

The Effectiveness of Treating Anxiety With Reiki

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Abstract

The effectiveness of treating anxiety with Reiki is explored within ten quantitative studies. Methodology utilized for a critical appraisal and systematic review of the literature is explained with inclusion and exclusion criteria. Theoretical framework for the project is grounded in the work of Hildegard Peplau, whose nursing theory based on the therapeutic use of self is foundational for Reiki implementation. A thorough critique of the literature is conducted for key components of robustness and believability. This critique is conducted using a structured guide addressing synthesized strengths and weaknesses of the body of literature. A synthesis of the literature explores the findings of the studies. This synthesis reports on Reiki's effectiveness in treating anxiety within a variety of patient settings and populations, its effect on subscales of anxiety, physiological manifestations of anxiety and pain associated with anxiety. Cultural considerations effecting Reiki's potential effectiveness are discussed. Gaps in the literature are examined, including the studies' narrow sample population, lack of participant exclusionary factors for controlled outcome data, and the lack of studies across time. Implications for future research are discussed with recommendations for expanded research that includes a broader variety of settings, age groups, and patient diagnoses, including anxiety disorders, for research data that is transferable. Implications for further practice for the advanced practice registered nurse (APRN) are explored, with the potential benefits for both providers and patients, including improved patient satisfaction and expansion of provider treatment modalities.

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The Effectiveness of Treating Anxiety with Reiki

Anxiety is a widespread mental health concern affecting up to one-third of the United States population at some point during an individual's lifetime [21]. Individuals with anxiety disorders often have impairments socially, professionally, and in their physical health [20]. National healthcare costs for the management of anxiety disorders are estimated at \$46.6 billion annually, 75% of the expenses being attributed to anxiety-related morbidity, mortality, and loss of job productivity [11]. The novel coronavirus of the 2019 (COVID-19) pandemic has increased these statistics globally, with 76 million newly diagnosed cases of anxiety disorders since its onset, with a 25% overall increase in the disorders'

prevalence [9]. With the increasing rates of anxiety disorders and the associated healthcare burden, a focus on the diagnosis and treatment of anxiety disorders claims new relevance.

Beyond the economic impact of anxiety disorders, the psychosocial impact on the quality of life is another concern. Mood disorders are often a precursor to substance use disorders. The comorbidity of the two disorders is not only predictive of their presence, but also of their severity, with a more severe mood disorder driving a more problematic or potentially fatal subsequent substance use disorder [16]. It is believed that up to 90% of individuals who commit suicide have a psychiatric illness, most frequently a mood disorder [23]. Suicide remains the tenth leading cause of death in the United States and the second leading cause of death among Americans ages 10-34, claiming over 47,500 American lives annually [5], and claiming over 700,000 deaths annually worldwide [28]. As with any disease process and its related mortality and morbidity rates, investigating contributing risk factors is essential.

Anxiety is assessed utilizing evidence-based standardized screening tools. The Generalized Anxiety Disorder-7 (GAD-7) screening tool assesses anxiety levels using subscale areas of anxiety on a 4-point Likert scale of seven items with scoring ranges from 0 to 21, addressing elements of anxiety including nervousness, irritability, worry, restlessness, and fear [19]. Other standardized anxiety screening tools include the State-Trait Anxiety Inventory (STAI), the Hospital Anxiety and Depression Scale (HADS), the Anxiety Depression Stress Scale (ADSS) and the Adult Manifest Anxiety Scale (AMAS) [10]. The Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), gives criteria for diagnosing anxiety disorders [1]. Symptoms assessed in this category include irritability, worry, fear, restlessness, fatigue, and muscle tension, with these symptoms often causing distress in social functioning [1].

Treatment for anxiety often includes psychopharmaceuticals, which can be effective in reducing anxiety symptoms while potentially introducing bothersome side effects, dependence, and compliance issues [3]. Given the large population affected by anxiety, and the obstacles involved with psychopharmacology use, Complementary Alternative Medicine (CAM) has gained interest as a treatment for anxiety. CAM includes modalities such as yoga, meditation, mindfulness, and Reiki. Among these, Reiki is less understood and researched for the potential efficacy in the treatment of anxiety.

