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HYBRID HEALING: REIKI AND THE INTEGRATION OF COMPLEMENTARY
AND ALTERNATIVE MEDICINE (CAM) INTO BIOMEDICINE

by

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A Thesis Submitted in Partial Fulfillment
of the Requirements for a Degree with Honors
(Anthropology and Psychology)

The Honors College

University of Maine

May 2012

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Abstract

This thesis explores complementary and alternative medicine (CAM) through research on the modality of Reiki. Reiki is an energetic practice that uses the “laying on of hands” to facilitate healing. The aim is to give insight both on a specific mind-body-spiritual practice and on how Reiki and similar modalities might be accepted as treatments and integrated into biomedicine. Research was completed through standard anthropological methods: interviews, participant observation, and field notes. Twenty-seven Reiki practitioners were interviewed to learn about their perspectives on Reiki and the progression towards integration.

Through analysis of the interview transcripts and participant observation, I developed a number of themes. For organizational purposes, the themes were grouped into three levels of analysis: the institutional level, the practitioner level, and the patient level, following the approach used by anthropologist Susan Sered in her 2007 article “Taxonomies of Ritual Mixing: Ritual Healing in the Contemporary United States.”

At the institutional level, I suggest that integration is based on a spectrum and that CAM modalities range in their progression towards integration in aspects such as insurance coverage and requirements for becoming a practitioner. At the practitioner level, I suggest that practitioners affect integration progression by impeding cohesion of Reiki as a modality through mixing rituals, individualizing philosophies, and individualizing terminology from biomedicine. Analysis of the patient level examines the ambiguity and mixed information given to Reiki clients. I also explore some of the possible ways that Reiki can heal and the kinds of conditions Reiki is being utilized to heal.

Acknowledgements

Thank you to all my committee members especially my advisor Ann Acheson, for without your guidance and support this thesis would have never have been completed. To my family and friends, thank you for being so understanding during the research and writing of this thesis. Your help and words of wisdom really help me to push through until the end. Finally, thank you to all the individuals who allowed me to interview them because without all the information, insight, and time you provided, this project would have never been possible.

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CHAPTER I: INTRODUCTION

"Approximately 4 in 10 Americans will use a complementary and alternative medicine (CAM) therapy this year" (Barrett 2003: 417)

"Peaceful Energies: Balance your Energetic Body, Physical Body, Emotions and Spirit," "Healing Arts and Psychic Festival," "Healing and Pray Circle-Free," and "Teachings of Tibetan Buddhism," are a few of the many healing modality advertisements appearing in the newspapers of Maine. In recent years, there has been an increase across the state in establishments dedicated to healing therapy, along with other sectors of complementary and alternative medicines. These range from aromatherapy in Richmond to aura cleansing in Freeport to acupuncture and Chinese traditional medicine in Hallowell. In Lewiston, the Patrick Dempsey Center for Cancer Hope and Healing at Central Maine Medical Center Hospital is having a workshop entitled, "Not Rakey, Reiki!" to teach the whole family about "Reiki and us[ing] healing energy to calm and soothe." The biomedical field has been the main resource for healing and curing disease and illness for over a century, but now complementary and alternative medicine (CAM) modalities are becoming increasingly popular.

In 1998, the National Center for Complementary and Alternative Medicine (NCCAM) was established by the National Institutes of Health to "explore these practices scientifically and to disseminate information to professionals and to the public" (Field 2009:3). The decision to establish a specific research center for medicine outside the biomedical field was based on the continuously growing interest in CAM that has been rising for over 30 years. In the 1970s, acupuncture gained media coverage after James Reston wrote about his experience with the practice in China. *The Relaxation Response*

by Herbert Benson was published in 1975 and explained how meditation could slow cardiac disease (Ruggie 2004:3). By 2001, "various studies have indicated that more than 40 percent of the U.S. population has used alternative therapies" (Rees 2001:vii). In a 2007 government survey, it was discovered that "Americans spent \$33.9 billion out-of-pocket on complementary and alternative medicine" (NCCAM "Americans").

