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A Systematic Review of the Use of Reiki in Health Care

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Reiki is an ancient Japanese form of healing that was rediscovered and developed by Dr. Mikao Usui in Japan in the late 1800s.[1] Reiki is founded on the notion that an energy flow that supports life exists within all living beings. This energy is known as *ki* in Japan, as *chi* or *qi* in China, and as *prana* in India.[3] The word "Reiki" means "universally guided" or "spiritual life energy," and consists of the two Japanese words Rei, which means "the hidden force" or "spiritual," and "*ki*," or "life energy."[3]

When *ki* is reduced or blocked, ill health can occur.[1]

Reiki is based on the concept of manipulating the body's energy field, located around the body, to assist in the healing process. In Reiki healing, the Reiki practitioner channels *ki* to the recipient, bringing about balance in mind, body, and spirit. In this procedure, the Reiki healer most commonly places his or her hands lightly on or just above the patient's body in a series of positions, so as to allow the flow of Reiki to wherever it is most needed. The Reiki practitioner does not "heal" anyone, but rather acts as a channel for the flow and rebalancing of the subject's energy, which is derived from the universe.

Despite the popularity of "touch therapies" such as Reiki, the theoretical mechanisms for their effects are not well understood.[4] There is little scientific "proof" of how or why Reiki works. In 1990, however, a photograph made with Kirlian photography showed a beam of energy or light emanating from a Reiki practitioner's hand while the practitioner was focusing on initializing the flow of Reiki.[5] More commonly seen are temperature changes in the hands of the Reiki healer during the treatment.

Independent research by Becker and Zimmerman during the 1980s into what happens during the practice of Reiki revealed that the brain wave patterns of the practitioner and receiver become synchronized in the alpha state that is characteristic of deep relaxation and meditation, but that the waves also pulse in unison with the earth's magnetic field, a phenomenon known as Schuman Resonance. During such episodes, the biomagnetic field around the practitioner's hands is at least 1000 times greater than normal, independently of the practitioner's internal body current.

Reiki is practiced universally. Training for Reiki includes a series of initiations, also called "attunements," by experienced Reiki master teachers. These attunements open the student's channels to facilitate the flow of Reiki for treating oneself as well as others.[7]

Several levels of Reiki practitioner exist, ranging from basic or level I practitioners, who engage in self-treatment or treatment of friends and/or family members, to master teachers, or level III practitioners. After undergoing attunement, the Reiki practitioner learns a series of symbols in a specific sequence, together with visualizations and breathing training, with the aim of concentrating the practitioner's attention and intent. A number of symbols may be used in Reiki to facilitate the flow of energy. Practitioners at higher levels can also direct energy flow to recipients at distant locations.[7]

Even though Reiki healing can be practiced on any person after level I training, competence in its practice comes with consistent and disciplined self-treatment as well as experience and attunements at higher levels.[8] Where there is no formally accredited Reiki training, such as in the United Kingdom, use of the technique may be unregulated, and its use by suboptimally qualified practitioners may be ineffectual at best and potentially damaging at worst.

The practice of Reiki has seen rapid growth since its introduction in Japan in the 1930s.[4,9] As with many other complementary and alternative therapies, Reiki is also popular in hospice and palliative care settings in the United Kingdom and United States.[1,10]

These facts and particularly the vulnerable nature of hospice and palliative care populations, make the need for Reiki's regulation and evaluation imperative.

There is a paucity of well conducted research on the effectiveness of Reiki in the health care environment. The research that has been done has tended to concentrate on selective outcomes, such as the physiologic effects of Reiki treatments,[4,11] the relaxing properties of Reiki,[2] pain relief,[12] and experiences of Reiki treatments.[13,14] Given the claim of Reiki to be a holistic treatment, such research may be considered as excessively narrowly focused and only peripherally relevant. Furthermore, few systematic reviews have been done on the use of Reiki or its overall value within health care, and those reviews that have been done are also narrowly focused and highly specific.[8,15,16]