Reiki is a form of biofield energy healing, aimed to balance the Chi, or universal energy, within the body [2]. Reiki was originally developed in Japan in the 20th century, as a way of clearing negative energy blockages that prevent the natural flow of this healing energy within the body [12]. The Reiki practitioner directs energy from the universe to the recipient in areas where energy blockages are sensed, using systematic hand movements above the recipient's body [27]. Energy imbalances within the recipient are cleared and homeostasis of mind, body and soul are restored, creating a sense of well-being [12]. The purpose of this study is to explore what is known about Reiki and its efficacy in treating anxiety, and to answer the PICO question: In patients with anxiety (P), how does the administration of Reiki (I), when compared to the administration of sham Reiki or no intervention (C), affect self-assessed anxiety levels (O)?

Methodology

A critical appraisal and systematic review of the literature was conducted using a comprehensive search of the Massachusetts College of Pharmacy and Health Sciences (MCPHS) library and Google Scholar databases. Articles obtained from the MCPHS database searches were

sourced from primary research such as Supplemental Index, Cumulative Index to Nursing and Allied Health Literature (CINAHL), HealthWatch, MEDLINE PubMed, eScholarship, Proquest, and ScienceDirect. Articles obtained from Google Scholar were sourced from primary research such as the United States National Library of Medicine-National Institute of Health, ScholarWorks- California State University, and SciELO- Scientific Electronic Library Online.

The use of the MCPHS online library and limiting the search to peer-reviewed articles published 2017 or later, resulted in 136 articles using the keywords: *Reiki* and *anxiety*. The same methodology was utilized in Google Scholar, in which over 4,190 articles were obtained. Additional keywords *energy healing* were utilized to broaden the search. The same filters were applied, and these keywords resulted in 99 additional articles. Reference sections of studies identified only duplicate sources, so these were eliminated. ResearchGate was utilized, resulting in a source emailed directly from the author.

Inclusion criteria for this project required that articles were published 2017 or later, as they offered research current enough to be meaningful for this study. Only primary research was considered for this study, regardless of the study design. Scholarly, peer-reviewed articles met inclusion criteria. Studies that did not assess anxiety levels of patients were excluded. Though depression is often linked with anxiety in mental health treatment, studies focusing solely on depression were excluded. Some articles were excluded due to lack of accessibility. Using these inclusion/exclusion criteria, 10 quantitative study articles remained for inclusion in this project.

Theoretical Framework

Hildegard Peplau was revolutionary in the field of psychiatric nursing. She is described in many accounts as the mother of psychiatric nursing [14]. Peplau created the interpersonal relations theory, a model of the nurse-patient relationship that unfolds in three basic phases: orientation, working, and resolution [22]. Peplau later expanded on this concept by introducing a model of interpersonal relations that replaced the working phase with two delineated phases: identification and exploitation [14]. Peplau identified six essential roles of the nurse within the interpersonal relations model: stranger, teacher, resource person, counselor, surrogate, and leader [18]. Peplau was the second published nurse theorist, following Florence Nightingale. Nightingale asserts that nursing cannot be led strictly by empirical science, rather the nurse's therapeutic use of self is essential to promoting patient well-being [14]. Peplau's conceptual framework can be applied to any area of nursing and fits especially well with the model of care for the psychiatric mental health nurse practitioner (PMHNP).

Patients with anxiety are particularly vulnerable. Easily flooded with overwhelming feelings, both emotional and physiological, they are at risk for termination of treatment if the treatment proves to be too stressful. It is the ethical and professional duty of the PMHNP to establish rapport with the patient and create a foundation of trust in the orientation phase of treatment. Incorporation of Reiki into a patient's treatment plan fits into Peplau's phases of nurse-patient relations model, with the role of PMHNP in its process spanning from stranger, to resource person to counselor. If the PMHNP is administering the Reiki therapy, the required, extended proximity to the patient demands a level of trust and respect that is best created with adherence to Peplau's interpersonal relations theory.

