Introduction

From ancient times, healers around the world have laid hands on others to ease their suffering. They generally attribute healings to manipulating an (ordinarily) invisible force in or around the patient’s body that causes misfortune, whether by removing an impure presence, balancing some disharmony, transferring vital power to rectify a deficiency, or calling on some non-human entity to perform such work through them. Modern practitioners often cite cross-cultural beliefs in an ineffable force that asymmetrically pervades existence, governs health, and empowers certain individuals to heal themselves and others, such as pneuma (Greek), prāṇa (Sanskrit), qi (Chinese), and mana (Polynesian). Contemporary healers increasingly refer to this force as a form of ‘energy’ and its healing applications as ‘energy medicine,’ drawing on scientific and medical authority while also setting themselves apart from physicians who work merely on the gross matter of physical bodies.

Energy medicine is a floating signifier in twenty-first-century complementary and alternative medicine (CAM). It is applied to a wide variety of therapies, from the use of magnets or magnetic fields to treat maladies or promote immunity (Eden and Feinstein 1998: 298–316; Mason 2004), to ‘Energy Psychiatry,’ a California psychiatrist’s ‘prescriptions’ to cultivate ‘positive energy’ in one’s life including finding ‘a nurturing spiritual practice’ (Orloff 2004), or to ‘the shaman’s path’ of working with spirit guides (King 2011). Practitioners of older healing traditions, including curanderismo and Kardecist spiritual healing in Latin America, have taken up the language of energy (Hendrickson this volume, Schmidt this volume), as have medical researchers of ‘biofield physiology’ (Hammerschlag et al. 2015). This chapter cannot address all the varied therapies that engage in energy medicine discourse. Rather, it focuses on three similar therapies practised around the world, including in both religious and medical institutions, often framed as paradigmatic forms of energy healing: Reiki, Therapeutic Touch, and Healing Touch.¹

These contemporary practices bear resemblances to earlier forms of religious healing through the laying-on-of-hands (or holding hands just above the recipient’s body), application of breath, visualization, and empowerment of objects. These resemblances include beliefs that: 1) some force pervades existence, particularly living things; 2) the proper circulation or distribution of this force regulates health, so disease results from its stagnation, deficiency,
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and/or imbalance; 3) through natural aptitude, initiation, and/or practice, humans can perceive this force and channel it to promote healing in themselves and others (sometimes described as stimulating the body’s natural ability to heal itself); and 4) while anyone can heal with this force, one’s abilities improve with self-mastery, that is, moral/spiritual development.

Modern energy healing systems, including those under consideration in this chapter, tend to hold three additional assertions: 5) since ancient days, spiritual adepts have used this force to heal, which is known by various cultures under various names; 6) although this force may not be directly detectable by present-day scientific instruments, it follows scientific principles, and will soon be technologically measurable; and 7) this healing is ‘spiritual but not religious’ and thus is appropriate for practice by individuals of any (or no) religious background in religious or secular spaces from churches to hospitals.³

Contemporary popularity

Reliable statistics are difficult if not impossible to obtain, as much energy healing takes place in informal settings, but it seems that millions of people have participated in modern forms of energy healing in sites around the globe in the last few decades. A landmark study in the US estimated that almost forty million Americans received ‘energy healing’ in 1997, an increase of about three times from 1990; however, its criteria included magnetic therapies, identified as the most common form of this therapy, followed by Therapeutic Touch and Reiki (Eisenberg et al. 1998: 1571–1572). More recent research by the US National Institutes of Health suggests over one million Americans annually received ‘energy healing therapy’—defined as ‘a technique that involves channelling healing energy through the hands of a practitioner into the client’s body’—between 2002 and 2012 (Clarke et al. 2015: 10).

Studies in Europe, Japan, and India around the turn of the twenty-first century suggest that energy healing has become popular in these sites alongside rising belief in ‘spiritual energy’ and self-identification as ‘spiritual but not religious,’ phenomena associated with the New Age movement that have spread along with other aspects of New Age culture (Pew Research Center 2009, 2018a, 2018b; Haga and Kisala 1995; Horie 2009; Stein 2012b). In most of these locales (except a few outliers like the UK), these beliefs are most widely held among the youngest demographics, so these numbers are likely to increase in decades to come.