The more encompassing holistic and highly therapeutic orientation of Reiki would seem to demand greater emphasis on its general effects on the individual, especially in ill health. A systematic evaluation of this would be consistent with the recommendations of the

Electronic Databases Searched

MEDLINE®
CINAHL
EMBASE
PsychINFO
Allied and Complementary Medicine Database (AMED)
British Nursing Index, MIDIRS, the RCN research database
Cochrane Database of Systematic Reviews
Database of Abstract of Reviews of Effects (DARE)
Cochrane Register of Controlled Trials (CENTRAL)
Cochrane Database of Methodology Review
Cochrane Methodology Register (CMR)
Health Technology Assessment database (HTA)
NHS Economic Evaluation Database (NHS EED)
Zetoc
Complementary and Alternative Medicine and Pain Database (CAMPAIN)
Health Management Information Consortium Database (HMIC)
Global Health

Reiki Regulatory Working Group (RRWG), an organization comprising the British Complementary Medicine Association (BCMA) and a number of other organizations involved in Reiki in the United Kingdom. The RRWG commissioned the present study in the belief that such an evaluation might identify gaps and trends in the evidence for Reiki, which in turn could help support and inform existing Reiki practice and regulation of training and practice in this healing technique, and direct the commissioning and development of future research in Reiki.

Purpose of the Study

The main purpose of the study was to determine what the national and international evidence reveals about the use of Reiki in health care. The study was designed as a systematic review of the available literature on Reiki, with extraction of all papers presenting primary research on its use in health care. Two chief independent assessors (S.H-M. and F.P-K.) conducted this systematic review over a 12-month period in 2005 and 2006. Specific data collected in the review included the: (1) aims and health care focus of the research and the country in which it was conducted; (2) professional group(s) involved in the research; (3) designs, samples, and methods used in each research study; (4) Reiki technique used and the duration and frequency of treatment, and level of expertise of the practitioner; and (5) outcomes of the research. Studies were also reviewed for the recommendations the researchers made for development of the practice of Reiki, its adoption and the scope of its use, and future research in Reiki.

Methods

Search Strategy

Studies were identified through a combination of searches of electronic databases (see box entitled Electronic Databases Searched) and supplementary searches including purposive manual searching of journals and citations (see box entitled Journals and Citations Searched), searches of Internet sites for associations and foundations related to Reiki (see box entitled Reiki-Associated Associations and Foundations Searched), and direct communications with experts and relevant organizations involved in Reiki. Global Health Search engines such as Ovid and Blackwell Synergy were used to identify other data sources, and Google Scholar was also searched. Project reports, unpublished doctoral dissertations, and other literature not generally available on Reiki were identified through the System for Information on Grey Literature in Europe (SIGLE), the National Research Register, Dissertation Abstracts, and the Social Science Information Gateway (SOSIG). The box entitled Terms Used in Search of Studies of Reiki for review lists the words/terms used in the search. These evolved as the search progressed, with the searched areas being recorded and tracked against each search term to ensure reproducibility and avoid omissions and overlaps in the search strategy.

Inclusion and Exclusion Criteria

In order to be selected in the initial process, a study had to (1) represent primary research; (2) involve any research methodology, including randomized, qualitative, and other methodologies, and any research method, including interview-based, questionnaire-based, and other methods; (3) be reported in English; (4) have been conducted in any sector or area of health care, including a national health service/program, private care, or voluntary care; (5) have been conducted by any professional health care group; and (6) have been based on funded or nonfunded research.[17] Studies were excluded if they were based on (1) the use of Reiki in social care, which in the United Kingdom is not funded through the National Health Service; (2) the use of Reiki on animals; (3) Therapeutic Touch; (4) Healing Touch; or (5) the use of Reiki on healthy subjects except for investigation of the physiologic or other scientific aspects of Reiki.

