Introduction

The existence of religion and medicine side by side is stamped by the local infrastructure, which determines the historical and legal frameworks in which both fields unfold. This contribution assumes an infrastructure that allows for the existence of competing medical and religious interpretations of health side by side and in competition. This is, among other things, the case in Germany, where biomedical views of health are institutionally separated from other health options that can be combined under the umbrella term complementary and alternative medicine (CAM). Within the framework of such an infrastructure, medical and non-medical views of health exist in a field of tension. The focus here is on providers of religiously legitimated health interpretations, which are also included in this field of tension.

This contribution is not on the welfare organizations or hospitals run by churches but on the service businesses that, in a sincere way, use religious ideas for the healing of body and mind. The chapter concentrates on small religious businesses, whose owners can be characterized as religious entrepreneurs (cf. Hero 2014). Religious entrepreneurs are almost exclusively self-employed and profile themselves as offering religious ideas and rituals that are related to physical and psychological health. The concept of ‘entrepreneur’ does not refer to the motivation of monetary gain or profit but to the situation- or demand-driven choosing and compiling of religious rituals. There is almost no limit to the creativity of religious entrepreneurs; the religious entrepreneur is not bound in any way by the dogmatic requirements of religious organizations or communities.

The services of religious entrepreneurs, such as Reiki therapists, spiritual healers, energy healers, or shamans have been popping up in Western European countries since the 1980s, and have multiplied since then. Historically, they emerged from the ‘new’ or ‘alternative’ religious movements. In the meantime, they are hardly to be captured by the concept of ‘communities’ or ‘social movements.’ Doubtless, the foundational ideological moments of the erstwhile ‘New Age’ (Sutcliffe 2004, 2014) have been preserved (not least the psychologization, somatization, and therapetization of the adherents)—the social structures and the social background of the former alternative movement have changed, however. Small businesses with marketable offers, which have to prove themselves in the context of an expanding health and therapy market, dominate in the current situation.
The role of religious entrepreneurs cannot be underestimated for the contemporary dynamic in the tension field between religion and medicine. The providers create religious explanations of health and offer these within the framework of service relationships. Here use is made of religious practices and rituals from various periods and regions, which are utilized in various ways in the sense of ‘tool kits’ (Lüddeckens 2018).

Starting with the positioning of religious entrepreneurs in the current health market (section 2), this contribution looks at their strategic possibilities and competitive advantages (section 3). We will see that religious entrepreneurs gain a competitive advantage to customers and clients through their social relationships. In many respects, the role of ‘patients’ here undergoes a revaluation that extends to the ‘sacralization’ of the patient. Religious entrepreneurs bring innovation and a dynamic to the health market not least through their efforts at marketing and professionalization (section 4). The final section (5) summarizes the influence the religious entrepreneurs exercise on the current relationship between religion, health, and medicine.

Religious entrepreneurs and the health market

Independent of the emergence of religious entrepreneurs, the health market in West European countries has experienced a period of growth in the last three decades (cf. Pundt 2012: 1105f). The boom in competing health promises is closely connected to the rise of new professional or semi-professional ‘health professions’ that challenge the traditional monopoly on definitions enjoyed by expertise of conventional medicine (cf. ibid.). Since the 1970s, an increasingly larger group has been offering such ‘alternative’ services related to the body and thus seems to have an important influence on the relativization of conventional medicine.

According to Bourdieu (1982: 561–585, 1992), the providers were recruited primarily from the ‘new’ middle classes that want to seek new fields of activity beyond the established labour market. The ‘new’ social milieu is characterized mainly by educational advancement beyond one’s parents, a middle-class background, testing new service professions in the areas of consulting, pedagogics, and health. The new middle-class milieu is disposed to ‘be alternative’ (cf. Vester et al. 2001): if one has to distinguish oneself from the established professions and their range of services, it is necessary to present an alternative.