Critique of the Literature

A comprehensive, in-depth critique of the included literature was conducted using step-by-step

guidelines [8]. Key components of the research believability and robustness were assessed per these guidelines.

Quantitative Articles

Ten quantitative studies were included in this research [2, 4, 7, 13,15,21, 24, 25, 26, 27]. These studies were analyzed using step-by-step guidelines for critiquing quantitative research [8].

Elements Influencing Believability of the Research

Elements that influence the believability of the research include the article's writing style, author's credentials, report title's conciseness, and presence and quality of the abstract [8].

Writing Style. The writing style of the included articles was overall of high-quality. Collectively, the writing was concise and well-organized and free from jargon and grammatical errors.

Authors. The authors were well-equipped to conduct studies on anxiety and its treatment. The articles were authored by writers with degrees in nursing, philosophy, psychology, or medicine [2, 7, 13, 15, 21, 24, 25,26, 27]. With degrees in medicine, nursing, psychology and philosophy, all writers also were credentialed to participate in studies focusing on Reiki and anxiety. They were similarly equipped to ask appropriate research questions relevant to the study focus [8]. One author is an undergraduate student whose major is not stated [4].

Report Title. Overall, the report titles conveyed the purpose of the studies concisely. Some exceeded fifteen words in length [4, 2, 7, 26]. This is the recommended limit for conciseness of quantitative research article titles [8]. None was too short or misleading in its wording. No grammatical or spelling errors were noted in any of the titles of the articles. Some of the titles included keywords *Reiki* and *anxiety* [2, 15, 24, 21, 27]. Two that lacked the keyword *anxiety* in the title included a related keyword, such as *well-being*, *stress levels* and *psychological health* [13, 26]. The remaining titles did not have clearly applicable keywords [7, 25, 26].

Abstract. The abstracts varied some in style and quality among the ten articles. Five were clearly written with bolded topics and conveyed a professional introduction to the study with clear and concise information, allowing for easy review of the article [13, 15, 21, 24, 26]. Five of the articles provided abstracts in paragraph format, which were slightly less concise and more cumbersome to review quickly, but provided similar information [2, 4,7, 25, 27].

Abstracts of high quality should include the following: purpose of the study, method, sample size and selection [randomized or not], findings, conclusions, and recommendations for future research [8]. Only one article effectively touched on all needed points [26]. Four articles covered all topics within the abstract, with the exception of including recommendations for future research [7, 13, 15, 21, 24]. The remaining abstracts were missing two or more elements [2, 4, 25, 27].

Elements Influencing Robustness of the Research

Elements of a study that influence the robustness of the research include a clearly stated purpose of the study, logical consistency of the flow of the article's elements, a comprehensive literature review, theoretical framework to ground the study, objectives that reflect the literature review, appropriate sampling of participants, ethical considerations, and solid methodology of the study with discussion of findings and recommendations for future research [8].

Purpose/Research Problem. In all included studies the research purpose is clearly stated in the beginning of the article [2, 4, 7, 13, 15, 21, 24, 25, 26, 27]. In eight of the studies the purpose was

stated in the article's abstract [4, 7, 13, 15, 21, 24, 25, 26]. In two studies the purpose was listed at the beginning of the article under a heading separate from the abstract [2, 27]. Overall, the research problems of the included studies were clearly stated and relevant for inclusion in this project [2, 4, 7, 13, 15, 21, 24, 25, 26, 27]. The research questions were narrow enough to be focused research topics [8].

Logical Consistency. The articles flowed in a logical manner. Each article opened with an introduction to the study and gave background information. The articles moved through each topic area in such a way that the reader could understand the background, methodology, study design and data analysis, ending with a conclusion and/or recommendations [2, 4, 7, 13, 15, 21, 24, 25, 26, 27]. Logical consistency aids the reader in following the steps of the research [8].