Selection Framework

The selection of studies for the review was done in four stages. In the first stage, one of the two chief investigators (F.P-K.) conducted an independent examination and review of the titles and abstracts of all studies with potential for inclusion in the review, using the inclusion and exclusion criteria described above. This investigator discussed the selected items with the second chief investigator (S.H-M.), and retrieved full-text papers. These were then independently assessed for inclusion and the outcome was recorded. Because studies were not identified on the basis of methodology or method, a combination of quality assessment criteria was used to establish a threshold of acceptability for the research of studies. The criteria used for qualitative studies were those listed by May and Pope.[18]

The criteria for inclusion of experimental, observational, cohort, case-control, and case-series studies were the checklists published by the Centre for Reviews and Dissemination Quality Assessment.[19] Studies that presented insufficient information for an assessment of quality were discarded. Only studies, for which the two chief investigators were in agreement, on a simple "Yes/No" basis, were selected for inclusion in the review. No further quality assessment of the included studies occurred.

Findings

Twenty-four (24) electronic databases were searched, with 1321 papers identified as potentially suitable for inclusion in the review. Of these, 111 were initially selected, to which the supplementary search added a further 15 studies that were identified as potentially suitable. Abstracts for these 126 studies were retrieved and further reviewed, with 20 of the studies then being excluded. Full-text articles for the remaining 106 studies were retrieved, with further examination leading to the exclusion of 96 of the studies on the basis of the criteria given earlier. The remaining 10 studies were included in the review.

Included Studies

We found no previous systematic or structured reviews of Reiki in health care, although we did find a review of the available research on Reiki in general[5] and two systematic reviews of its use in distant healing, in which the practitioner focuses on a distantly located patient, using Reiki symbols and the patient's name (and possibly also a picture of the patient) to assist healing.[15,16]

Research on the use of Reiki has been undertaken in the areas of surgery,[12] chronic illness,[20] neurology,[21] stroke rehabilitation,[22] cancer care,* cancer pain,[23,24] and mental health.[25–27] One study was undertaken in the voluntary sector[25] and two in private health care.[26]

In patients with advanced cancer, Reiki reduced pain over a 4-day period, as well as improving quality of life over a 7-day period.

The professional groups that tended to conduct research on the effects of Reiki were organizations for nurses,[23,24] psychologists,[20] mental health professionals,[27] medics,[21] rehabilitation professionals,[22] and cancer care professionals.* Several studies did not specify this information.[12,25,26]

Among the papers that were reviewed, research into the use of Reiki in health care took place in the United States of America,[12,20,22,26,27] Canada,[23–25] India,[21] and Australia.* No research on Reiki in the United Kingdom was deemed suitable for inclusion in the final review. Experimental,[12] quasi-experimental,[22] cohort-study,[20,24,26] and case-series[21,23,25,27,*] designs were used in the studies included in the review. Data-gathering methods tended to consist of questionnaires or visual or analogue scales. None of the included studies used interviews or focus groups to gather data.

*Popescu A. SCGH Brownes Cancer Support Centre Patient Care Report. Unpublished report. Perth, Australia, 2002.

Journals and Citations Searched

Alternative Therapies
The Journal of Alternative and Complementary Medicine
Complementary Therapies in Medicine
Alternative & Complementary Therapies
Complementary Therapies in Clinical Practice and Holistic Health
British Medical Journal
Holistic Health Practitioner
International Journal of Palliative Nursing
Holistic Nursing Practice
Journal of Holistic Nursing and Advances

The aims of the research in the reviewed studies varied enormously and ranged from the use of Reiki in poststroke rehabilitation to its effects on pain after surgical removal of molar teeth[12]; on pain in chronically ill patients[20]; in reducing pain and the use of analgesic agents and improving the quality of life of advanced cancer patients[23,24]; on changes in pain, fatigue, nausea, breathing, and sleeping in cancer patients*; on changes in the isoprenoid pathway with Transcendental Meditation™ and Reiki healing practices in seizure disorders in epilepsy[21]; and on survivors of child sexual abuse[25]; on the effects of Reiki as compared to touch on symptoms of depression and stress[26]; and on the use of Reiki and psychotherapy in patients receiving long-term care for mental health.[27]

Three (3) of the reviewed studies[20,22,26] used placebo Reiki to minimize the suggestive effect of Reiki and the effects of therapists' time and attention on patients who had never previously had Reiki treatment, and to ensure that the effective element of the treatment was Reiki and not simply physical touch. The placebo consisted of the use of lay assistants who had been trained in Reiki I but had not been attuned in Reiki.[20,22] In two of these studies neither the patients nor the lay assistants were aware of the lack of attunement. In the third study the participants believed that all of the subjects would receive distance Reiki healing.[26] Authentic Reiki treatment with full attunement was offered to all participants and Reiki practitioners at completion of the 3 studies.