From the side of the consumer, it is the constantly accelerating expansion of new body and health ideals that conditions an increasing demand for services that help to optimize body and mind. From once being an existential need, health has now become a permanent lifestyle marker (cf. Richter and Hurrelmann 2016). New health models are being propagated that are directed at ‘prevention,’ ‘activity,’ and ‘personal responsibility.’ There is an ideological change from pathogenesis to salutogenesis, which is an important feature of the ‘second’ health market. Personal responsibility for health, nutritional awareness, physical fitness, stress management, and environmental stability are among contemporary consumer motifs. Competition dynamics in the freely accessible health market produce constantly changing modes of ‘wellness,’ ‘holism,’ and ‘mindfulness.’

Since the beginning of the 1980s, the rise of religious entrepreneurs has introduced a unique type of offer in the health sector. Religious entrepreneurs compete with ‘conventional medicine,’ with other CAM providers, and the various therapeutic professions. The plurality of providers in the field relativizes the power of each individual provider to be able to attract a steady clientele. Conversely, the choices for potential interested parties have increased. To avoid discouraging potential clients through group pressure, hierarchical structures, high thresholds, or appearing to be some kind of cult, use is made of more open and flexible organizational
structures (cf. Lüddeckens and Walthert 2010a). The religious interests of an emancipated clientele are related organizational forms that allow a voluntary, temporary, and always revocable membership.

This is made possible by episodic forms of interaction, which, in contrast to classical religious memberships, can be characterized as a customer- or client-oriented form of religiousity. Seminars, workshops, or weekend courses for personal healing and/or salvation stand out because there is no obligation to attend and they are relatively non-binding. Because the various meetings can be attended independently of each other, they offer the opportunity to arrange their own ideas about healing or salvation according to their own preferences.

The offers of religious entrepreneurs have one dominant approach: that of making religious ideas fruitful for health services. Through their recourse to ‘holistic’ or ‘spiritual’ proposals, new forms of ‘treatment of body and soul’ (Bourdieu 1992: 233) are being propagated. The orientation to ‘body and mind’ can be viewed as a constitutive element of the respective offers: Shamanism, Reiki, Tarot, Bach flowers, channelling, rebirthing, aura cleansing, astrology, geoaesthetics, Qui Yong, yoga, meditation, and hypnosis are accepted with respect to their ‘psychotherapeutic and medicinal claims’ (Straube 2005: 19) by a broad public in society. Whether intended or not—with the orientation to body-related rituals and counselling—the religious entrepreneurs enter competition in the health market, thus they are in competition with ‘conventional medicine,’ ‘alternative medicine,’ and a number of other professional and semi-professional specialists on the body.

**Niches and competitive advantages of religious entrepreneurs**

Health professions, regardless of what legitimation pertains to them, belong to the ‘speaking professions’ (Geisler 2008). The prominent importance of the factor of communication has long been well known and can be documented in different cultures and periods. Through the development of modern medicine, which has increasingly relinquished its embedding in the humanities in favour of a natural science epistemology, the consideration of communication and language has, however, moved to the background. As is well known, two factors in particular have contributed to this. As such prominent observers like Talcott Parsons (1951), Karl Jaspers (1958), and Michel Foucault (1973) have emphasized, the development of modern medicine has focused on the ailment. The latter has drawn all attention to itself, and the person and the identity of the patient has been lost to view. The patient becomes a passive object in the medical procedure of gaining knowledge. It is not the patient, but the illness, which stands in the foreground.

In addition to this epistemological argument, the organizational rationality of the hospital (Vogd 2011) has become increasingly important. The professionalization of the personnel, the technologization of diagnosis and treatment, the economization of the procedures and the specialization of knowledge have decisively increased the social distance between the medical staff and the patient. In the meantime, the sociology of medicine no longer speaks of an ‘asymmetry’ of doctor—patient talks but of the patient as a ‘disruptive element’ (Dierks 2001) in the medical business. In the context of rationalization and cost containment, the orientation to the patient has shifted even more to the background.