Reiki appears to be far-and-away the most common form of energy healing in the early twenty-first century, with significant numbers of practitioners throughout the Americas, Europe, the former Soviet Union, and India, and instructors (called Reiki Masters) in nearly every country. Most Reiki practitioners receive training outside of any institution, making it impossible to know how many worldwide have received the initiations that authorize practice, but estimates by practitioners and scholars range in the millions.³ These estimates cannot be verified, but worldwide interest in Reiki is supported by a substantial, multilingual internet presence: an April 2020 Google search for ‘Reiki’ yielded over ninety million hits, the Cyrillic ‘Рэйки’ yielded nearly twenty million hits, and the Japanese katakana ‘レイキ’ yielded over five million more. More support for Reiki’s global popularity comes from a 2012 study by Chile’s Ministry of Health that found that roughly 10 per cent of urban Chileans have received Reiki, suggesting well over 500,000 people in Chile have experienced Reiki or similar practices (Subsecretaría de Salud Pública 2012).

Therapeutic Touch (TT) and Healing Touch (HT) have significant presences in US hospitals and have been the subject of many clinical trials, but, compared to Reiki, they are practised by far fewer people in a much narrower geographic distribution. The Therapeutic Touch
International Association lists chapters in twelve countries outside the US, but several of those chapters appear to only have one member; 90 per cent of the practitioners in their directory are based in the US, with the remainder split between Canada, Europe, and Australia. Similarly, HT is apparently taught on five continents (Eschiti 2007: 10), but over 90 per cent of the HT practitioners registered in a ‘worldwide directory’ were located in the US or Canada, and nearly all of the ‘worldwide’ chapters listed by the Healing Touch Professional Association are in the US.

**Gender**

Practitioners and recipients of energy healing tend to be female. While this tends to be true for CAM usage in general (Bishop and Lewith 2008), discrepancies between male and female use seem to be even more dramatic in the world of energy healing. While surveys in the US and England found that adult women were roughly 30–40 per cent more likely to use CAM than adult men (Barnes et al. 2004, 2008; Thomas et al. 2001), my ethnographic work suggests that roughly two to three times more women than men use energy healing.

Why is this? When I have asked practitioners, I am often told that women’s inherent nature (or, less frequently, their socialization) as sensitive nurturers tends to make them more ‘receptive’ to the healing energy and more capable healers. A common etic explanation for women’s disproportionate involvement in alternative medicine and spirituality is that they have relatively more opportunities in those fields than in orthodox medical and religious organizations, where women often face systematic barriers, particularly from leadership roles. Sointu and Woodhead (2008: 268–269) offer a third explanation: that ‘holistic spiritualities’ like energy healing therapies validate the work of relational care, emotional care, and bodily care that have historically been designated ‘feminine forms of identity and labor,’ while also emphasizing ‘the cultivation of [a woman’s] bodily well-being for the benefit of the woman herself.’ As such, they argue, such spiritualities may disproportionately attract women as they both legitimate and subvert traditional discourses of femininity.

**Settings**

Energy healing is performed in both public and private settings, but most relevant for this chapter are sites clearly demarcated as religious, medical, or both (such as Catholic hospitals). Religious and medical sites have been important venues for modern energy healing therapies from their inception, both as means to gain access to new practitioners and clients and as means to establishing the authority of these practices, which potential clients, students, or gatekeepers might consider unorthodox or suspect. Reiki has long found homes in religious settings, from Japanese American Buddhist temples in 1930s Hawaii, to metaphysical Christian churches in 1970s American suburbs, to mainline Protestant churches in early twenty-first century North America (Klassen 2005; Stein 2017). It was also practised in clinical settings in Japan in the 1930s and in American hospitals possibly as early as the 1950s (Stein 2017); today it is practised in hospitals and palliative care centres across the Americas and in Europe. TT and HT were both designed in the late-twentieth-century US by nurse educators for clinical use and since that time have been practised in hospitals, predominantly in the US, but with some representation in Australia and Europe. Moreover, as described in more detail later, HT has also become adopted in some US mainline Protestant churches.
Historical development

For millennia, healers from various cultures have used their hands, gaze, breath, and visualization to convey restorative powers to the bodies of the infirm or to charge physical objects for the sick to ingest or wear on their person. These purported powers were often associated with the spiritual or divine world. In the second half of the seventeenth century, English natural philosophers began referring to these forces as ‘energies,’ (derived from Aristotle’s *energeia*, which denotes the actualization of a thing’s potential), which included both natural forces, such as magnetism, and spiritual forces emitted by God and human souls; the latter were considered capable of violating natural law to animate living things and to heal their bodies (Glanvill 1665: 156–157, 176–184; Hale 1677: 30, 293, 345; OED Online 2018). In the early eighteenth century, Isaac Newton, Richard Mead, and George Berkeley further developed the idea of ‘occult action’ (i.e. the ability to exert influence over a distance) by positing a rarefied substance called ‘the aether’ that permeates all space; in the latter half of that century, aetheric theory influenced Benjamin Franklin’s ideas about electricity and, more importantly for the field of energy healing, Franz Anton Mesmer’s animal magnetism (Airaksinen 2010; Leventhal 1976: 182; Pattie 1956).