Some of the papers selected for review did not identify full details of the Reiki intervention used,[23] but most of the studies attempted to list the duration of treatment, type of treatment, and level and training of the practitioner. Duration of Reiki was reported to be 15 minutes or more.[12,24,26] Several papers did not state the duration of intervention.[21,27] The course of Reiki treatment varied from a few sessions within a 1-week period[20,24] to 1 treatment every 9 weeks.[25]

The type of treatment ranged from the *Usui* system of Reiki, which is the most widespread style of Reiki treatment,[22,24] to Reiki-like hand healing, which was not described in further detail,[21] and distance healing.[12] Several studies used direct physical touch on participants,[22,24,26] and 1 study reported no direct physical touch.[20] Various studies reported using a number of specific hand placements.[20,22,24,26]

The level of expertise of the Reiki practitioner varied from Reiki Master[20,22,24,26] to Reiki practitioner at level II.[26,27] In 1 study, Reiki was performed by Reiki practitioners of level I as

Reiki-Associated Associations and Foundations Searched

Royal College of Nursing
Prince of Wales' Foundation for Integrated Health
Reiki Regulatory Working Group
British Complementary Medicine Association
Embody: Complementary Therapists Association
Federation of Holistic Therapists
Independent Professional Therapists International
UK Reiki Federation
UK Reiki Alliance
Reiki Healers and Teachers Society
Reiki Association in the United Kingdom
Reiki Alliance
International House of Reiki
International Centre for Reiki Training
International Association of Reiki Professionals
Tera-mai Reiki and Seichem Healers Association
Canadian Reiki Association Reiki and Seichem Masters

a comparison to treatment by a Reiki Master.[23] However, several studies did not state the level of expertise of the practitioner.[12,21,25]

With regard to study outcomes, Wirth et al. suggested that Reiki may significantly reduce postoperative pain after tooth extraction.[12] In patients with advanced cancer, Reiki reduced pain over a 4-day period, as well as improving quality of life over a 7-day period.[24] Shore demonstrated that after 6 weekly sessions of Reiki, symptoms of depression, hopelessness, and stress were reduced[26] with effects that were reported to last for at least 1 year. MacDermott and Epstein suggested that Reiki is effective in improving quality of life as well as improving sleeping and eating habits and reducing anxiety and body pain in survivors of child sexual abuse.[25] Dressen and Singh indicated that Reiki could be effective in reducing pain, depression, and anxiety in chronically ill patients,[20] and Popescu found that Reiki treatments reduced pain, fatigue, and nausea.*

However, Shiflett et al. stated that Reiki was ineffective in functional recovery during rehabilitation from subacute stroke.[22]

Excluded Studies

Some interesting trends in the use of Reiki were identified in the studies excluded from review, and do have some contextual relevance to our findings. In general, these studies suggest that (1) Reiki is practiced on healthy subjects rather than in the health care environment or in patient groups[13,28,29]; and (2) in terms of Reiki's physiologic effects, Reiki improves the relaxation and immune responses, reduces anxiety, and reduces heart rate, and diastolic and systolic blood pressure.[4,30–32]

Anecdotal evidence suggested that Reiki can reduce stress preoperatively, decrease recovery time, decrease use of analgesia, and reduce hospital length of stay following surgery[33–37]; reduce stress[38–40]; reduce fatigue and improve coping ability in patients with myalgic encephalomyelitis (ME)[41]; reduce pain and improve comfort and quality of life in palliative care[42,43]; and aid relaxation in patients with human immunodeficiency virus (HIV) infection/acquired immune deficiency syndrome (AIDS).[45,46] No anecdotal evidence was found to suggest that Reiki can harm recipients, although this is unsurprising given the tendency of journals to publish reports with positive findings.