In light of this deficit of ‘conventional medicine’ and the anxiety associated with that, it is hardly surprising that certain groups seek out ‘alternative’ or ‘complementary’ healthcare. As health science studies show, this consists primarily of three groups: patients with chronic conditions (primarily skin and respiratory tract ailments), patients with environmental illnesses, and patients whose illness has been diagnosed—from a medical point of view—as ‘incurable.’
These patient groups have in common the fact that the symptoms of the illness cannot be traced to causes of disease that can be easily fixed. Moreover, ‘alternative patients’ are characterized by an inclination to critique experts as well as by the desire for a stronger connection to their identity or biography in the treatment.8

Religious entrepreneurs’ resources for competition are found in the structural failures and shortcomings of biomedical orthodoxy. Among the various providers in the health market, hardly any has the latitude for such an orientation to the patient as the religious entrepreneur. The religious entrepreneur replaces the interrogative anamnesis of conventional medicine with a biographical narrative conversation. Independently of standardized disciplinary requirements, a customized religious narrative can be designed and be used to put identity, the personal, and biographical needs of patients in the foreground. The patient can be drawn actively into the communication about health via recourse to a global ‘tool kit’ of religious ideas. Here it is necessary to negotiate shared conceptual categories by which communication on the identity or the body becomes possible. Such ‘shared beliefs’ (Kaptchuk and Eisenberg 1998: 1061) are attractive, especially if they link up immediately with the individual—biographical situation of the patient, that is, manage to legitimize ‘diagnosis’ and ‘therapy’ in such a way that the distinctive identity of the patient comes to expression in it.

Embedding diagnosis and therapy in a religious narrative leads to a certain form of patient-centredness. The more the religious ideas emphasize the symbolization of his/her person and his/her sensitivities, the more this becomes a sacralization of the patient.

The concept of sacralization refers to a ‘praxis of ascription’ (Schlette and Krech 2018: 411), that (in addition to the transcendental valorization of places and objects) can also lead to a ‘reverential sanctification of persons’ (ibid.: 458). The object of such reverence is, in our case, the patient who receives a special form of homage. A special personal religious recognition is attributed to him or her; he or she is to be given a distinctive religious identity and individualization. The ‘ascription of holiness’ (ibid.: 444) leads to ‘anthropocentrism’: a transcendent ideal, a unique ‘holy’ identity is attributed to the patient, for example through the rhetoric of a ‘higher self.’9 The patient should find his or her way to that higher self through spiritual techniques and rituals he has appropriated and that valorize his or her identity or health according to the provider’s promises: ‘You can make more out of yourself’; ‘You have to let go.’ The mobilization of one’s own strengths and resources occurs within the framework of a religious narrative that specifies a way of salvation and a salvific goal.10

Within the framework of sacralization, the healer mobilizes a ‘transcendent source’ (Stöckigt et al. 2015a) adjusted to individual needs that allows the patient to make his being tangible and identifiable as an ordered cosmos. That religious narrative then grants orientation and identification to the involved part—especially if it can answer the following questions concretely: ‘Why do I suffer from this problem?’ ‘How can I grasp my situation?’ ‘Which therapy is the right one for me?’

It is not for nothing that such ideas spread in the religious health businesses that enable the development of a ‘typology’ (like in the example of astrology). It is precisely this typology that can serve as a vehicle for the therapy goals of alternative medicine of ‘empowerment, authenticity, and enlarged self identity’ (Kaptchuk and Eisenberg 1998: 1061). Tailored to the individual customer or client, they convey clear messages about lifestyle that can restore ‘a bond of “internal determination,” individual character type” or “spiritual vocation”’ (Koch 2006: 175). To engage in such individual counselling tailored to the customer requires temporal resources, however. We will explore the temporal aspect of the orientation to the patient in the next section.
Apparently, for conventional medicine, the form of patient-centredness portrayed here would take up too much of the doctor’s available time, which is substantially restricted and set by the conditions of health insurance. The guideline for the tight time schedule comes from planning considerations: it is part of the economization of medical activity. Especially in hospital, at present the talk with the patient is a ‘business luxury,’ it is a casualty of savings targets. The economically rational medical business has downgraded the doctor-patient consultation to a secondary matter. The modern patient, who is subject to the organization, submits to this pressure, s/he gradually learns that a concise description of her or his suffering focusing on physical symptoms in the form of a ‘report’ is expected (Lalouschek 2002: 24). If s/he adopts this communication form, s/he is viewed as a good patient.