Mesmer (1734–1815) was a Viennese physician who, in the 1770s, began treating patients with practices that he said manipulated a subtle fluid in their bodies called animal magnetism. Even distributions of this fluid guaranteed health, whereas deficiencies in any bodily organ produced disease. Thus, Mesmer reasoned, ‘there is only one illness and one healing’ (Fuller 1982: 1). Today, Mesmerism is associated with hypnotism, but nineteenth-century practitioners distinguished between two main forms of therapeutic Mesmerism: somnambulism, the origin of modern hypnotherapy, and magnetic healing, the forerunner of modern energy healing. Through ‘magnetic passes,’ Mesmer and his followers—so-called magnetists—ran their hands over patients’ bodies to transfer magnetic fluid to them or ‘harmonize’ their magnetic currents (Crabtree 1993: 14).

In the 1830s, Mesmerism (in both its somnambulistic and magnetic forms) came to New England and quickly spread to other parts of the US, where it influenced the development of many new spiritual healing practices. American health reformers and spiritual reformers (often the same individuals) began using terms like nerve energy, nerve force, vital electricity, and vital magnetism to discuss the physical effects of moral and immoral behaviour, combining vitalist and Christian rhetoric to argue for temperance, chastity, frugality, and ‘naturalness.’ This unification of popular health practices and religious beliefs in the terms of divine vitalism influenced the development of chiropractic, diet therapies (especially vegetarianism), hydrotherapy, and osteopathy, as well as Adventism, Christian Science, New Thought, and Spiritualism (Albanese 1990: 106–128, 141–142; Albanese 2007: 285–303; Folk 2017: 60; Numbers 1992: 154–156). Around the turn of the twentieth century, Theosophists combined aspects of American ‘metaphysical religion’ with Tantric visions of occult energies and the developing sciences of radio, X-rays, and radiation, producing vitalistic anatomies of ‘subtle bodies,’ ‘chakras,’ and ‘rays’; these Theosophical vocabularies, in turn, provided the foundation for influential energy healers of the 1980s New Age, like Barbara Brennan and Rosalyn Bruyere (Albanese 2007: 343, 453–465; Leland 2016). Since the early twentieth century, metaphysical healing practices developed in the US with transnational influences from Europe and Asia have themselves circulated transnationally to sites including Iran, Japan, and India, taking on new meanings and techniques in dialogue with local religions, including Islam, Hinduism, Buddhism, and shamanism (Doostdar 2018; Gaitanidis 2012; Green 2015). Yet, while untold numbers around the globe have studied the methods of varied healers, through enrolling in
workshops and reading their books, the energy healing practices that have made the greatest inroads into biomedical hospitals and medical research journals are the three under consideration in this chapter: Reiki, TT, and HT.7

Reiki

There are various styles of Reiki, most of which developed since the 1980s, but in their common basic practice, practitioners (authorized by a series of initiations from a ‘Reiki Master’) gently place their hands on themselves or on another (or, increasingly, just above the recipient’s body) in one or (more typically) a series of positions. This basic practice is thought to channel a ‘universal life force energy,’ also called reiki, from the cosmos; regular treatments are said to benefit both the practitioner and the recipient on physical, mental/emotional, and spiritual levels, and to help the practitioner become a better channel for the energy. Advanced students are taught sacred ‘symbols’ (mostly adapted from Sanskrit and Chinese characters) to strengthen their treatments, treat mental distress or bad habits (such as smoking, overeating, or alcoholism), and to perform ‘distance treatments’; these symbols, which the practitioner traces with a hand or visualizes, are not to be taught to the uninitiated and derive from earlier religio-magical practices (Stein 2017: 93–94).

Reiki is often described as a millennia-old practice with origins in ancient India or Tibet, but its specific forms were first codified by a Japanese polymath named Mikao Usui (1865–1926) in the 1920s.8 Japan at that time was awash in healing practices influenced by American Mesmerism, and Usui created his system by combining elements of Japanese religious practice derived from esoteric Buddhism (mikkyō)—including the empowerment rituals of kanjō (Skt., abhisekha) and kaji (Skt., adhisthāna)—with elements of localized forms of American healing practices. These latter influences included Japanese therapies developed in the 1910s and 1920s that were inspired by Christian Science—which taught that physical illness results from mental error—and the Pranic Healing of Yogi Ramacharaka (né William Walker Atkinson, 1862–1932)—a prolific author whose ‘ancient’ Hindu yogic practices repackaged elements of Mesmerism, New Thought, and physical culture (Deslippe 2011; Hirano 2015: 78–82; Stein 2017: 89–95).