As public interest rises, policymakers within the government as well as health care industries, insurance companies, and the health care community have given more recognition to complementary and alternative medicines. Integration of CAM is the process of a complementary or alternative medicine shifting from "marginal to mainstream" including: insurance coverage, use as a treatment in allopathic medical settings, acceptance, etc. (Ruggie 2004). In the state of Washington, it is mandated that health insurance plans cover CAM therapies, while the federal government has given NCCAM a 121 million dollar budget to research CAM therapies and their implications (Barrett 2003:417, Scienceblogs.com). Hospitals and physicians try to integrate "CAM therapies with the conventional health care system" in various ways by having physicians take classes in CAM therapies or by having CAM practitioners come into the hospital (Barrett 2003:417, Ruggie 2004:xiii). All over the nation "CAM therapies are used in addition to and/or instead of conventional forms of medical care available in U.S. hospitals or licensed physicians' offices" and "a number of 'integrated' delivery systems have been born" (Barrett 2003:417).

With the interest in CAM expanding, I decided to carry out a project to explore CAM through research on the modality of Reiki. Reiki is a mind-body-spiritual practice that uses the "laying on of hands" to facilitate healing. I came to the decision to research

the modality of Reiki and its integration into biomedicine for my thesis after a semester of exploring psychological and anthropological journals trying to find a topic that pulled my interests in religion and medicine together into the academic realms of both psychology and anthropology. Through this pursuit, I stumbled upon a text edited by Linda Barnes and Susan Sered: *Religion and Healing in America*. Many of the articles discussed spiritual healing therapies, CAM practices and their place in the United States. This text sparked my interest in CAM and its integration into biomedicine. It was during a conversation with my aunt, while discussing my new-found idea, that I was introduced to Reiki. She told me her experiences and provided some resources "just to check them out." I found Reiki as a healing modality to have a wealth of practitioners in the state of Maine. I also found many documents that tied to Reiki's integration into the biomedical field. After a discussion with my advisor and some additional preliminary reading, I decided to study the process of CAM integration into biomedicine through a focus on Reiki. I carried out research about Reiki through interviews, field notes, and participant observation, which are common practices in anthropology. Library research helped supplement information I gathered through these methods.

My research considers why Reiki is used in the U.S; how it is transmitted; and the psychological and socio-cultural reasons for the growth in Reiki. My aim is to give insight both on a specific healing practice and on how Reiki and other similar modalities might be accepted as treatments and integrated into biomedicine.

What is CAM?

Complementary and Alternative Medicine (CAM) is a concept derived from two smaller terms: complementary medicine and alternative medicine. Defining these two terms revolves around defining biomedicine. Biomedicine, or western medicine, is the “mainstream” or accepted healing practices of the United States that are based on the belief that biological factors are the basis for all ailments and illnesses (Straub 2007). Complementary medicine is any healing practice used in conjunction with or as a “complement” to biomedical practices (MacIntosh 1999:1). Alternative medicine is any healing practice that is used to replace or be an “alternative” to biomedicine practices (NCCAM “What”). Since both these terms have the common strand of dealing with practices outside the biomedical field, the practices are generally grouped together, especially since any medical practice outside biomedicine could be either complementary or alternative medicine, depending on how the individual uses the therapy (NCCAM “What”). With these two terms being fused together, the definition has become a very broad statement about what CAM is: “complementary and alternative medicine is an umbrella term given to a collection of disparate healing practices” and “the use and practice of therapies or diagnostic techniques that fall outside of conventional biomedicine” are how many of the definitions have been framed (Ruggie 2004:3, Straub 2007:429).

National research groups have developed more academically detailed explanations of what CAM has come to embody. One such group is the Cochrane Collaboration, an international group that facilitates the meticulous review of health care practices, including CAM (Cochrane). The definition given by the Cochrane

Collaboration explains CAM in terms that include more detailed analysis of healing practices and their placement in society:

Complementary and alternative medicine (CAM) is a broad domain of healing resources that encompasses all health systems, modulations, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. (Rees 2001: 2)

NCCAM recognizes four major categories of healing techniques within the CAM field: natural products, mind-body medicine, manipulative and body-based practices, and other CAM practices. The "other CAM practices" categories have subcategories of movement therapies, traditional healers, energy medicine, and whole medical systems (NCCAM "What"). Each one of these categories and subcategories is given its own definition. It is important to note that each modality does not fit neatly into each category and that there is no "authority over how CAM is classified or how CAM practices are defined" (Evans NCCAM). The energy medicine subcategory is particularly relevant to my work as this is the category under which Reiki has been placed. Energy medicine deals with "manipulation of various energy fields to affect health" (NCCAM "What"). There are two types of energy fields: veritable and putative. Veritable energy fields are based on energy fields that are measured, such as electromagnetic fields. CAM modalities such as light therapy and magnet therapy are under the veritable category. Putative energy fields are based on energy fields that have "yet to be measured" like qi gong and healing touch (NCCAM "What").