Literature Review. Seven of the ten articles included a literature review [4, 2, 13, 15, 25, 26, 27]. Three of the articles' literature reviews were detailed and thorough [15, 26, 27]. The literature review was logically organized in only two of the seven articles with literature reviews [26, 27]. Two of the seven literature reviews focused exclusively on studies published within five years of the article's publication [13, 25]. Studies included in quantitative research are held to the standard that they are current, having been published within five years of the article [8]. Primary sources of empirical nature were exclusively reviewed in four of the seven articles [4, 15, 25, 27]. One literature review included a balanced critical analysis, discussing strengths and weaknesses of the studies reviewed [15]. Four of the seven articles' literature reviews consisted of a brief paragraph or two, lacking detail, depth, or analysis [4, 2, 13, 25].

Theoretical Framework. Only two of the ten articles incorporated a theoretical framework that was clearly stated [2, 15]. In these articles the conceptual framework was both adequately described and appropriate for the studies [2, 15]. The connection of the two are essential for a solidly grounded theoretical framework [8].

Aims/Objectives/Research Question/Hypotheses. Seven of the studies clearly stated objectives [4, 13, 15, 21, 24, 25, 26]. Two of the studies identified as experimental or quasi-experimental [15, 24]. Two of the studies included a research hypothesis [4, 7]. A hypothesis is an essential component in the format of experimental and quasi-experimental studies [8]. One study, identified as a randomized control trial (RCT), also included both a study objective and linked hypotheses [7].

Sample. Sample sizes varied widely among the included studies. The smallest included a sample of only four participants, which the writer acknowledged as a limit to transferability of the study data [27]. Other sample sizes ranged from 46 to 1,411 subjects [2, 13]. These larger sample sizes reflect a more appropriate number of participants to ensure accurate study results. It is known that errors in research decrease, and transferability increases with larger sample sizes in studies [8]. A target population was identified in each article, except for two that focused on a general population with no specified criteria [4, 13]. Seven of the ten articles utilized probability sampling [2, 4, 7, 13, 21, 26, 27]. The remaining three articles utilized non-probability convenience sampling [15, 25, 27]. Exclusion/inclusion criteria were identified in seven of the ten articles [2, 7, 15, 21, 24, 25, 27]. The remaining three articles did not mention utilization of exclusion/inclusion criteria [4, 13, 26].

Ethical Considerations. Eight of the ten articles addressed ethical considerations [2, 7, 13, 21, 24, 25, 26, 27]. Ethical considerations should ensure that participants are fully informed of the nature of the study, confidentiality measures are taken, participants are protected from harm, and ethical

permission was granted for the study by an appropriate overseeing committee [8]. Two of the ten articles included ethical considerations covering all required elements [2, 7]. One article covered all ethical elements, with the exception of citing ethical permission granted by an oversight committee [25]. Another article covered all ethical elements but did not mention confidentiality [21]. The remaining four articles were missing multiple elements of research ethics [13, 24, 26, 27].

Operational Definitions. The terms, theories and concepts mentioned in the studies were clearly defined [8]. The definitions assist the reader in understanding the methodology of the study and the tools utilized to measure the data obtained by the study.

Methodology. The design of the studies was identified in each article and varied widely among the included studies. None of the studies identified a precursor pilot study, however two were identified as being pilot studies [2, 4]. Reliability and validity testing were undertaken in all included studies using standardized, evidence-based instrument design for data assessment, and with results discussed in all articles.

Research Design. Of the ten studies, two were three-arm pilot studies using a Reiki intervention group, a sham Reiki group, and a standard of care (SOC) control group [2, 4]. Sham Reiki utilizes a non-certified layperson to mimic the hand movements of a Reiki practitioner while the recipient lies on a therapy table receiving what appears to be a valid Reiki session [2, 4]. Four of the ten studies were two-arm studies, with a Reiki intervention group and a SOC group [7, 15, 21, 24]. The four remaining studies were single-arm studies assessing only Reiki intervention groups [13, 25, 26, 27].

Data Collection. Data collection was conducted through written surveys completed by participants, except for one study, which utilized a verbal survey [4].