It is difficult to know exactly how Usui Reiki Therapy (Usui Reiki Ryōhō) was taught in pre-war Japan since a code of direct transmission from master to disciple prohibited many of its teachings from being printed in detail. However, it seems to have resembled other contemporaneous Japanese therapies that taught practitioners to channel reiki (‘wonderful ki’) with their hands, gaze, breath, and visualization in order to heal themselves and others (Stein 2019: 84–89). Usui also taught his students to recite the poetry of the Meiji Emperor and ‘five precepts’ (gokai: just for today, do not anger, do not worry, be grateful, fulfil your duties, be kind to people); these recitations were thought to help ‘correct’ the practitioner’s heart-mind (kokoro), which, in turn, would help improve one’s practice. Like martial arts and other Japanese arts, teachers of Usui Reiki Therapy supervised students’ progress through practice at training centres (dōjō) and recognized their progress through a series of ranks. At each meeting, teachers performed a ceremony called reiju (‘wonderful bestowal’), which, along with practice and their embodiment of the spiritual inspiration of Usui and the Meiji Emperor, would help students’ ability to channel reiki (Stein 2017: 90–97).

By the 1930s, the reiju ceremony had been adapted into an initiation, likely by Usui’s disciple Chūjirō Hayashi (1880–1940), a retired naval captain made famous through his own disciple, the Hawaii-born Japanese American named Hawayo Takata (1900–1980). One of Hayashi’s students from the 1930s suggested that Hayashi had developed a five-day intensive
training course with daily reiju for students who lived in outlying regions without local instructors in order to accelerate their advancement through to the intermediate rank (Yamaguchi 2007: 27–30), but Takata’s diary and certificates suggest she also underwent one of these intensive classes at Hayashi’s headquarters in Tokyo in 1935 (Stein 2017: 106–107). Takata recalled to her students that, in this class, Hayashi likened reiki to radio waves; she likened the initiation to the teacher’s adjustment of the student’s antenna to get clear reception (Fueston 2017: 82–83). Subsequent generations of Reiki students explain this in terms of tuning the student’s ‘subtle bodies to a higher vibratory level, aligning them more strongly with [the] universal life force,’ releasing ‘negative thoughts and old conditioned behaviors of a lower vibration’ (Barnett et al. 1996: 30), a language of ‘higher’ and ‘lower’ frequencies that seems influenced by Theosophical teachings via New Age discourse.

Today, most of the estimated millions worldwide who have undergone Reiki initiations trace their lineages to about fifteen of the twenty-two communally recognized Reiki Masters that Takata initiated in the roughly five years before her death in 1980. Like yoga and Buddhist meditation, Reiki’s Japanese lineage appealed to people interested in ‘the mystic Orient.’ Indeed, Takata promoted it as a ‘Buddhist secret’ derived from ‘ancient sutras,’ as did her students. In the decades following Takata’s death, aspects of other healing systems became incorporated into Reiki; some (like the chakra system and other practices ascribed to ancient India, Tibet, China, and Egypt) accentuated Reiki’s ‘Eastern’ exoticism, while others (like the use of angels, spirit guides, or ‘Ascended Masters’) made it more familiar to Euro-Americans with metaphysical Christian backgrounds. Takata made some of her own adaptations in her forty-five year teaching career: discontinuing the recitation of the Meiji Emperor’s poetry; making some changes to Usui’s ‘five precepts’ (which became ‘the Reiki Ideals’); referring to reiki as ‘God power’; developing the ‘foundation treatment’—a set of twelve hand positions on the head, abdomen, and back which can be held for about five minutes each—that standardized treatments to one hour; and setting fees for treatments. Interestingly, Takata’s professionalization of Reiki was concomitant with her students increasing consideration of the practice as a spiritual calling (Stein 2017).

**Therapeutic Touch (TT)**

Reiki may be the most prominent form of energy healing worldwide, but the practice that has received the most attention by medical researchers is another modality called Therapeutic Touch (TT). A review of sixty-six English-language, peer-reviewed randomized clinical trials on human subjects with quantitative results that examined ‘proximal’ (as opposed to ‘distant’) applications of energy healing found that twenty-seven focused on TT; qigong and Reiki tied for second with ten studies each; and HT, Johrei, and ‘spiritual healing’ each had five studies (Jain and Mills 2010). Recently, HT, developed out of TT, seems to be gaining in popularity among nurses and an increasing number of studies focus on this modality (Anderson and Taylor 2011; Anderson et al. 2017). Medical researchers’ interest in TT and HT is probably due to both of these therapies being closely tied to the nursing profession from their inception. However, both therapies also have spiritual or religious dimensions that are often obstructed or obscured in medical contexts.

