



Reiki Research

It's Time to Shift Gears

BY ANN LINDA BALDWIN, PHD AND ANN THOMPSON

Introduction

Providers and recipients of Reiki experience its benefits first-hand. However, Reiki is not universally offered to patients by medical practitioners, nor is it usually paid for by medical insurance in the USA. As a result, many people have never heard of Reiki or are doubtful that it can help them. In order for Reiki to become an established, routine and widely available therapy in the medical world, its benefits must be scientifically established as evidence-based, rather than just anecdotal. Although a strong body of scientific evidence is emerging in support of Reiki's effectiveness, it has not currently reached the required level to convince the majority of medical professionals.

Scientific Status of Reiki Is Based Largely on the Results of Pilot Studies

From 1989 to 2019, there have been 77 English language research articles on Reiki published in peer-reviewed journals. (See www.centerforreikiresearch.org.) Of the higher-quality studies, those comparing Reiki to at least sham Reiki or standard-of-care treatments largely support the hypothesis that Reiki may help in increasing relaxation and wellbeing and reducing pain, burnout, and, in some cases, anxiety and depression. As a reminder, sham Reiki refers to the situation in which a person who is not trained in Reiki pretends to give the recipient Reiki by mimicking the hand positions. In this way, the recipient receives the personal attention and touch he or she would experience from a Reiki practitioner, but without the Reiki energy. By comparing peoples' responses to Reiki and sham Reiki, it is possible to distinguish the effects of the actual energy.

Of the above mentioned 77 peer-reviewed articles published on Reiki, all but seven are pilot studies—that is, a small-scale, preliminary study that is conducted to determine the feasibility, required time, cost, and risk of adverse events involved in this research, as well as the statistical variability within the data it produces. With this information, investigators can determine whether it is worth upscaling the study to a full-scale research project. It also enables the scientists conducting the research to determine the appropriate number of patients required to obtain meaningful results (Hulley, 2007). Pilot studies are conven-

tionally carried out before conducting large-scale research, in an effort to avoid wasting time and money on an inadequately designed project. The overall success and quantity of the Reiki pilot studies conducted to date suggests that the scientific community is ready for the next step: large-scale, randomized, controlled clinical trials to quantify the effects of Reiki on patients with various medical conditions.

What Are Clinical Trials and Why Do We Need Them?

Clinical trials are research studies designed with large numbers of subjects, to remove the risk of bias that could occur on a study with smaller numbers of participants. For example, pilot studies are often performed on people who are personally known by the investigator and they might not be representative of a larger population. Conducting larger-scale studies also helps to reduce the possibility of error in the findings that may occur when testing a small group of subjects which may include some people who are atypical. The exact number of participants required to reduce the risk of bias and error will depend on the number of experimental groups in the study's protocol but is usually at least 50-100 participants per group. For this reason, large studies are far more expensive to conduct than pilot studies.

The best clinical trials are controlled and randomized. That is, the study will include at least two groups, one of which (the "control" group) receives a placebo treatment, thereby serving as a comparison group when the findings are evaluated. Including a control group is an essential element of any well-designed experiment. The control group in most of the best Reiki studies usually receives sham Reiki or no treatment at all. In a double-blind, controlled clinical trial, neither the patient nor the researcher knows who is receiving Reiki and who is not. The best studies also include a "no-treatment" group, against which the sham-Reiki group is compared, to determine whether sham Reiki has any therapeutic effect on the patient. In randomized controlled trials, participants are allocated to each group (control groups or real Reiki recipients) by chance alone. If the assignment is not randomized, more participants would likely choose to be in the Reiki group, and very few would opt to be in the "no treatment" group.

Reiki research has now reached a point at which enough promising pilot data have been obtained to support the funding of the large-scale clinical trials required to provide scientific validation for offering Reiki routinely in hospitals, hospices, clinics and other medical settings. Of the seven pilot studies cited above, six found that Reiki is significantly more beneficial than standard-of-care treatment for a range of disorders, including high blood pressure (Salles et al, 2014), discomfort during chemotherapy (Catlin and Taylor-Ford, 2011), pain (Gillespie et al, 2007; Kurebayashi et al, 2016), depression (Charkhandeh et al, 2016) and anxiety (Chirico et al, 2017). Although one study indicated that neither Reiki nor sham Reiki improved fibromyalgia, no standard-of-care group was included for comparison, so the findings are not as elucidating as they could have been. The research on Reiki's effectiveness is promising, but more large studies are needed to convince medical practitioners and business people to invest their time, money and effort in researching how Reiki can serve as an adjunct to allopathic medicine. Only through successful, scientifically robust, large-scale clinical trials will the decision-makers at top scientific and medical institutions be convinced to support the widespread use of Reiki in hospitals, clinics and hospices.

Reiki for Knee Surgery—Justification for a Clinical Trial

Total knee arthroplasty (TKA), also known as total knee replacement, is one of the most commonly performed orthopaedic procedures in the United States. As of 2010, over 600,000 TKAs were being performed per year (per the Healthcare Cost and Utilisation Project). The number of TKAs performed annually in the United States is expected to increase by more than a factor of eight by 2050, as compared with 2012, resulting in 2,854 procedures per 100,000 patients (Inacio et al, 2017).

Two pilot studies have been conducted on the effects of Reiki on patients who underwent TKA (in 2016 by Notte, Fazzini, & Mooney; in 2017 by Baldwin, Vitale, Brownell, Kryak, & Rand), and both showed positive results. In both cases, Reiki was given to patients before and after surgery, and in both cases the patients who received Reiki experienced significantly less pain than those who did not. In the 2017 study, patients were randomly assigned to Reiki, sham Reiki or bed rest. When comparing pre-surgery findings to the patients' symptoms 48 hours after surgery, only the Reiki group showed significantly less pain, lower blood pressure and reduced anxiety. The Reiki group also needed significantly less pain medication than the other two groups, and a greater percentage of them had been discharged from the hospital 48 hours after surgery.

These feasibility studies support the pursuit of a large scale clinical trial to evaluate whether Reiki will be a useful addition to routine care of patients undergoing total knee replacement surgery.

Reiki for Knee Surgery—Outline of Clinical Trial

A large-scale, randomized, controlled, multi-center clinical study is now planned at University of Massachusetts Medical Center in Worcester, MA and Saint Vincent Hospital in Worcester, MA. There will be a total of 50-100 participants in the Reiki group, 50-100 participants in the sham-Reiki group, and 50-100 participants in the control group. Subjects will be assessed for pain level, blood pressure, respiration rate and anxiety both before and after surgery, and the use of pain medication also will be monitored.

In addition to the clinical results that will be gained from this planned study, the data on patient outcomes and satisfaction obtained from the two hospitals, for such a low-cost offering as Reiki, should indicate the potential for significant cost-savings to healthcare providers, insurers, and patients alike. Pain-management medications cost hospitals, on average around \$20,000 annually for opioids (Hassan et al, 2016) and an average length of stay costs about \$2,383/day in the United States (Shaffer et al, 2016). Moreover, providing a non-narcotic alternative to pain management fulfils a key Joint Commission mandate¹ and may reduce the risk of post-surgical opioid addiction. Thus, positioning Reiki as a cost-effective and regulatory-compliant adjunct to standard-of-care treatments should foster a more widespread adoption and acceptance of Reiki across a wide range of clinical settings.

Make A Donation

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Footnote

¹ Per the Joint Commission, at: https://www.jointcommission.org/assets/1/118/R3_Report_Issue_11_Pain_Assessment_2_11_19_REV.pdf.

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