What Is Reiki, and Does It Really Work? An Investigator Puts It to the Test

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The 2015 *National Health Statistics Report* (2002–2012) stated that 40% of Americans are using some form of complementary and alternative medicine (CAM). Although many CAM modalities have proven efficacy, there is still some hesitation in their use, and there are roadblocks to their regulatory acceptance. Many of these roadblocks are attributed to the following:

- Confusion in the terminology/definitions
- Poor scientific rigor on studies and few replication studies to validate
- Varying training/certifications requirements within and across modalities
- No consolidation of CAM efforts across and within health care organizations
- Inability to compete with the pharmaceutical industry's marketing and clinical trial research funding

All of these factors confuse patients, hindering their ability to make sound and safe choices regarding CAM. In military health care, many of these modalities are underused compared to civilian health care or are not available. Reiki is a prime example.

Reiki is a Japanese technique for stress reduction that also promotes healing, based on the principle that a universal life force energy flows through every person. (Photo courtesy of http://myhih.com/reiki.)

Reiki

Reiki (pronounced *ray-kee*), a biofield energy therapy, was formalized in Japan by Mikao Usui in the early 20th century and brought to the United States in the 1940s. The principles are based on the premise that everything in the universe is made up of energy and when that energy is out of balance, illness or disease occurs. This imbalance can be corrected by a trained practitioner skilled in the ability of passively flowing energy to the recipient, allowing the rebalanced body to heal itself. During a Reiki session, the practitioner places her or his hand slightly above or directly on the recipient in a systematic series of placements. The practitioner is trained by a Reiki Master and can achieve three levels of skill (Level 1, Level 2, and Level 3: Master), each having its own defined scope of capability. Sessions can last between 30 and 75 minutes, with most recipients stating that they feel tingling, warmth, and/or an extreme state of relaxation during their session.

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The concept of Reiki is not new to the military. Organizations such as the nonprofit Cause (Comfort for America's Uniformed Services) have offered free Reiki therapy sessions to Service members across the nation. However, many military health care beneficiaries and providers still express confusion about the difference between Reiki and other similar modalities, such as Healing Touch and Therapeutic Touch, and may not know the appropriate questions to ask when seeking a reputable practitioner.

Purpose of the Study

The purpose of this study was to (1) educate a group of military health care beneficiaries with complaint of chronic pain about the concept of Reiki, (2) give them the opportunity to have six Reiki therapy sessions, (3) assess Reiki's efficacy in reducing their chronic pain over the course of those six sessions, and (4) assess their thoughts about Reiki as a possible future option for the management of their chronic pain.

Participants

The participants were 30 military health care beneficiaries with complaint of chronic pain. To participate in the study, participants had to (1) have chronic pain (defined as pain that had lasted more than 6 months since first onset), (2) be receiving a stable pain medication regimen (defined as a regimen that has not increased 10% to 20% in the week prior to enrollment), (3) be affiliated with at least one of the installations in Kaiserslautern Military Community in Germany, (4) be eligible to receive health care at Landstuhl Regional Medical Center, (5) be at least 18 years old, (6) be able to read and speak English, and (7) be able to commit to six treatments (lasting approximately 11–21 days). Participants were excluded if they (1) were scheduled for any surgeries or painful procedures during the study or (2) already had a working knowledge of Reiki or had had Reiki therapy in the past.

This study showed that Reiki is a viable complementary and alternative option for managing chronic pain.

	n	%
Gender		
Female	18	60.0
Male	12	40.0
Race		
Asian	3	10.0
Hawaiian/Pacific	1	3.3
White/Caucasian	26	86.7
Hispanic (Ethnicity)		
No	29	96.7
Yes	1	3.3
Military Status		
Active Duty	9	30.0
Dependent	14	46.7
Reservist	1	3.3
Retiree	6	20.0
Military Branch		
Air Force	17	56.7
Army	11	36.7
Navy	2	6.7
Area of Chronic Pain		
Upper Body	6	20.0
Lower Body	3	10.0
Back	8	26.7
Generalized	13	43.3

Average participant age: 46.93 (SD 11.9).