As TT is less diverse than Reiki, its five-step basic practice is easier to describe without overgeneralizing. First, the healer ‘centres’ herself by assuming an erect posture, breathing naturally, cultivating awareness of her own and others’ energies, and setting her intention for the healing about to occur. This ‘centred’ state is to be maintained throughout the treatment. Second, she assesses the recipient’s ‘energy field’ by moving her hands a few inches
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over the body and attuning herself to any perceived changes in temperature or sensations of tingling, pulsing, pressure, et cetera. Third, she ‘unruffles’ the recipient’s field by passing her hands over the body, generally downward from the head toward the feet. Fourth, based on the information gained during the assessment and using her intention, she ‘directs’ some of ‘her own store of vital energy’ and ‘modulates the healee’s vital energy flows’ to try and make the recipient’s energy field symmetrical and balanced. Finally, when she considers the field to have ‘harmonized,’ she recognizes it is time to stop (Krieger 1979; Kunz and Krieger 2004: 2–3). As in Reiki, TT has intermediate and advanced workshops that are generally only taught after practitioners gain some experience with the basic practices. Reflecting its close ties to the nursing field, TT has formal mentorship requirements before practitioners are considered qualified to set up their own practice.

TT developed out of the collaboration between a medical professional and a spiritual healer. In 1971, Dolores Krieger (1921–2019), a registered nurse and professor of nursing science at New York University (NYU), began a series of studies on the effects of hands-on healing. The healer in her studies was Dora Kunz (1904–1999), a lifelong Theosophist (and president of the Theosophical Society in America from 1975–1987) who was recognized as a young child for her clairvoyant powers and trained as a healer by the eminent Theosophist Charles Leadbeater (1854–1934). In 1972, Krieger and Kunz developed a curriculum to teach TT to nurses and nursing students, which became ‘an intrinsic part’ of NYU’s Master’s in Nursing programme in 1975 (Kunz and Krieger 2004: 2; van Gelder and Chesley 2015).

Through Kunz, Therapeutic Touch bears Theosophical influences, most noticeably in its reference to chakras: a system of ‘inner energy centres’ derived from Tantric South Asian meditation practices (White 2012: 14–15). Krieger’s landmark book on TT says the chakras in the hands are the ‘functional agents in all therapeutic uses of hands’ (Krieger 1979: 46). Citing Leadbeater’s influential book The Chakras (1927), she argues that the primary chakras along the central channel of the brain and spinal cord are ‘related to the endocrine glands’ as well as the nervous system (Krieger 1979: 46–47). Also echoing Theosophical teachings, Kunz taught that the human energy field has different layers, ranging from the ‘etheric field’ to the ‘astral body’ (Hover-Kramer 2002: 69). By introducing these ‘subtle anatomies’ into nursing programmes, Krieger and Kunz medicalized Theosophical healing practices.

TT spread quickly among American nurses through professional development programmes. Krieger claims by the end of the 1970s, over 4,300 nurses (including many NYU graduates) had attended her TT programmes (Krieger 1979: vii). Around the turn of the millennium, Krieger said she had personally taught TT to nearly 50,000 healthcare professionals and the Therapeutic Touch International Association (TTIA) website now claims that approximately 100,000 people have trained in TT (Horrigan 1998; TTIA 2019).

Healing Touch (HT)

Janet Mentgen (1938–2005) was a long-time registered nurse living in Colorado when she began practicing TT in 1980. She was an enthusiastic practitioner, publishing an article in the Journal of Pediatric Oncology Nursing encouraging readers to get their hospitals to recognize TT ‘as a nursing procedure,’ including it in policy and procedure manuals as well as in patient notes (Mentgen 1989: 30). In the early 1980s, Mentgen began developing her own system, which she taught nurses at the Denver-area Red Rocks Community College, and in 1989 she and two collaborators dubbed this system HT (Hover-Kramer 2002: 4). In 1990, the American Holistic Nurses Association (AHNA) approved HT as a course offering and the Colorado Nurses Association recognized it for continuing education credits. In 1993, Mentgen started
her own HT training centre and the AHNA began certifying HT practitioners. In 2008, HT formed its own certification board and professional organization and today there are seventy local chapters in the US, Canada, and Australia (Healing Touch Program n.d.). HT training has four levels (with levels two and three each separated into two parts), requiring many hours of coursework and clinical experience.