Reiki is an energy modality that falls under the putative energy field. It is a modality that uses the "laying on of hands" to facilitate healing. Specifically, a practitioner channels healing energy from the outside world through their hands into the

clients' bodies to fix blockages or disturbances within the client's personal energetic system (NCCAM "What"). Each person has their own energetic system, and when it becomes blocked this is when physical ailments manifest. Reiki works to heal these blockages before manifestation can occur.

Psychological Framework

Psychology has a number of ways to study CAM. One theoretical framework is based on the evidence-based medicine approach. Evidence-based medicine is the same approach by which biomedical practices have been studied and allows for the effectiveness of an intervention to be tested. Specifically, the evidence-based medicine approach "promotes the collection, interpretation, and integration for the best research-based evidence in making decisions about individual patients" (Straub 2007:428). This research allows for the benefits and risks of each treatment in CAM to be assessed and evaluated as to whether the treatment is worth utilizing (Elstein 2004:s185). One example of research-based evidence would be Baldwin, Wagers and Schwartz's (2008) study on the effects of Reiki on the heart rates of laboratory rats. Sprague-Dawley rats were implanted with radiotelemetric transducers and exposed "daily for 8 days to a 15-minute white noise regimen" (Baldwin, Wagers and Schwartz 2008:417). The laboratory rats were divided into two groups; one group which would receive Reiki and one group which would receive sham-Reiki. Sham-Reiki can be defined in a number of ways. It may be that a practitioner does not approach a client with the intent to heal them and just uses hand positions in Reiki, or a person with no Reiki training intimates a practitioner during a "session." Reiki or sham-Reiki was applied for the last five days (Baldwin, Wagers and Schwartz 2008:418). The research team found that Reiki "significantly reduces the heart

rates in the rats, but neither Reiki nor sham-Reiki had an effect on the mean arterial pressure (blood pressure)” (Baldwin, Wagers and Schwartz 2008:420).

Psychology also uses the mind-body model of health to study CAM. This model addresses the "complex interaction of mental, physical, and spiritual dimensions of health and illness" (Rockefeller and Brown 2007:xvii). The use of evidence-based medicine and mind-body approaches allows for a more complete view of why CAM may not be effective physically, but has mental and emotional positive effects that interact with the physical body positively. The biopsychosocial model (sometimes called the biopsychosocialspiritual model) takes the concepts of the mind-body model a step further to assimilate behavior, cognition, life-styles, and "mind, body, and spirit" to make a "whole person" approach to researching CAM (Rockefeller and Brown 2007:xviii).

Another approach psychologists use to research the integration of CAM modalities is to look at attitudes, perceptions, and feelings related to CAM. Ditte et al. (2011) and Furnham and McGill (2003) both address medical students’ attitudes to CAM and how their attitudes may affect CAM. Skepticism about CAM modalities was the main attitude found among medical students, especially more educated students (Ditte et al. 2011:232; Furnham and McGill 2003:284). Negative attitudes developed during biomedical training may impede the integration of CAM modalities into the mainstream medical setting.

Anthropological Framework

The theoretical framework within which anthropology studies CAM is based on making connections to broader issues in the culture surrounding medicine (Saliant and Genest 2007:xxviii). Anthropology strives to understand what health and healing is and how these notions of health and healing are connected to cultural beliefs, broader issues

and changes. Anthropologists have looked at how complementary and alternative medicines fit into the complex paradigm of health and healing. The hegemony of medicine in Western thought and impacts on social structures are a few of the factors being studied. (Saliant and Genest 2007:xxviii).