Discussion

The review revealed a corpus of methodologically sound research into Reiki, generally supporting the conclusion that it can have a positive effect on health. Most of the evidence for this focuses on the impact of Reiki on human physiology, the experience of Reiki for both the therapist and the client, Reiki as a complementary and alternative therapy, and the professionalization of Reiki. Substantial anecdotal evidence for Reiki also exists. However, most of the empirical research on Reiki involves healthy volunteers, with little evidence derived from its use on specific patient groups within a health care environment.

Research on Reiki has been conducted in a variety of clinical settings, mainly in fields of physical health care (e.g., surgery, chronic illness, and cancer care), with a few studies of Reiki's effects on mental health. Yet the present review may not give an accurate picture of the extent of Reiki practice in health care. Thus, for instance, Reiki treatment is offered to patients undergoing cardiac rehabilitation at some hospitals in the United Kingdom (e.g., Worcestershire Acute Hospitals NHS Trust), but no documented research is available about this service.

As a treatment technique, Reiki is not linked with any specific professional group. A range of health care professionals, from nurses to psychologists, have undertaken research on the use of Reiki in health care, suggesting that Reiki is widely used by different health care professionals in a variety of health care settings. However, it is essential that increasing numbers of practitioners of Reiki become more involved in research on this technique to ensure that its practice is evidence-based. This is especially important in view of the often-unregulated nature of Reiki applied to vulnerable patient groups. In this regard, Kelner and colleagues reported some Reiki practitioners as having found conventional health care practices to be inappropriate for their own, individual use.[46]

Among the interesting methodological aspects of the studies included in our review was the use of Reiki as a placebo. It has been argued that this use of Reiki is not possible, since patients would be aware of not undergoing Reiki[28] and it has been suggested[5] that Reiki practitioners, once given attunement or initiation by their teachers, cannot provide sham versions of energy healing. This was overcome by training lay assistants to level I of Reiki practice without attunement, which is the crucial part of Reiki training. Several studies have shown placebo Reiki treatments to be effective[20,22,26] and have suggested that the consequences of Reiki are not due to physical touch but to the effects of Reiki healing. Much research exists on physical touch in health care, with reported benefits including calming and comforting effects,[47] and it is these effects that need to be distinguished from Reiki. All use of placebos demands ethical consideration with regard to participants' human vulnerability.

Sampling may have been biased in many of the studies selected for review, since recruitment often depended on subjects' desire to be part of a study.[24–26]

The lack of random selection and treatment allocation could also conceivably influence results, since participants seeking to derive beneficial effects of an intervention are likely to create demand characteristics for themselves that obscure the real effects of the intervention. Another issue in the studies reviewed was sample size, which was typically small (N = 21–50), thereby compromising the statistical power of the studies. While the available research on Reiki is often exploratory, it is nonetheless the case that the findings would have greater validity if derived from larger and ascertainably randomly selected samples.

The wide methodological variation in the studies examined in the review—in purpose or focus of Reiki use, type of Reiki treatment given, and duration of treatment sessions and courses of treatment, to consider but a few variables—makes comparison of their findings impossible.

Worthy of particular comment is the range of individual treatment times found in our review, which ranged from 15 minutes to 1.5 hours. While this probably reflects the reality of practice of Reiki, whose use is patient-centered and holistic, it is conceivable that short treatment sessions (e.g., ~15 minutes) may be too short for full and effective treatment. Furthermore, some studies provided Reiki therapy for as little as 1 week, while others provided it for 6 weeks. Because it has been suggested that the effects of a Reiki treatment last for 2–3 days and are cumulative,[24] greater methodologic rigor and outcome comparability are likely to be achieved by standardizing the timing of the evaluations across studies. Of further interest was the finding by Shore and colleagues of a reduction in symptoms of depression and stress when measurements were made a year after the last Reiki treatment.[26] Their study included 45 subjects, each treated over a 6-week period with Reiki sessions lasting 1.5 hours. While this long-term effect of Reiki may simply reflect the normal recovery process, it may also be a direct effect of therapeutic intervention, since anecdotal evidence suggests that Reiki can have a life-changing spiritual effect. Further research is needed to establish the duration of effects of Reiki.