Mentgen based HT’s theory and practices on those of TT, but introduced other techniques, giving its practitioners more choices regarding how to manipulate the recipient’s energy field. Its founders describe these practices as adapting the teachings of healers such as Barbara Brennan and Rosalyn Bruyere, as well as ‘concepts from shamanic and aborigine traditions’ (Hover-Kramer 2002: 4, 105). Thus, in addition to TT’s centring, unruffling, and modulating techniques, HT has additional energetic interventions, some of which appropriate the vocabulary of medical technologies, such as ‘Ultrasound’ and ‘the Energetic Laser’—both hand positions to focus energy on a particular area—and others that sound like medical interventions, like ‘the Lymphatic Drain’ (Hover-Kramer 2002: 135–137, 147–148).

Like Reiki and TT, HT also teaches that practitioners’ experience will lead to personal development and spiritual growth. The HT textbook makes use of a variety of spiritual and religious vocabularies, from chakras to transpersonal psychology to specific religious traditions, encouraging practitioners, for example, to consider difficulties from the perspective of a ‘Higher Power as you understand it’ and that of ‘Buddha or Jesus or Mary’ (Hover-Kramer 2002: 230–232).

‘Spirituality’ as a boon to access to medical and religious sites

All three of these energy therapies integrate elements from religious traditions, but their promoters tend to identify them as ‘spiritual, but not religious’ (SBNR). A precise definition of spirituality is notoriously slippery, but energy healing practitioners, including nurses, report that their experiences deepen their sense that human health is governed by supra-human forces (Fuller 2001: 119–121; Wardell 2001). Like ‘religious’ practices, SBNR practices provide metaphysical interpretations of physical and mental phenomena (including health and disease), as well as rituals believed to cultivate morality and oneness with the divine; however, SBNR discourse critiques ‘religion’ as overly dogmatic and static (see Lüddeckens and Lüddeckens, this volume). This SBNR identity lets energy healing move differently in medical spaces than religious practices like chaplaincy, while the assumed universality of energy healing’s spirituality allows practitioners access to some religious spaces, where practitioners have been able to integrate their practices into host traditions without triggering fears of mixing two ‘incompatible religions.’

For some hospitals, including those with religious affiliations, energy healing’s spirituality makes it particularly attractive because it resonates with their mission statements. A 2007 study found that 57 per cent of American hospitals surveyed said they offered CAM services because these reflected their organizational mission; the author particularly characterized religious-affiliated hospitals as wanting to ‘tend to the whole person—body, mind, and spirit’ (Ananth 2008: 9). Robert Schiller, chair of family medicine at Beth Israel Medical Center, a renowned Jewish-affiliated New York hospital, called Reiki ‘perhaps the best introduction to patients of the therapeutic effects of Integrative Medicine,’ precisely because it ‘can combine the “felt experience” with concepts of theory and an application of the spirit.’ He argues, ‘Using Reiki only as a healing technique without developing its spiritual component through regular self-practice limits Reiki’s full therapeutic potential’ (Schiller 2003: 20–21). Thus, in
some biomedical settings, energy healing is seen as attractive due to, not in spite of, its claims to ‘spirituality.’

The idea that energy healing is spiritual but not religious has also allowed it to be adapted to religious settings. Reiki has been taken up by Christian clergy in the US and Europe, especially by Catholic nuns. Pamela E. Klassen (2005: 383) describes an Anglican monk studying to become a Reiki Master, who described its energy as identical to that described in Biblical accounts of healing. Sister Mary Mebane, a Reiki Master and chaplain at a Catholic medical centre in California, writes that she trained ‘a large number of nurses, a few physicians, and a number of [other] employees’ in Reiki. Mebane uses scripture to justify many different aspects of Reiki, from Usui’s foreignness to the ‘charging’ of physical objects with reiki energy, and writes, ‘the value of Reiki and its very simplicity of use especially in a medical setting are inestimable. . . [and] it is my fervent hope that it will soon be accepted fully in the medical field’ (Mebane n.d.). Sister Mariusza Jadwiga Bugaj, a Polish nun and Reiki Master, received an Apostolic Blessing from Pope John Paul II in recognition of her work with Reiki (Beauregard 2009).

A more structured example of the interface between energy healing and religious organizations is the Healing Touch Spiritual Ministry (HTSM). In 1997, due to student demand, Janet Mentgen’s administrator, Linda Smith, developed the HTSM curriculum integrating Healing Touch with a ‘Christian approach to energy healing based on the laying-on-of hands . . . to help those who had problems with a language they deemed too “new age”‘; this programme eventually began offering certifications (ISHA n.d.). By the early 2000s, mainline American Protestant churches interested in healing by the laying-on-of-hands—but without the practices common in evangelical and charismatic churches—began sponsoring HTSM courses for their congregants, who could then practise HT in the church (Erickson 2006). Thus, universal ‘spirituality’ provides a kind of fluidity that can help energy healers access medical and religious spaces while affirming particular religious identities or eschewing them altogether.