The research on integration of CAM has been conducted with the same approach mentioned above; specific research and results are used to exemplify or enlighten the larger issues. Herron-Marx et al. addressed what “national and international evidence reveals about the use of Reiki in health care” (2008:38). They accomplished their research through searching electronic databases, such as PsychINFO, Cochrane Database of Methodology Review, and Zectoc, selecting articles and abstracts that fit the criteria determined for the study, such as representing primary research and being reported in English. After synthesis of all the data collected, the researchers found that “Reiki has potential as both a treatment modality and an adjunct therapy in health care” (Herron-Marx et al. 2008:41). There was "a corpus of methodologically sound research into Reiki" (Herron-Marx et al. 2008:40). Much of the research was conducted in a clinical setting with a few studies done on Reiki's effects on mental health. The research team did state that the lack of random selection played a part in influencing the results; however, through their research it "clearly emerges that 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" (Herron-Marx et al. 2008:41). Herron-Marx et al.'s study gives a deeper understanding of smaller studies on Reiki and other healing modalities in their relation to each other.

A study by Barrett through literature reviews focused on the "potential barriers

and facilitators to potential integration" of CAM modalities overall (2003:417). Potential barriers discovered included: cost containment, fear of liability, and lack of efficacy evidence, while potential facilitators included: consumer demand, lower overall costs, and the lower risks of CAM therapies (Barrett 2003:422). Barrett's final argument is for "an accessible, multidisciplinary and evidence based, yet humanistic and patient-oriented approach" (2003:417).

Anthropology works on many platforms to learn about how complementary and alternative medicines, including the integration of CAM, fit into the larger complex study of culture. Diaz-Rodriguez et al.'s study aimed to research the effects of Reiki in nurses diagnosed with Burnout syndrome (2011:1132). Eighteen nurses with Burnout syndrome were randomly assigned to a Reiki treatment or sham Reiki group. Burnout syndrome is "a prolonged response to chronic emotional and interpersonal job stressors" (Diaz-Rodriguez et al. 2011:1133). Salivary IgA (immunoglobulin A) and blood pressure were measured throughout the study and a two-way analysis of variance (ANOVA) was used to analyze the data (Diaz-Rodriguez et al. 2011:1135). The results showed a statistically positive result for the use of Reiki in both IgA markers and blood pressure. Diaz-Rodriguez et al.'s final remarks were that "the application of Reiki treatments could be a cost effective approach for managing and preventing the negative effects of job stress" (2011:1137). Information about specific studies dealing with Reiki and other CAM modalities give insights to how these modalities can be applied and where further research can be conducted.

In her article "Taxonomies of Ritual Mixing: Ritual Healing in the Contemporary United States," Sered presents research about syncretism of ritual healing in the United

States (2007). The differences in syncretism prompted her to propose three levels in which ritual mixing takes place: the individual (idiosyncratic mixing), the professional/practitioner, and the institutional level (Sered 2007:224). She argues that these levels “allowed more nuanced understandings of the ways and contexts in which ritual mixing occur” (Sered 2007:224). The individual level of analysis shows that individuals “learn multiple traditional and nontraditional belief systems from a variety of sources” and that individuals feel “relatively free” to make independent decisions on what healing modalities to utilize (Sered 2007:227). For the professional/practitioner level, Sered argues that mixing of CAM occurs to “enhance the professional's ritual efficacy, status, or power” (2007:238).

Sered's study breaks down the institutional level into four parts: antisyncretism, synergy, syncretism, and appropriation. Antisyncretism explores the "articulated distinctions" between practitioners that are relatively close through geography or content (2007:231-232). Sered discusses synergy as "mutually beneficial mixings in which each party to the mixing maintains a clear sense of separate identity and refrains from claiming ownership" over the practices that are borrowed (2007:238). Syncretism is the mixing of elements that "may have originated in or been associated with a variety of societies or contexts" and are joined together by one institutional system (Sered 2007:238). Appropriation, Sered states, is when one group "helps itself" to elements from other groups, usually without permission (2007:238). Throughout her discussions of these overarching themes, Sered ties in anecdotal evidence through her previous research.

I found that the three levels Sered suggests work well to analyze and organize my own data regarding the integration of CAM and biomedicine, how Reiki might be

integrated into biomedicine and the mechanisms of integration of CAM. Through research specific to Reiki I hope to be able to make general statements about the integration of CAM modalities that can be further studied and compared with other healing practices.