Study Procedures

After being screened and providing consent, participants were scheduled for an appointment to complete a demographic questionnaire, the Brief Pain Inventory (BPI), and the Reiki Knowledge Assessment Questionnaire. Participants were then provided a brief overview on the history, concept, and uses of Reiki. Upon departure, participants were given a pain medication diary to record anything (e.g., medication, nonpharmaceutical interventions) that was used to relieve their pain.

On the day of their Reiki sessions (a minimum of 1 day to a maximum of 3 days between sessions), participants completed a series of questionnaires (the Defense and Veterans Pain Rating Scale, DoD/VA Pain Supplemental Questions, BPI, McGill Pain Questionnaire—Short Form, and Patient Global Impression of Improvement Scale) to provide data regarding their pain. Participants then received a 30-minute Reiki session by a trained Level 1 practitioner. All practitioners repeated the same script, performed the same 10-position hand placement protocol, and were told to keep talking to a minimum. Fidelity checks were performed to ensure that the protocol was being followed consistently. At the end of the study, participants completed the Reiki Knowledge Assessment Questionnaire once again, along with a post-study questionnaire about their experience.

Results

Study Aim 1: Examine patient knowledge, satisfaction, acceptance, and impression of Reiki therapy as a complementary and alternative option for the management of pain.

A comparison of the pre- and post-Reiki knowledge assessment scores showed a 43.4% increase in the number of people who obtained a perfect score. The most commonly missed question, however, remained distinguishing between Reiki, Healing Touch, and Therapeutic Touch.

After the completion of six sessions, participants completed a post-study questionnaire. When asked, "Would you recommend Reiki?" 80.8% of the participants said yes. When asked, "If Reiki services became available at Landstuhl Regional Medical Center, would you make an appointment?" 80.8% also said yes. Finally, when asked, "How many times per month would you be willing to come in for a Reiki session?" 41.7% indicated "four times per month," followed by 29.2% indicating "more than four times per month."

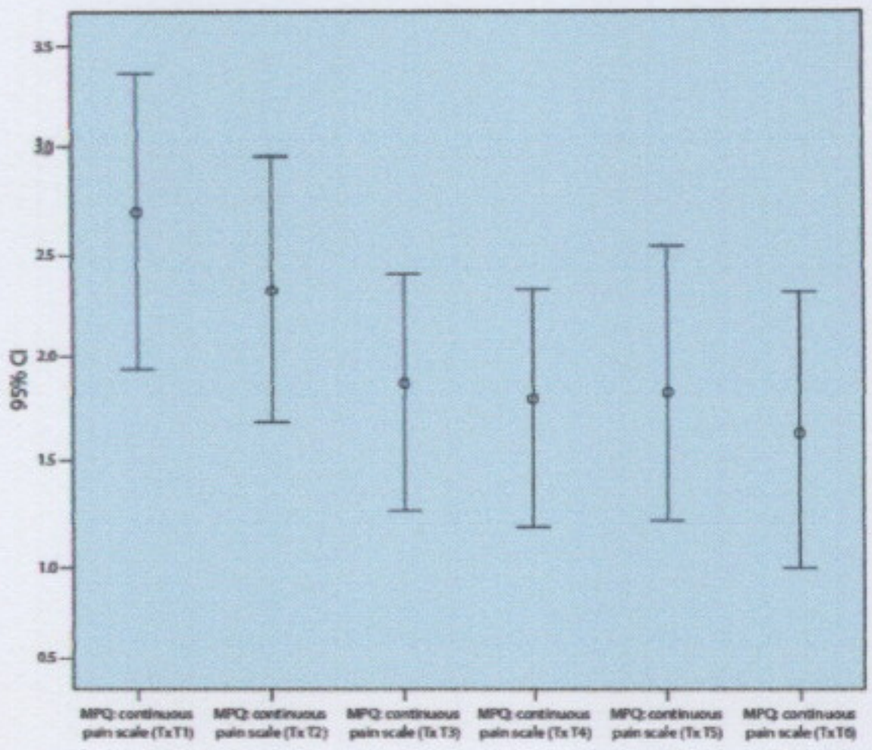
Participants' impression of their improvement was assessed at Treatments 3 and 6. At Treatment 3, 60.0% reported feeling "a little better," and 30.0% reported "no change." However, at Treatment 6, 46.7% reported feeling "a little better," and 26.7% reported feeling "much better."