**Spirituality as an obstacle to access**

While ‘spirituality’ can facilitate the adoption of energy healing in biomedical and religious settings, it can also sometimes limit or prevent access. For example, in ‘How We Got Reiki into the Hospitals,’ two Reiki Masters describe actively refraining from describing their practice in spiritual terms when establishing a Reiki clinic in an American hospital’s oncology department. To ‘“normalize” Reiki’ for medical professionals, they said, they avoided discussion of ‘channeling, auras, energy fields, guides, and spirituality,’ to which they partly attribute their appearance as ‘normal’ to the Director of Complementary Care. They advise readers to constrain their discussion of spiritual topics to a vague concept of a ‘Mind/Body/Spirit connection’ while also encouraging them to ‘follow and trust the energy’ to establish their own programmes (Wolf and Wing n.d.). This kind of secularizing ‘code switching’ is a mirror image of the ‘religionized’ one employed by the aforementioned Anglican monk, who calls reiki’s energy ‘the spirit’ when laying hands on more conservative worshippers (Klassen 2005: 382).

Although Therapeutic Touch founders Krieger and Kunz told students that TT is a spiritual practice, this goes unmentioned by the vast majority of clinical literature on TT. An April 2020 PubMed search yielded 307 results with ‘Therapeutic Touch’ in the title, but only two articles contained the word ‘spiritual.’ This shows the degree to which the therapy is divorced from its spiritual roots and manifestations, such as the chapter on angels in Krieger’s book on TT’s
‘spiritual dimension.’ She comments that, while ‘belief in angelic presence is not a part of the teachings of Therapeutic Touch,’ TT can attune therapists to the reality of angels, which can come to their aid during treatment (Kunz and Krieger 2004: 217–218). Naturally, when TT is taught for nurses’ continuing education credits, angelic intervention does not appear on the formal curricula.

Spirituality as insufficiently ‘religious’

Sometimes, gatekeepers consider spiritual energy healing to be insufficiently religious. In the US in the mid-1980s, Reiki Master Don Alexander found himself unable to enter certain hospitals to give Reiki, so he became ordained as a minister of the Universal Life Church (ULC); he recalls this allowed him to access ‘an intensive ward in El Paso General where . . . even next of kin were not allowed’ (personal communication). This mobilization of religious authority to gain hospital access demonstrates that sometimes SBNR practices cannot receive the same institutional access as legally recognized religious organizations. In the twenty-first century, thousands of Reiki practitioners and other energy healers have become ULC ministers to practise without fear of legal liability (Hoesly 2018: 189). However, some individual hospitals’ guidelines prohibit even hospital chaplains from practising Reiki (Cadge 2012: 113).

In 2009, the United States Conference of Catholic Bishops Committee on Doctrine published a recommendation that Catholic hospitals and retreat centres refrain from promoting or supporting Reiki. This document was issued in response to Reiki’s rising popularity in Catholic settings, especially (as previously mentioned) among nuns. The National Catholic Reporter’s annual directories of conferences, retreats, and workshops show that the number of advertisements for U.S. Catholic retreat centres offering Reiki treatment or Reiki training grew dramatically in this period, from one in 1994 to thirty-four in 2002. The bishops’ statement that ‘the Church recognizes two kinds of healing: healing by divine grace and healing that utilizes the powers of nature’ but that Reiki operates ‘in the realm of superstition, the no-man’s-land that is neither faith nor science’ (USCCB 2009: 1), suggests they could find Reiki acceptable if it were more explicitly Christian or if its mechanisms were scientifically verifiable, but its SBNR identity makes it irredeemable.

Energy healing as ‘bad religion’

A final critique by American Christians is the idea that energy healing poses as SBNR but it is rather an un-Christian, even demonic, form of religion. Some point to Reiki’s Eastern origins as proof that it is essentially Buddhist and thus religious (Brown 2013: 180ff.; McClenton 2011: 37ff.; Mooney 2006). Another approach is to say that energy healing’s ‘occult’ aspects make practitioners and recipients vulnerable to ‘malevolent forces or powers’ (USCCB 2009: 6; see also McClenton 2011; Mooney 2005, 2006).

Conclusion

Energy healers’ common identification of their practices as ‘spiritual but not religious’ has presented them with both opportunities and challenges to access medical and/or religious spaces. Some have responded with a strategy of obscuring its ‘spiritual’ dimensions while emphasizing discourses of the host culture, whether biomedicine or Christianity. Others have gotten religious or medical accreditations, such as the ULC ordination or massage licences,
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to gain access to hospitals, help patients get health insurance reimbursements, or avoid legal difficulties.