Instrument Design. Standardized anxiety screenings were utilized in seven of the ten studies [2, 7, 15, 21, 24, 25, 27]. The State-Trait Anxiety Inventory (STAI) was used to measure anxiety in four of the eight studies [2, 7, 15, 24]. The Hospital Anxiety and Depression Scale (HADS) was used in one of the eight studies [21]. The Anxiety, Depression, Stress Scale (ADSS) was used in one of the eight studies [25]. The Adult Manifest Anxiety Scale (AMAS) was used in one of the eight studies [27]. These evidence-based, standardized instruments for gathering data about anxiety are appropriate for the purpose of the studies [8]. The remaining three studies utilized non-standardized questions about anxiety levels, rated on a 10-point or 11-point Likert scale, designed for the purpose of the study [4, 13, 26].

Validity and Reliability. Utilization of evidence-based, standardized instruments helps to maintain consistency and validity of results [8]. The studies utilizing these methods meet this standard. The authors utilizing questionnaires designed for their studies risk known efficacy and substantiality for measurement of the addressed research variables [8].

Data Analysis and Results. Data Analysis was conducted through commercial statistical analysis software and by using standardized statistical tests in six of the ten studies [4, 7, 13, 15, 21, 24]. Two of the four remaining studies did not disclose the data analysis method or tests utilized to analyze the data [25, 26]. One of the remaining studies did not state the commercial statistical analysis software that was utilized but did state which standardized statistical tests were utilized [2]. One study utilized a visual analysis due to the small sample size [27]. Those that utilized commercial software and standardized statistical testing were appropriate in nature as they ensure reliability of data analysis [8]. All or most of the sample participants did participate in the studies conducted, avoiding response bias [8].

Discussion/Conclusion/Recommendations. All articles discussed the strengths and limitations of their study design, except for one [25]. Seven of the ten articles made recommendations for future research based on their study's findings, strengths, and limitations [2, 4, 7, 13, 15, 26, 27]. Three of the articles did not include recommendations for future research [21, 24, 25]. In the two studies with an identified hypothesis, one study's findings supported the hypothesis [7]. One study's findings did not support the hypothesis [4]. In the seven articles with literature reviews, five linked their findings back to the reviews [4, 13, 15, 25, 26].

References. In each article, all sources of information were accurately referenced at the end of the article [2, 4, 7, 13, 15, 21, 24, 25, 26, 27].

Synthesis of the Literature

A synthesis of the literature reports the studies' findings in a cohesive manner, identifying themes that emerged from the sum of the articles. Data are reported with levels of statistical significance of findings [8]. The following themes were identified: the effect of Reiki administered in various settings, the effect of Reiki on manifestations of anxiety, Reiki's interconnectedness with pain and anxiety, and cultural considerations of the implementation of Reiki.

Effect of Reiki on Anxiety

Reiki was found to reduce anxiety levels in all ten studies [2, 4, 7, 13, 15, 21, 24, 25, 26, 27]. Seven of the studies showed a statistically significant reduction in anxiety scores ($p < 0.001$) [2, 7, 13, 15, 25, 26, 27]. The remaining three studies showed reduced scores ranging from a 0.21 to 0.6 average decrease in points, however these reductions in points lacked statistical significance ($p > 0.05$) [4, 21, 24].

Effect of Reiki on Anxiety in Various Settings

Five of the studies focused on a preoperative/preprocedural setting [2, 7, 15, 21, 24]. Four of the studies were conducted in outpatient therapeutic settings [4, 13, 25, 27]. One study was conducted in an inpatient hospital setting [26]. In seven studies, Reiki administration was reported to reduce anxiety levels in all settings with statistically significant scores ($p < 0.001$), with STAI scores averaging a reduction of 4.8 to 7.0 points and other scales scores averaging a reduction of 1.9 to 5.25 points [2, 7, 13, 15, 25, 21, 24, 26, 27]. Reiki sessions varied widely in duration with sessions ranging from 15 to 90 minutes in length, and in quantity, with participants receiving a single session to daily sessions for 45 days [2, 7, 13, 15, 25, 26, 27]. In the remaining three studies, Reiki administration was found to reduce anxiety levels in each setting, however, with scores that lacked statistical significance [4, 21, 24]. Scores ranged in reduction from 0.21 to 1.2 points [4, 21, 24]. Reiki sessions varied less in this group, ranging in duration from 10 to 20 minutes, with each participant receiving one or two Reiki sessions [4, 21, 24].