It also appears that the type of treatment given depends on the training and philosophical/theoretical orientation of the Reiki practitioner. This may not be problematic in practice, but it is problematic in research into a procedure or process where interventions need to be identical or at least very similar to ensure reliable results of a review such as ours. Furthermore, assurance of the clinical effectiveness of Reiki may mean that its practice needs to be standardized, which in practical terms would mean regulation of its professional use, training, and education.

Recommendations for Reiki Research and Practice

Although previous research on Reiki has not necessarily focused on its use in health care, the spectrum of evidence suggests that it has potential as a treatment modality for health care and also as an adjuvant therapy. Our review indicates the need for more research in order to establish a rigorous evidence base for Reiki practice. Such research should be conducted in all areas of health care in which Reiki is practiced, and should examine the impact of Reiki standardized according to type, frequency, duration, and other aspects of Reiki on large, matched sample groups, with use of a control group whenever possible, and over extended periods. Much prior research has tended to concentrate on the efficacy of Reiki healing evaluated against a range of measurable clinical outcomes. Although this is important for research on Reiki in health care, more patient-focused investigations are needed to assess the experiential facets of Reiki therapy. Albeit the randomized controlled trial is the current "gold-standard" method for generating valid empirical results in health care research, the holistic nature of Reiki suggests a need to incorporate qualitative methods, such as Q methodology, a methodology based on factor analysis and which draws on the strengths of both qualitative and quantitative methodologies for studying subjective experience, for capturing the experiential aspect of Reiki.[48] In any event, studies of Reiki need to involve collaborations between caregives, patients, and differing health care groups to ensure that their results reflect health care needs.

It is difficult to make recommendations about the practice of Reiki on the basis of the limited evidence provided by a single review such as ours. However, it clearly emerges that all Reiki practice needs to be evidence-based, especially given the unregulated nature of its practice and the widely varied patient groups on whom its use is typically focused. Insufficient attention has been given to where, when, and how Reiki can be used in health care and who practices it, but in an increasingly litigious culture, it would seem to be a minimum condition that practitioners of Reiki satisfy stipulated training criteria, especially if people are to practice within health care settings. In the United Kingdom, the RRWG has taken steps toward voluntary self-regulation among practitioners of Reiki, and recommends that all of its practitioners be trained to Reiki level II and be able to demonstrate evidence of ongoing clinical experience and continuing professional development in order to practice on the public.

Terms Used in Search of Studies of Reiki for Review

Reiki	Adult
Healthcare	Alternative Therapies
Energy Healing	Children
Surgery	Vibrational Medicine
Non-procedural Touch	Disability
Palliative Care	Integrated Therapies
Vibrational Healing	Learning Disability
Older Adult	Integrated Health
Complementary Therapies	Mental Health

Conclusion

Our review demonstrates that Reiki has potential as both a treatment modality and an adjunct therapy in health care. However, further research is needed to establish a rigorous evidence base as a platform for the practice of Reiki. This research should be done in all areas of health care in which Reiki is practiced, and should examine its effect on large, matched patient groups over extended periods, using a Reiki intervention standardized according to type, frequency, and duration of

practice, with a control group included whenever possible. While much past research has tended to concentrate on the efficacy of Reiki healing as measured against a range of clinical outcomes, it is also important to assess the experiential aspects of the therapy from the patient's standpoint, and to consider the use of more qualitative methodologies. Additionally, the way in which anecdotal evidence can influence practice must be debated, and all health care practitioners using Reiki in any care practice or setting must be fully trained in it and subject to ongoing regulation of its practice. □

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