Summary of Chapters

In the body of the thesis, I explore Reiki, its integration, and how it ties into CAM integration of biomedicine. In Chapter II, I explain my research methods. I discuss the setup for the structured interviews approved by the Institutional Review Board process, how I quantified my qualitative data, and how I analyzed it. I explain my use of field notes and participant observations. In Chapter III, I provide a deeper explanation of the CAM modality of Reiki. This includes the mechanics; how Reiki is performed; and how it is defined. This discussion is drawn from literature and from the ethnographic notes taken during participant observation. In Chapter IV, I begin to discuss the study results, beginning with the institutional level. I compare Reiki and other CAM practices to show how integration is based along a spectrum. Each modality is at a different place on the spectrum from being “integrative” to being an outlying CAM therapy. In addition, practitioners’ reports of potential barriers to the progression of integration and improvements to aid in progression will be discussed. Chapter V discusses the practitioner level, specifically considering how practitioners may be impeding the progression of Reiki into a more integrative status on the spectrum. I describe how practitioners mix healing modalities and personal mantras, and their reasons for becoming practitioners. In Chapter VI, I look at the individual patient level and explore the points of ambiguity and mixed information given to clients. I also explore some of the

possible ways Reiki can heal and the kinds of conditions Reiki is being utilized to heal. Chapter VII, the conclusion, highlights and brings together points and gives suggestions where more research is needed, based on what I have learned in doing this research.

CHAPTER II: METHODS

“Clearly, integration of alternative and conventional medicine will require bending and mincing of both perspectives and practices.” (Barrett 2003:423)

Research Design

To conduct my research, I followed standard anthropological methods. A topic is chosen for exploration, and steps are taken to make it a manageable study. As stated in the previous chapter, I chose to explore the integration of CAM modalities into biomedicine. I narrowed my research to explore the healing modality Reiki and its integration into biomedicine. Research about Reiki was carried out through interviews, field notes, and participant observation. I supplemented the information gathered from these methods with library research.

I interviewed Reiki practitioners to learn about Reiki and their views on integration. I did not interview other groups such as biomedical physicians and Reiki clients for two reasons. The major reason was to manage the time constraints this research was under and to have a manageable undergraduate research project. A second reason is that interviewing clients would have entailed a more complicated institutional review board proposal and review process.

Institutional Review Board

In order to conduct research with human subjects, I was required to take the training course and submit a proposal to the University of Maine Institutional Review Board for the Protection for Human Subjects (IRB). The IRB had to verify that I was going to comply with all procedures that “exist for the rights and welfare of the people who participate in UMaine research” (IRB).

Following the training, I submitted my proposal. The proposal submitted to the IRB must include a structured proposal sheet and all materials that would be used in relation to potential human participants. My proposal materials included a summary of the project, informed consent documents, a copy of the email being sent to potential informants, and the interview questions that were going to be used (Appendix A).

I particularly had to stress the confidentiality of my proposed research since I wanted to work with a recording device. By adding this component to my research, I had to stress in the proposal and informed consent the precautions and steps taken to protect the identity of the informants. This entailed stating that all names and information related to the informant would be known only by the researcher. All digital recordings would be coded as soon as possible to protect confidentiality; moreover, digital recordings would be transcribed as soon as possible after the interview. After a transcription had been created, digital recordings would be destroyed. All of these steps led to my research being in compliance with the University of Maine Institutional Review Board.

Research Environment

The locations where I conducted my research were primarily in Maine with the exception of one visit to New Hampshire. Within Maine, much of my research took place in the southern and coastal areas. This was due to the need to optimize travel time to every destination (via car) from my residence, and because of the time frame of my research. I had only a few months between semesters to make contact, travel, and interview each practitioner who decided to participate. This meant that I needed to contact many practitioners at once to allow them time to respond to my initial email and to have time to set up interviews at their convenience. In addition, summer proved to be

an opportune time to attend holistic fairs that occur over the spring and summer months. This allowed me to find more practitioners who may use Reiki as a summer job and to find more advertisements for their practices.

Recruitment

My initial recruitment technique was searching for Reiki advertisements. I found that attending holistic fairs, searching through holistic journals, and online searches were the most fruitful in finding Reiki practitioners to contact. As I began interviewing, I implemented snowball sampling, which entails having study participants make suggestions or recruit future participants from their acquaintances. Through these recruitment techniques, I acquired 67 contacts. Email and phone inquiries were used to make initial contact (Appendix A). The email and phone inquiries were a basic introduction to myself and what my research was about; I inquired if the person would be interested in being interviewed; and I gave my contact information. About half of the practitioners responded to my initial inquiry. A total of 27 practitioners completed interviews.