Study Aim 2: Assess a six-treatment course of Reiki therapy on pain outcomes (present, average, and worst pain; intensity levels; and perceptions of pain relief) in military health care beneficiaries experiencing chronic pain.

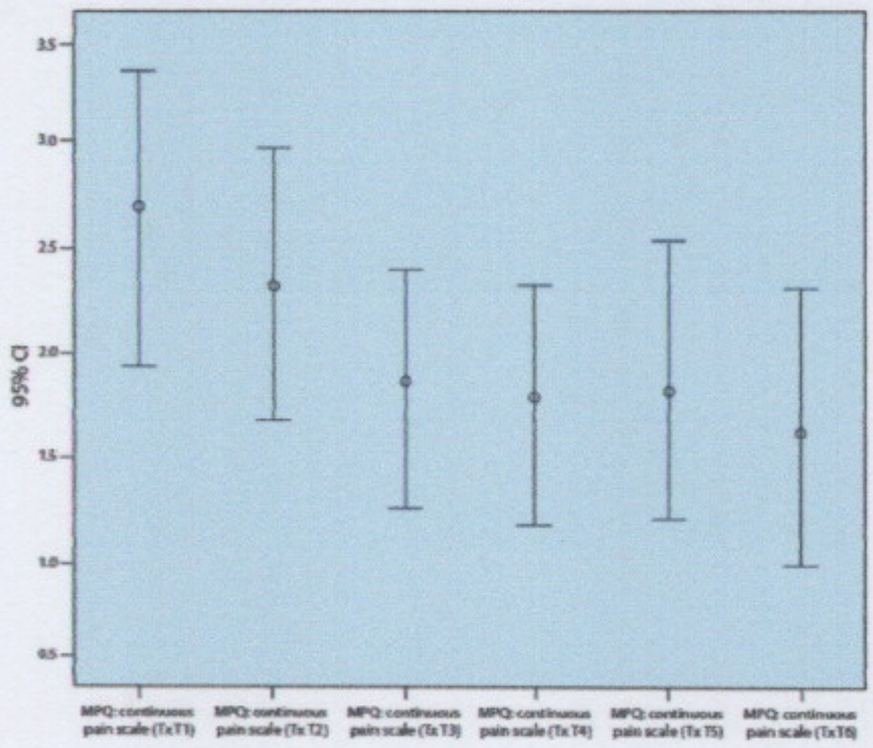
There was a significant difference ($p \leq .001$) in present, average, and worst pain over the six sessions, showing a 25.6%, 18.0%, and 16.2% decrease, respectively, with the biggest effect occurring after Treatment 3.

Study Aim 3: Assess the trend of a six-treatment course of Reiki therapy on the pain interference, character, and quality of pain.