The adaptation of the patient portrayed here can lead to a pitfall in medical operations. According to current studies in health sciences, ‘patient satisfaction’ and ‘patient compliance’ are connected directly with the information and exchange of knowledge that occurs. This, however, requires temporal resources that cannot be realized in the clinical operation. Survey studies in the health sciences underscore an international variation in time budgets, which can turn out to be minimal depending on the country. In Germany, doctors have a tight eight minutes for the treatment and the ensuing consultation with the patient. In contrast, in Sweden or in the USA, doctors have around twenty minutes (Irving et al. 2017). The alternative religious health market, however, offers—in line with one’s interests and willingness to pay—a spectrum that can range from short individual appointments to a longer, therapeutic relationship. We can have recourse to a differentiation that Rodney Stark and William S. Bainbridge (1985) have developed to provide a simple analytical distinction. In producing a typology of the offers made by alternative religious services, the authors distinguish between ‘audience cults’ and ‘client cults.’ The different organizational forms are distinguished not only on the basis of time spent with the client/patient but also through the cognitive and emotional requirements that are made of the parties involved.

The audience cult is characterized as an ideal-type by the fact that there is no lasting social relationship beyond the individual act, of consumption. Interest is shared only for a limited time in the same seminar, the same workshop or the same lecture. In accordance with the short-term nature and lack of continuity of the relationship, there can hardly be any patient-centred systematization and development of health proposals in the audience cults. Nevertheless, the social arrangement at least permits questions of life and illness in the discussion and interpretation. Religious entrepreneurs currently offer individual consultation beginning at twenty to thirty minutes, while lectures and seminars usually last at least two hours.

The short temporal relation in the audience cult comes up against its limits when the transfer of a service leads to a long-term, dialogical relation between producer and consumer necessary. This is especially the case in healing services in which providers and consumers make higher therapeutic or intellectual claims. Here we can also include therapies that are focussed on the individual wishes and sensitivities of the clients and convey personal attention. To characterize such forms of long-term relationships of alternative healing, the concept of the so-called client cult can be used. In such arrangements, it becomes a matter of continuous contact oriented to dialogical exchange based on an expert—client relationship. The time periods on the current esoteric market range from weekend courses and long-term repeating relationship episodes to ‘training courses’ lasting months or even years (cf. Hero 2010). Here the clients themselves can learn and take on the services they practise—for example, Reiki as an idea of understanding health as well as a plurality of meditation, breathing, and movement techniques that promote health.
Religious entrepreneurs and health market

The relation between religious entrepreneurs and their clients is stamped by shared social features. Social proximity arises through similar biographical experiences (cf. Hero 2014; Stöckigt et al. 2015b). Religious entrepreneurs advertise with their biographies, even with their individual life crises and experiences of illness (Hero 2014). The preponderance of a rhetoric of ‘development,’ of ‘creativity,’ of ‘progress,’ or ‘the way’ in the respective advertisements can hardly be ignored by the observer of contemporary health spirituality. With this biographical presentation of themselves, the religious entrepreneurs portray themselves as examples of a successful salutogenesis. They attempt, on the basis of their own biographies of personal progress, to come across as an authentic guarantee of the ideas of salvation they propagate.