It is important to note that since this was a volunteer based recruitment technique there are potential limits to this study. Informants may have an agenda to want to work towards integration of Reiki and found this project as a good way to express these views. In addition, these people may have more time in general or may be more dedicated to Reiki than other people who are trained in Reiki, so experiences that were common in these interviews may not be common while reviewing the whole Reiki population.

Sample Population

The population was drawn primarily from the southern and coastal areas of the state. There is no practical way to determine the population of Reiki practitioners in Maine for several reasons. There is no main governing body for Reiki. Any person in the state of Maine can be a practitioner without having to be recognized for it. This lack of certification makes it hard to know the number of Reiki practitioners, and makes it nearly impossible to learn what level of Reiki training a person has completed and how many Reiki practitioners there are at each level of training. Advertisements were the easiest way to find Reiki practitioners, but this does not give a good estimate of how big the Reiki practitioner population is. Many practitioners may not use formal advertisements or be open about their Reiki practitioner status.

Table 2.1: Characteristics of Practitioner Respondents

	Number
Age Range	
20-29	2
30-39	6
40-49	6
50-59	8
60-69	4
70+	1
Gender	
Male	4
Female	23
Level of Reiki Training	
Level I	1
Level II	1
Level III	2
Master Level	19

The participants for this research are not of a specific gender, age, ethnic group, etc. No specialized groups were used in this study. The only characteristic the participant

needed was to be a Reiki practitioner. No level or degree was specified for the informants to have completed. There was no length of time required for how long they had to be a practitioner for this study. However, these types of information were observed or recorded during the interview (Table 2.1). One characteristic that was asked in the interview was “what is your relationship with western medicine and practitioners?” I found that there were five informants who were trained in biomedicine: two nurses, two EMTs, and one physiatrist. Other characteristics are described later in this thesis, such as why these informants decided to become practitioners.

Data Collection

Interviews

Interviews were scheduled for approximately one to two hours; the length of time was chosen to allow ample time for the informant to fully answer each question. Practitioners were contacted by phone or email to see if they would be interested in participating. Once they expressed interest, interviews were scheduled. Interviews were scheduled for the convenience of the practitioners, which included the date, time, and place of meeting. Meetings were held in a variety of places. Many occurred in restaurants, parks, and in practitioners’ offices. The places chosen were commonly semi-private, quiet areas that allowed for the interview to take place in a comfortable safe environment for both the interviewer and informant.

The informant was reminded that the interview was on a voluntary basis, and permission was asked before digital recording took place. There were no complaints about digital recording from any of the informants. Each informant was also given the informed consent sheet which was reviewed before the interview began. Interviews

occurred in face-to-face interaction with the exception of one voluntary email. Face to face interviews allowed for rapport to occur and to have questions answered to their highest potential. In addition, the questions in the interview were designed to aid the face to face interview design. Questions were placed to build upon each other to make the transition between questions fluid. The questions began with Reiki and being a practitioner. The questions then transitioned to inquiring about the informant's views on health, biomedicine, and the interface of Reiki and biomedicine.

In addition to the designed questions, probes were used to help the process of the interview. The probe of silence was used to allow informants to have time to think of their next thoughts and to complete their ideas for a question. Recasts were used to repeat information back to the practitioner to make sure the interviewer understood the information provided. This also allowed the practitioner to hear his or her own thoughts echoed to them, so there would be the inclination to fix or add more to the statement if he or she thought something was missing. The "tell-me-more" probe was implemented to provoke more information from the practitioner about a specific question without trying to imply what the interviewer was looking for. Each of these probes aided in each question being fully answered before moving onto the next question. Interview length ranged from 18 minutes to 1 hour 29 minutes, with an average of about 40 minutes.

Once the interview was complete, each informant was thanked for their time and participation. Following the completion of the interview the informant was coded into the system to keep their name from the interview itself. Additionally, codes have been used to cite each interview in my thesis to differentiate the quotes from separate practitioners.