Preoperative/Preprocedural

Reiki administered to preoperative/preprocedural patients resulted in statistically significant ($p < 0.001$) reduced average scores ranging from 4.8 to 13.76 points less than baseline, utilizing the State-Trait Anxiety Inventory, Y1 (STAI-Y1), [2, 7, 15]. Post treatment assessments of the religious and cultural considerations were thought to have resulted in reduced assessment scores that lacked statistical significance, with p -values ranging from $p > 0.05$ to $p = 0.782$ [21, 24].

Inpatient Medical

Reiki offered to patients on inpatient medical units as non-pharmacological intervention for anxiety

demonstrated statistically significant reduced anxiety scores ($p < 0.05$) on standardized screening scales [26]. The 11-point Likert scale questionnaire resulted in scores that averaged 3.94 at baseline pretreatment and 1.73 posttreatment, with a mean change of -2.21 points [26]. These patients were hospitalized for varying illnesses and conditions [26]. Reiki was more effective than massage in the reduction of inpatient anxiety levels with statistically significant scores ($p < 0.05$) post treatment in the two groups [26]. The massage intervention group showed a reduction of 1.84 points from baseline, compared to the 2.21-point reduction in the Reiki intervention group, and with a p -value of < 0.001 [26].

Outpatient Clinic

In the outpatient setting, the administration of Reiki resulted in a statistically significant reduction of self-reported anxiety levels, ranging on average a decrease of 1.9 points to 5.25 points on the various scales utilized to measure anxiety levels [13, 25, 27]. One study conducted in the outpatient setting showed reduced self-reported stress levels ranging from a 0.2 to 0.5 percent improvement over control group scores, however findings lacked statistical significance ($p > 0.05$) [4]. In this study the Reiki treatment group showed an average reduction of 2.5 points, while the sham Reiki and no intervention group ranged from 1.2 to 1.9 average reduction of self-reported stress levels [4].

Effect of Reiki on Related Manifestations of Anxiety

Seven of the ten studies assessed related manifestations of anxiety [2, 4, 13, 15, 21, 26, 27]. Three of the studies looked at vital signs in response to Reiki treatment as a physiological demonstration of anxiety [2, 4, 15]. Four of the studies looked at emotional subscales of anxiety, including tension, irritability, jitteriness, nervousness, fatigue, and stress and worry related to social concerns, rating them with standardized scales, such as the Positive and Negative Affect Schedule (PANAS) and the Spiritual Well-Being Scale (SWB) [7, 13, 26, 27]. The data from these related manifestations of anxiety and emotional subscales of anxiety will be discussed in detail.

Emotional Subscales of Anxiety

In studies of Reiki administered for the reduction of anxiety, four studies assessed specific subscales measuring facets of anxiety [7, 13, 26, 27]. These subscales measured tension, irritability, jitteriness, nervousness, fatigue, and stress and worry related to social concerns [7, 13, 26, 27]. Tension, irritability, jitteriness, nervousness, fear, fatigue, and worry and stress related to social concerns were reduced with statistically significant lower scores ranging in t -test score changes of -20.03 to -28.8, ($p < 0.0001$) [7, 13, 26, 27].

Physiological Manifestations of Anxiety

The autonomic nervous system responds to anxiety with nonspecific physiologic changes. Reiki treatments have been shown to reduce these vital signs with statistically significant scores ($p < 0.05$) [2, 4, 15]. After the administration of Reiki, blood pressure was reduced with systolic scores reduced in range from 141 mm Hg to 116 mm Hg, and diastolic scores from 77.1 mm Hg to 59 mm Hg [2, 4, 15]. Heart rate was reduced in a range from 75.6 bpm to 66.3 bpm with the administration of Reiki [4, 15]. Respiratory rate was reduced in a range from 20.1 breaths per minute to 16.3 breaths per minute [2, 15]. Reiki sessions ranged in duration from 10 to 30 minutes, and in quantity, with participants receiving one to four sessions [2, 15].