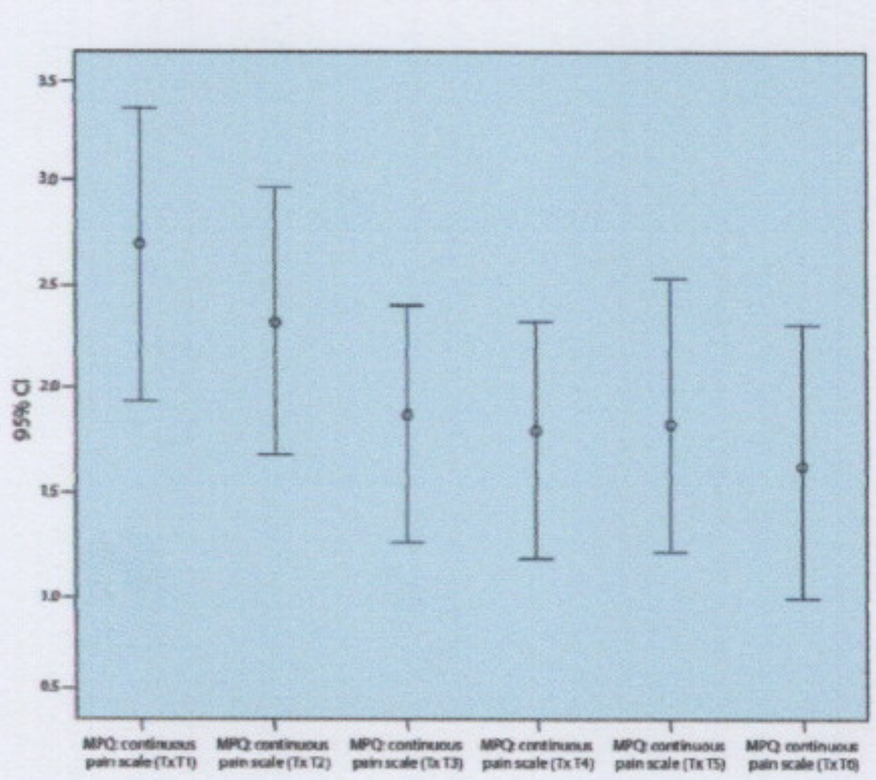
When the level of pain interference in participants' life was assessed, Reiki significantly ($p \leq .002$) decreased pain interference in six of the seven domains, with the biggest impact occurring at or after Treatment 3. Of the 23 different descriptors of pain that were assessed, Reiki had the most significant effect on pain that was described as throbbing, cramping, sharp, achy, tingling, or neuropathic ($p \leq .006$). Finally, whether the pain was continuous or intermittent, Reiki had an equally significant ($p < .001$) effect, once again showing the most impact at or after Treatment 3.



Present Pain



Average Pain



Worst Pain

Summary

This study showed that Reiki is in fact a viable complementary and alternative option for managing chronic pain, especially if the recipient receives at least three sessions (with no less than 1 and no more than 3 days between sessions). Reiki can be performed in clinics, at the bedside, and even in a deployed environment. It is safe and easy to administer, requires few resources, and can be taught to military nurses. It is imperative for military nurses to stay current on CAM modalities and to hone their ability to weed out literature that does not have scientific rigor, as well as to educate and provide opportunities for their patients to experience something that they might otherwise shun as ridiculous.

Reiki Master Petra Krebs; project director Judy Orina; and Reiki practitioners Shirlene Oduber, Jasmin Jacobs, Casey Villanueva, and Anja Seidl

Clinical Questions

Below are some great clinical questions that have been mentioned in the previous months. Many of these questions urgently need evidence to support future clinical and policy decisions. These would be great topics to consider if you are a current (or future!) military nurse looking for a project idea or if you are able to incorporate a few extra data points into an existing study.

1. What will the impact of the National Defense Authorization Act be, particularly with respect to potential changes in nurse staffing and nursing practice?
2. What are the gaps between usual evidence-based nursing practice at a military treatment facility (MTF) and a deployed location (for example, monitoring/clinical guidelines/bundles), and how could those gaps be mitigated?
3. What is the physiological effect of traumatic injuries that are submerged in salt water?
4. What is the influence of nursing on military-specific preventive care provided to warfighters in the deployed setting and at home station?
5. How should the military measure nursing-sensitive quality indicators that can be compared and benchmarked to civilian facilities?
6. What is the best way to share information about ongoing evidence-based practice projects that are being conducted at individual facilities?
7. What is the impact of vitamin D deficiency on military readiness?
8. What new strategies could a program (such as TSNRP) implement to enhance collaboration among military nurse scholars?

If you identify other questions that haven't been addressed in the literature, feel free to submit them to TSNRP. We will compile them and include them in future newsletters as a way to share these ideas with the broader community. If you are addressing one of these gaps in the evidence, we want to hear about that, too!