes
State name(s)

_____ _____ _____

I am a:
[ ] member [ ] on executive
[ ] on committee(s) specify _____

17. Time devoted to Reiki Association/organization activities per week
[ ] 2 hrs or less [ ] 3-5 hrs [ ] 6-8 hrs [ ] greater than 8 hrs
If greater than 8 hrs (specify) _____

Demographic Tables

Table 3.1a Participant Profiles

Region n=50
NS 21
NB 4
ON 25

Sex n=50
Females 32
Males 18

Age n=50
21-30 yrs 1
31-40 yrs 12
41-50 yrs 6
51-60 yrs 15
61-70 yrs 12
71-80 yrs 3
81+ yrs 1

Ethnicity n=50
Canadian
(Mix of Irish, French, Italian,
British, Scottish, Welsh Heritage) 39
Western European (Germany, Austria) 6
British 4
Pakistan/East Indian 1

Gross Annual Family Income n=36
$20,000 or less 2
$21,000 to $40,000 10
$41,000 to 60,000 14
$61,000 to $80,000 3
Greater than $81,000 7

Highest Level of Education n=50
Some High School 3
High School 6
Community College 12
Nursing Diploma 1
Some University 4
University Degree 10
Some Post Graduate Education 2
Postgraduate Degree 12

Table 3.1b Participant Profiles

Form/Style of Reiki Practice n=50
Usui Independent 29
Usui Shiki Ryoho 10
Gendai 2
Usui Tibetan 3

Trained in Combination of Reiki Styles n=6
Usui Tibetan, Usui Reiki Ryoho, Jikiden=1
Usui Tibetan, Karuna, Seichim=1
Usui Shiki Ryoho, Komyo=1
Reiki, Seichiem, Golden Dragon=1
Usui Tibetan/Radiance=2

Reiki Training Costs

1st Degree or Level 1 Training n=46
Range $35 to $390; Average $134; median $137.5
$50 or less 2
$51 to $100 12
$101 to $150 26
$151 to $200 3
$201 to $250 1
$251 to $300 1
$301 or above 1

2nd Degree or Level 2 Training n=43
Range $65 to $500; Average $270; median 250
$100 or less 4
$101 to $200 13
$201 to $300 14
$301 to $400 3
$401 to $500 9

Advanced Reiki Training n=33
Range $100 to $14,500; Average $1233; Median $650
$1000 or less 24
$1000 to $1099 3
$10,000 to $10,999 5
$ 11,000 or more 1
* Cost in Canadian $

Table 3.1c Participant Profiles

Non-Reiki Employment Status n=45
Working full time 16
Working part time 12
Self Employed 2
Full time Student 1
Laid off 1
Long Term Disability 1
Homemaker 1
Retired 11

Non-Reiki Occupations of Participants
Massage Therapy
Social Work
Counseling
Occupational Therapy
Family Medicine
Clinical Psychology
Hospital Communications Officer
Nursing (RN)
Vision Care
Dental Hygiene
Child and Youth Worker
Child Care
Homemaking
Education: elementary school, high school; art education, music education
Accounting
Retail
Real Estate
Farming
Engineering: construction, environmental
University Instructor: computer science
University Professor: engineering

Reiki Employment Status n=50
Work full time for pay 4
Work part time for pay 27
Mainly work as a Volunteer 4
Mainly treat family and friends 15

Reiki Years of Practice n=49
Less than 5 years 13
5 to 9 years 20
10 to 14 years 6
Fifteen years and over 10

Reiki Highest Level of Training n=50
1st degree/ Level 1 practitioners 2
2nd degree/Level 2 practitioners 13
3rd degree/ Level 3 and above 35

*Non -Reiki occupations revealed by participants during interviews