Field Notes

I kept a field notebook to have a place to jot down notes, retellings, and experiences throughout the research process. Most of my entries were written after each interview. These notes gave me a reference for particular comments that caught my attention, suggestions for websites or books to look at, and comments on the look of Reiki practices I encountered.

In addition, my field journal became the ideal place to write down my experiences with participant observations I made throughout the summer. The three main experiences I wrote about were two Reiki treatments and the level I Reiki training I completed. This aspect of my journal was invaluable, giving me a place to write down as much ethnographic information as I could about these experiences to manage my thoughts about the events in which I participated. Ethnographic notes, or an ethnography, is “the systematic description of a single contemporary culture” (Barfield 1997:157). For my field notes, I took down particular observations of each interview so I could compare what happened. I also wrote down as much detail as I could from the two Reiki treatments to make it easy to see congruencies; I also recorded in my field notes detailed observations of my Reiki training.

Data Analysis

Transcription

Following the interviewing process, I transcribed the digital recordings verbatim into word processing documents. Two interviews were not digitally recorded, but the interview written notes were put into word processing documents as well. I used a basic

setup for each interview to keep them uniform. Each question was bolded and the answers were typed in block form. I reread each interview document to check for any major flaws in transcription. I completed another rereading of the word documents, and each time a change of subject occurred in a question or a new thought took place an extra space was added, thus, allowing for easy appraisals of the information after it was uploaded into the software NVIVO 8.

NVIVO 8 and Coding

The NVIVO program is a qualitative research analysis program. This program allowed me to “manage, shape and make sense of [my] research” (QSR). The program gives the ability to create categories into which segments of interviews or other materials can be placed. Overall, NVIVO is organizing software that allows the researcher to see research patterns and themes in more detail and depth.

Within NVIVO, I formulated basic themes, or “nodes,” from my interviews and field notes. These nodes related to how Reiki practitioners view Reiki and integration. Information from my interviews was coded to be under the appropriately related node to start processing. For me, coding in NVIVO meant reading each interview and highlighting over key words or sections that I thought related to a topic I wanted to explore. For example, if I wanted to group the particular ways practitioners wanted to improve their relationship with conventional medicine, I would highlight each suggestion individually and place it in a node that would relate to that particular suggestion. This meant all the suggestions for referrals would be in one group or node, education of Reiki would be in node, and tolerance for Reiki would be in another node.

“Free nodes” and “tree nodes” were both used. Free nodes are standalone categories that are not considered to be connected to any other theme or node and do not have a sub-category related to them. Tree nodes are interconnected coding items. Tree nodes have one main node that has sub-categories that relate to the larger theme. For example, one main node I used was “terminology.” The subcategories under this node were specific words that practitioners varied in usage, such as “channel,” “belief,” “cure,” “patient,” and “diagnosis.” The majority of my nodes were this type. Many nodes were developed throughout the coding process and adapted as I became more intimate with my information. Some of the key nodes were “terminology,” “modality usage,” “defining Reiki”, and “health and healing.” Using this program allowed me to take my data and make it more manageable to work with. Also, it allowed me to create anonymous cases connected with data. This helped see how demographics might relate to the responses.

CHAPTER III: WHAT IS REIKI?

Better than medicine is care of the health
-Japanese Proverb

The practitioner and I walked to the back of the store, to the Reiki/massage room. The room was much quieter than the rest of the store. There were no windows, though there were a couple of lamps for dim lighting. The walls were pale colored, and a few small posters decorated the space. A small shelf was mounted in the corner to hold the radio/cd player, with a cabinet to hold extra sheets and blankets below. The massage table was in the middle of the room covered with a sheet, two pillows (one for head and one for knees), and a blanket folded at the end.

The practitioner began the Reiki session by explaining to me what she was going to do. Before beginning the session, she explained the “swipe,” a technique used to cleanse the room of all the energy from previous people. She moved her hands in a sweeping motion, starting on the right hand side of the room and pushing the energy to the left side, sweeping it towards the doorway to clear the room.

First, she explained how she was going to place her hands on my head at the crown chakra, then going to my face, my third eye (brow), behind the ear, and the sides of my face. She clarified that sometimes she does not touch the throat chakra; some people get squeamish about the throat area. Next, she was going to place her hands on top of one another on my chest (above my breasts) for my heart chakra. The practitioner described how she was going to hover her hands in a vertical line over my breast bone. Then, she would perform Reiki on my solar plexus, upper stomach, and sacral, a hand’s

width down from there, but she does not do the root chakra. Finally, she would touch my knees, ankles, and feet.