The biographical narratives of the provider frequently reveal the motif of a salvation narrative that consists in the emancipation from a past experienced as problematic.12 The ‘path’ that one has followed is emphasized as leading from a crisis experience in order to strive for a new identity with a new mindset. In this context, the step towards self-employment as a religious entrepreneur has a special significance. Self-employment represents not only liberation from the past labour and life relationships now viewed as obsolete; it also offers the providers the possibility to visualize, repeat, and to implicitly confirm their progress and their search for identity in their communication with their clients.

From an economics of religion perspective, the performance or self-presentation of the provider functions as a signal (cf. Hero 2014). The patient is confronted with the question of whether the provider personally believes what s/he claims to believe, whether the provider has internalized the ideas of salvation s/he propagates. Because the patients are concerned with personal problems of identity or health, they expect a sincere attitude. The credibility of the provider is thus crucial to the spiritual service industry: he or she is expected to show ‘real’ interest, his or her ‘own’ interest in the health ideas proclaimed and the interests of the clients. To meet this requirement, the successful provider has to communicate biographical signals that are not accessible to ‘everyone.’ The personal identity of the religious entrepreneur moves to the foreground as an advertising and competition strategy.

The more clearly a provider can show identical or similar personal biographical problems and processes as the patient, the more credible he or she appears. The more s/he is seen to have been forced to struggle with similar crises and even found sustenance in the healing s/he proclaims, the more authority the provider has. In short, a successful religious entrepreneur has a performative behaviour that demonstrates him/herself as living proof of the path and ideas about healing.

The pattern of the ‘exemplary prophet’ (cf. Weber 1976: 273) is expressed in the legitimation mechanism mentioned. What is decisive for the trust of the patient is whether the identity, lifestyle, and past of the provider are seen as congruent with the salvific ideas offered. The mutual recognition then results from the possibility of a reciprocal perspective. The ‘empathy’ between providers and consumers then follows from the ability to empathize with and to understand the feelings and ideas of the other.

Equally important for the empathy between providers and consumers is gender. Women are dominant on both the provider side and the consumer side. The high number of women among religious entrepreneurs (Hero 2008) corresponds with what has been found in the general literature in the area of new, alternative forms of spirituality, according to which the number of women is disproportionally greater than that of men (Heelas and Woodhead 2005; Hotman and Aupers 2006; Woodhead 2007).

In addition to the competition, resources mentioned in the previous sections there are social-structural commonalities that support the faith of the patient in the healing process.
The patient not only wants curative help but also confirmation of identity, social nearness, and emotional support as well—needs that the alternative health market is currently and essentially better able to meet than conventional medicine (Teut et al. 2014).

**Marketing and professionalization**

In the struggle for social recognition, religious health providers tend to organize themselves into professional associations. Already in the 1980s, organized interests can be seen in the context of the rising esoteric market. The providers of the different techniques and therapies formed associations that represented the interests of their members to the general public as well as in regard to non-organized competition. This includes the major Reiki and yoga associations, the miscellaneous associations of astrologists or the interest groups/organizations of the various healers and psychics. We could mention the following German examples: the Deutsche Astrologen Verband (German Astrologists’ Association), the Bundesverband für Feng Shui und Geomantie (National Association for Feng Shui and Geomancy), the Reiki Verband Deutschland (Reiki Association of Germany) and the Reiki Alliance Deutschland (Reiki Alliance of Germany). The association structures encourage a boost in professionalization, they regulate the admission requirements for religious healing, set quality and ethical guidelines for the members of the association, require regular advanced training, and provide legal advice for the transaction and billing for health services. Membership in the association serves the religious entrepreneurs as identity documentation in the health market.

The marketing of religious entrepreneurs (Hero 2014) relies upon naming themselves and their services. There is a wide range of strategies for presenting themselves. One can think here above all of those strategies that are aimed at conferring a higher social recognition of their existence and the services offered, such as ‘Certified Shamanic Counsellor,’ ‘Astrology Graduate,’ ‘Reincarnation Therapist,’ ‘Certified Rebirther,’ or ‘Holistic Aura Consultant.’