Reiki's Interconnectedness With Pain and Anxiety

Reiki's effect on perceived pain was assessed in four of the ten studies utilizing a ten-point scale, with ten being the worst pain and zero being an absence of pain [2, 13, 15, 26]. Findings on Reiki's effect on pain as it relates to anxiety levels will be discussed further.

Pain reduction with Reiki Intervention

Pain scores were shown to be reduced with statistical significance ($p < 0.05$) with administration of Reiki preoperatively, when compared to sham Reiki and SOC control groups [2, 13, 15]. Pain scores reduced from an average of 4.75 to 1.4 on a 10-point Likert pain scale [2, 13, 15, 26]. Postoperative and postprocedural patients who received Reiki also reported statistically significant reduced pain scores ranging from 1.4 to 2.71 average lower scores when compared to SOC control groups, with p -values ranging from $p < 0.001$ to $p < 0.003$ [2, 15, 26]. Pain reduction associated with congruent anxiety reduction was observed with a Pearson correlation coefficient of $r = 0.20$ in one study that measured this relationship [13]. Reiki sessions ranged in duration from 20 to 90 minutes, and in quantity, with participants receiving one to four Reiki sessions [2, 13, 15, 26].

Cultural Considerations with Potential Effectiveness of Reiki

Studies involving American patients showed that Reiki provided a statistically significant ($p < 0.001$) reduction in anxiety symptoms [2, 13, 15, 26, 27]. These studies utilized various screening tools, such as the STAI, AMAS and a 10-point Likert scale with up to 8% reduction in anxiety scores [2, 13, 15, 26, 27]. Reiki sessions ranged in duration from 15 to 90 minutes [2, 13, 15, 26, 27]. Italian and Indian patients studied also showed statistically significant ($p < 0.001$) reduction of anxiety levels, with scores 25% to 50% lower after the administration of Reiki [7, 25]. These studies ranged widely in their administration of Reiki, with sessions lasting 15 to 60 minutes, for anywhere from one to 45 sessions [7, 25]. Turkish and Brazilian patients did not show similar results with reduction of anxiety scores [21, 24]. Turkish patients did show statistically significant different scores ($p < 0.05$) between the Reiki administration group and the control group due to increased self-reported anxiety levels of the control SOC group, as reflected with STAI scores decreasing from 40.03- 39.82 in one, 30-minute Reiki session [24]. Brazilian patients did show statistically significant improvement in self-reported existential and spiritual well-being after two, 20-minute Reiki sessions, and the authors note that the interpretation of well-being and the absence of anxiety symptoms are filtered through a cultural lens [21]. These scores were reduced on average from 2.1 points to 7.9 points on the Spiritual Well-being Scale [21].

Gaps in the Literature

The existing literature on Reiki's effect on anxiety is minimal and does not cover a wide range of study participants. Only two of the studies focused on the effect of Reiki on anxiety for individuals in treatment for an anxiety disorder [25, 27]. It is important that the research answer the question of Reiki's effectiveness in the treatment of anxiety for those experiencing it on a regular basis: patients with anxiety disorders. Only three of the ten studies indicated that taking anxiolytics or other psychotropic medication for mood was an exclusionary factor for study participation, therefore, a comparison of individuals with and without preexisting anxiety conditions, and with and without psychopharmacological treatment was not conducted [2, 15, 21].

Five of the ten studies focused on the effect of Reiki on preoperative patients' anxiety levels, which focused half of the literature on a narrow population [2, 7, 15, 21, 24]. One study that conducted three or four Reiki sessions per patient, with one session preoperatively and the remaining postoperatively, did not report on the anxiety levels of participants after their first Reiki session preoperatively [2]. The scores reported in this study were assessed prior to the first treatment preoperatively, then at discharge after subsequent treatments, when preoperative anxiety is naturally concluded and mood-altering pain medication is likely being given [2]. Six of the ten studies utilized only a single Reiki session to assess anxiety levels, as opposed to looking at cumulative effects of the intervention over time [4,7,13,15,24, 26]. Two of the studies utilized convenience sampling at Reiki centers, where the participants were biased towards open mindedness and previous knowledge of Reiki's potential benefits [4,13].