Will energy healing continue becoming more integrated into mainstream medical care or is it a temporary trend? In the scientific journal *Nature*, Reiki’s presence in prestigious hospitals was recently held up as part of a slippery slope toward the public’s inability to distinguish medicine from pseudoscience, particularly troubling during the COVID-19 crisis (Caulfield 2020). Yet, the same month, *The Atlantic* ran a long-form article titled, ‘Reiki Can’t Possibly Work. So Why Does It?’ expressing that, while it remains inconclusive whether Reiki outperforms placebos, its efficacy for a range of hard-to-treat issues has made believers out of many medical professionals.

Unlike the many FDA-approved medications that barely beat a placebo in studies and carry negative side effects, Reiki is cheap and safe to implement . . . For decades, experts weren’t precisely sure how acetaminophen [paracetemol] eases pain, but Americans still took billions of doses every year . . . Why should this be different? (Kisner 2020)

Despite the displeasure of some medical gatekeepers, energy healing seems here to stay for the foreseeable future, as it continues entering (or appropriating) various healthcare sectors. American and Canadian healthcare professionals receive continuing education credits for studying energy healing and hospitals in Europe and Latin America increasingly start energy healing programmes (Lepine n.d.). In the US, nurses can bill insurance companies for ‘energy field disturbances’ and energy healers’ clients can get reimbursed by some insurance plans with a letter from their physicians (FSAstore.com n.d.; Shepherd-Gentle n.d.). Energy therapists have formed a number of professional organizations, offering members liability and malpractice insurance. As many, if not most, of these therapists claim spiritual identities for themselves and their practices, energy healing represents a new arena for the relationship between religion and medicine in the twenty-first century.

Notes

1 For descriptions of these three as representative, see Engebretson and Wardell 2012; Hart 2012; Micozzi 2019: 234. Other examples of modern energy healing systems include Polarity Therapy, Pranic Healing, Spiritual Human Yoga, Jin Shin Jyutsu, and Reconnective Healing. Some Reiki practitioners challenge its classification as energy medicine, as they say that the force it employs is ‘much subtler than . . . bioenergies’ and it is not directed by the practitioner (Miles 2006: 9–10).

2 That said, some new religious movements are also centred around practices that closely resemble energy healing. Among the most prominent worldwide are two related movements founded in mid-twentieth century Japan, which each have a number of splinter groups: The Church of World Messiah (Sekai Kyūseikyō), and its practice of jōrei, and Mahikari, and its practice of okiyome. I have argued these groups’ theology of purity and pollution differs from energy healing’s emphasis on balance (Stein 2012a).

3 The most widely cited estimates are by the American Reiki Master William Lee Rand that, by the late 1990s, that the US had at least one million Reiki practitioners, with another million in India (Rand n.d., 1998: v). Around the same time, the Japanese Reiki Master Toshitaka Mochizuki claimed there were approximately five million Reiki practitioners in 121 countries worldwide (1997: 14). Naoko Hirano (2016) has also estimated the number of Reiki practitioners worldwide to be in the millions.

4 As of February 2020, therapeutictouch.org listed 184 practitioners, 160 of whom were in the US, followed by Canada (eleven practitioners), Austria (four), Germany (three), Australia (two), and then Spain, Switzerland, Turkey, and the UK (one in each).
As of February 2020, out of the 1781 practitioners listed on hppractitioner.com, 1490 (83.7%) were in the US and 157 (8.8%) were in Canada; sixty-two of the sixty-eight chapters listed on htpprofessional-association.com were in the US, with three each in Australia and Canada.

A 2007 survey by an affiliate of the American Hospital Association suggests that a little over four percent of US hospitals (about 250 hospitals) offered Reiki at that time (Ananth 2008: 3); that number has likely significantly increased since then. Those hospitals include many of the country’s most prestigious, including Johns Hopkins, Massachusetts General, Mayo Clinic, New York—Presbyterian, and UCLA Medical Center. See Lepine (n.d.) for accounts of Reiki in the hospitals of other countries in Europe and the Americas.

That said, Healing Touch incorporated some of Brennan and Bruyère’s practices, as described below.

These mistaken attributions of Reiki’s origins to ancient Tibet began in emic texts in the 1980s, but they have since been uncritically reproduced in etic texts. See Ray 1983: 45; Wetzel 1989: 47; Anderson and Taylor 2012: 45. To avoid confusion, Japanese names in this chapter are written in Western fashion, with family name last.


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