Despite all these promotional and professionalization strategies, the religious entrepreneur as a provider of alternative treatments in the health sector remains an outsider or challenger (Bourdieu 1992). In contrast to the prevailing conventional medicine, they still do not have the decisive capital of scientific legitimation at their disposal. The scientific legitimation of spiritual health rituals is just beginning. We can observe a new scientific interest in ‘spirituality’ however: doctors, psychologists, and psychotherapists are investigating ‘spirituality’ as social technology, as a vehicle for increasing therapeutic success (cf. Möller and Reimann 2003; Stöckigt et al. 2013; Jeserich et al. 2015). In this process, ‘spirituality’ has already gained access to the infrastructure of health in palliative medicine, in rehabilitation medicine, in psychotherapy, and in hospice care (Mezger 2018). The academic and scientific findings on therapy-promoting resources of ‘spirituality’ are conveyed to the various health professionals in the field in the meantime in courses and to advisors. Religious entrepreneurs will profit in the short and long term from this boost in legitimacy through science and academics.

**Consequences: the religious entrepreneur as innovator in the tension between religion, health, and medicine**

In their search for new health practices and experiences, religious entrepreneurs have emerged as trendsetters for a new taste for health. They cover a plurality of contemporary health modes and technologies of the self, whose common factor is constituted by the focus on salutogenesis, on personal responsibility, and an orientation towards experience. The traditional notion of a separation between ‘religion’ and ‘medicine’ thus becomes increasingly inapplicable, like
the opposition between the ‘salvation of the soul’ and ‘physical healing.’ To somatize religious ideas and to promote religious rituals for aims of therapy is constitutive for the ‘profession’ of the religious entrepreneur.

The body- and health-oriented use of global religious heritage forces a popularization, even an inflation of religious practices—it contributes to defining constantly new modes of the adoption of ‘yoga,’ ‘meditation,’ or ‘Ayurveda.’ The popularization of religious interpretations of health becomes apparent when looking back at the ‘New Age’ movement, which was seen in the 1980s as the epitome of exclusivity and the avant-garde (cf. Knoblauch 1989). Three decades later, religious interpretations of health have long been included among ‘popular religion’ (Knoblauch 2008), they have become an easily accessible form of religious praxis. Apparently, this change is due to the embedding of alternative religiosity out of the structures of precisely defined communities and organizations (Hero 2009; Lüddeckens and Walthert 2010a, 2010b). With the rise of the religious entrepreneur, ‘meditation,’ ‘shamanism,’ ‘oscillation,’ or ‘Feng Shui’ are distributed and communicated in a quite accessible way.

The religious entrepreneur has, however, inspired not only the religious landscape. Medicine and its related socio-medical research is noticing the expanding health market. The learning process from the success of CAM has become a topic in relevant literature. At any rate, the image of the patient has decisively changed in medical textbooks: the patient is now discussed as ‘mature’ and ‘informed’ (cf. Koerfer and Albus 2018). In conventional medicine, a paradigm shift has been taking place over the last two decades: from a ‘biomedical’ to a ‘biopsychosocial’ approach (Engel 1997), which emphasizes in new ways the importance of communication and participation in the doctor—patient interaction.

Conventional medicine is currently going through a ‘communicative change,’ a ‘narrative change,’ and a ‘participatory change’ (Koerfer and Albus 2018: 42) in that it is being oriented towards virtues that have long ago been anchored in the praxis of religious entrepreneurs. There is a growing recognition that health and illness have not only biological, but also communicative and social aspects.