Implications for Future Research

Patient satisfaction is indicated in future research implications, as an increase in Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys benefits both the hospitals and the consumers [2]. These patient satisfaction scores are public and affect hospital Medicaid and Medicare reimbursement rates [6]. For a broader and deeper understanding of Reiki's potential benefit in the treatment of anxiety, several different settings, diagnoses, and age groups need to be studied [2, 15]. Reiki's benefit on inpatient settings where anxiety levels are commonly high, such as on intensive care units, burn units, and inpatient substance abuse units, would broaden the research and make findings more transferrable [24]. Including all age groups in various studies would indicate if the intervention is beneficial across the lifespan [15]. Studies need to be conducted in a wide array of settings, both inpatient and outpatient, to show the full potential of Reiki as an intervention for patients receiving primary, secondary and tertiary care [15]. Differentiating studies and study participants by whether preexisting anxiety disorders are present, and if anxiolytic or other psychopharmacological treatment is being utilized, is critical in creating studies that identify individuals who would benefit from Reiki treatments for anxiety. These studies need to be conducted over time to explore the potential long-term benefits of Reiki as a treatment for anxiety, utilizing a series of Reiki sessions to explore potential maximum efficacy [13,7, 26]. Reiki practitioners work at three different skill levels, including level one, level two, and Reiki master. The skill level of the Reiki practitioners in a study should be congruent, ruling out wide variance of the treatment rendered [13].

Implications for Further Practice

For the advanced practice registered nurse (APRN), research on Reiki could potentially open the door to a low-cost, safe alternative intervention for treating anxiety across many patient care settings. Identifying means to treat anxiety nonpharmacologically allows the APRN to limit prescribing risks associated with anxiolytics that are controlled substances, such as dependence and diversion. Having CAM modalities offered alongside traditional therapies within the APRN practice increases patient satisfaction [26]. Patients report higher levels of satisfaction with their care when they experience their provider as unhurried, present, and compassionate [15]. Nurses are trained on a holistic body, mind, and soul model, which is well-tailored to the implementation of a guided energy therapy such as Reiki. Hildegard Peplau's interpersonal relations theory sets solid theoretical framework for the appropriateness of studying Reiki's potential benefit for patients of APRNs [22].

Conclusion

The existing literature on Reiki's effectiveness in treating anxiety shows great promise for its potential as a low-cost, low-risk alternative treatment modality. With up to one third of the US population being affected by anxiety at some point in their lives, treatment for anxiety has great significance to society [21]. The studies included in this work are representative of current, primary research on Reiki's effectiveness in the treatment of anxiety, screened with a comprehensive search of two major databases. This project was grounded in the nursing theory of Hildegard Peplau, who theorized that nursing care cannot be led strictly by empirical science, but requires the nurse's therapeutic use of self [14]. This theoretical framework supports both the need for substantial research to provide evidence-based data on Reiki's effectiveness, as well as the need for the APRN to identify as part of the therapeutic alliance. The ten studies included in this project were subjected to a comprehensive, in-depth critique for believability and robustness. All ten studies included in this work demonstrated reduced anxiety scores when Reiki was administered, seven of them with statistical significance [2, 4, 7, 13, 15, 21, 24, 25, 26,27]. These reduced anxiety scores were demonstrated across a variety of populations and settings [2, 4, 7, 13, 15, 21, 24, 25, 26, 27]. Reiki was shown to affect not just anxiety, but nuanced subscales of anxiety, pain, and physiological manifestations of anxiety [2, 4, 13, 15, 26]. Cultural considerations showed that Reiki, when filtered through a cultural or religious lens, may yield different results and require further research [7, 25, 21, 24]. More research needs to be conducted to determine the extent of the potential efficacy of the intervention. Broader research needs to be conducted to examine which settings and populations could benefit from Reiki as a treatment for anxiety. Large, randomized sample sizes in blind studies will yield transferrable results. With additional research on the potential effectiveness of treating anxiety with Reiki, the world of CAM is furthered and APRNs broaden their options for delivering safe, effective, evidence-based care to their patients.

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