Notes

1 A clear picture of such a small religious business can be found in Frisk (2013).
2 For England (Heelas et al. 2005) and some Scandinavian countries (cf. Ahlin 2015; 2017) the increase in importance of the numbers of the providers and consumers can be established quite clearly. In Germany, approximately 1,100 small religious businesses could be found in North Rhine-Westphalia (17,600,000 inhabitants) (Hero 2008); reliable numbers are not available for Germany as a whole, however. In retrospect, one can assume with relative certainty that the number of providers has increased. An estimation from 1975 reports that up till that time there were about 100 ‘spiritual centres’ nationwide (cf. ibid.). Health science studies suggest that the increase in importance of ‘alternative medicine’ occurred above all in the period from 1980 to 2010 (cf. Harris et al. 2012).
3 An overview of these developments can be found in Eitler (2007).
4 The distinction between ‘customers’ and ‘clients’ is based on a temporal distinction that is explained more precisely below (3.2). The social relationship to a ‘customer’ can be characterised as short term, while the ‘client’ to his or her provider is, in contrast, of a longer duration.
5 The concept of a ‘second health market’ has been developed in reference to the freely accessible health market. This refers to all health-related services and goods that are not covered by a private or required health insurance scheme in the framework of state health insurance or financed by taxes (‘first market’).
6 For the causes, see Hero 2011.
7 An up-to-date summary and analytical specification of these developments in medicine can be found in the article by Starystach and Bär (2019).
An informative summary of the health science studies in question can be found in Ahlin (2015). In summing up, he argues that the attention for alternative medicine largely comes from ‘push factors,’ thus from the dissatisfaction of the patient with ‘orthodox’ medicine.

More extensive examples of the corresponding rhetoric can be found in the study by Teut et al. (2014).

Sered and Agigian (2008) have researched the construction of such narratives and metaphors for the treatment of breast cancer patients. Detailed qualitative studies on communicative negotiation of the religious narrative are offered by Stöckigt et al. (2015a; 2015b) and Jeserich et al. (2015).

The willingness of the patient to achieve proper therapy and health results, in cooperation with the treating physician, is called ‘compliance.’ The frequently documented inadequate ‘compliance’ is the cause of delayed healing processes, a plurality of complications and avoidable treatment costs (cf. Schäfer 2017).

The reference to one’s ‘own development’ or ‘own progress’ emerges in the narrative-biographical interviews that were conducted with religious entrepreneurs. Within the context of the DFG research group, Transformation der Religion in der Moderne (in summary form in Damberg 2011), it was sought, via biographical interviews with religious entrepreneurs, to find their reasons for making the step into (uncertain) self-employment. Here it is shown that the corresponding drive, like the beliefs of many providers, directly coheres with the biographical crisis experiences and requirements for accomplishments (cf. Hero 2014). Stöckigt et al. (2015a, 2015b) also highlight the healer—patient relation as an integral element of the healing process. The connection is characterised by mutual respect, esteem, and proximity. This foundation makes it possible for the healer to conjure up a transcendental power as a mediator between the two and to make use of it for the healing process. Stöckigt et al. also use the concept of ‘empathy’: it allows the healer to feel what the client is experiencing.

Cf. the contributions in Lüddeckens and Schrumpf (2018) and Klinkhammer and Tolksdorf (2015).

Examples of such advisor/consultant literature are Dale (2014) and Koenig (2012).

‘Thinking outside the box’ with regard to the field of medical competition is clear, for example, if one follows the relevant contributions in the German medical journal. The coexistence as well as the possibility of mutual benefit is regularly emphasised here. (cf., among others, Willich 2004; Spielberg 2007)

The significance of the linguistic exchange is emphasized not only for the production of ‘compliance’ (cf. Schäfer 2017). The successful communication has, in the meantime, been made fundamentally responsible for the success of the treatment; ‘relational medicine’ discovers the ‘self-healing processes of the patient (Di Blasi et al. 2001), particularly in the successful doctor—patient talk. Here, with the help of ‘psychoneuroimmunology’ it can be explained—also in a natural science model—why communication and language are relevant in the healing process.

**Bibliography**


Religious entrepreneurs and health market


Markus Hero