She had me lie down on the table with the pillows in place and a blanket placed over me. She began the Reiki session. She touched my crown area. I really didn't feel anything, other than the light pressure of her hands on my head. Then she touched my third eye, which is the place right between a person's eyebrows. As she touched there I felt an extreme heat on my brow, but the rest of my face that was being touched by her hand was cool. She then touched the side of my face. This is when I noticed that her right hand was very hot, but her left hand was still the same temperature it began with. She did my heart chakra next and moved on towards my shoulders. She placed one hand on the top side of my shoulder and one underneath. I found it interesting that she moved to this place because I had been experiencing a lot of pain in both of my shoulders from injuring them at work. I had not mentioned my injury to her, but she moved directly to the place it hurt.

By this point, I was feeling very relaxed. I was trying to stay totally conscious, but felt myself slip into my own thoughts. I still had an idea where she was with the hand placements as she moved down my body, but no real observational intake. She touched my hip after my feet and did my feet again. She touched my ankle, the top and bottom of my feet, and then my toes. I could feel the extreme heat from her hands by this time. Being so relaxed, I wasn't sure if I should open my eyes. After a while, I decided I should and by this point she was sitting on the stool waiting for me to wake up, not touching me. "Welcome back," were her first words to me. She said she was trained to not wake a person up, but let them wake up naturally. I found this interesting because I was sure that

I had been conscious and remembered her touching my feet and such, but that I was just very relaxed.

She asked me if I was going to be doing any heavy physical lifting later today. I told her yes, as this was a large part of my job. She continued, “oh well, I don’t usually do this, but I think you can handle it. I don’t usually get this, but your shoulders are hurt. They are not hurt to their full extent.” She stated that she could feel the pain in my shoulders. Also she recommended that should I either have them checked out or reduce what I am doing, because I was going to cause permanent damage. I was really intrigued by this because my shoulders had been in a lot of pain lately. I had been trying to get my work load reduced or duties switched to relieve the discomfort. I also thought it was interesting that she mentioned this to me. I didn’t tell her anything about my shoulders, so for her to pick up on it was intriguing. It also left me with the question “What is Reiki?”

Defining Reiki

“What is Reiki?” is a simple question with a complicated answer. Reiki is considered a complementary and alternative medicine in the United States (NCCAM “Reiki”). Reiki literature and practitioners who treat with Reiki have come to describe this healing modality in distinctive ways.

The definition of Reiki from literature, academic and spiritual- Reiki journals, keep a fairly consistent meaning of Reiki. The word “rei” in Japanese represents “the spiritual source of the universe or higher mind,” while “ki” represents “the primal energy of the universe” (Rand 2005:27). The word “Reiki” comes to represent “universally guided or spiritual life energy” (Herron-Marx et al. 2008:37). Reiki realigns the “energy balance in areas of the body experiencing disease and discomfort.” Through this

realignment, Reiki is “increasing the quality of life” (Olson, Hanson and Michaud 2003:992). Written sources about Reiki also mention the effects of Reiki, such as “stress reduction,” “relaxation,” and the promotion of healing (Richeson et al 2000:187, Rand 2005:27).

“That is a big question; that is like how do you define God?” (713111).

Practitioners find defining Reiki to be more of a challenge. Many comments were made by practitioners stating that it is impossible to define Reiki or *“I don’t do it”* (81011). Practitioners’ explanations were less concise than the ones in literature, but followed some common themes. When beginning to define Reiki, practitioners would give the typical literature definition: *“Reiki is universal life energy”* (62711). From this definition, they would move on to give a more in depth explanation as to what makes up this universal life energy. “Holism” and “balance” were the biggest additions to defining Reiki to further explain how it heals: *“What Reiki means to me is that the mind, body, and soul create equilibrium”* (81110). Reiki is used *“to correct imbalances [and] just kind of support us emotionally and physically”* (82411). However, there are many defining aspects of Reiki that were incorporated into each response as well, *“Let’s see...for myself umm love and wishing well”* (81011). The explanation would vary from practitioner to practitioner, and as many stated, *“how I define Reiki is in quite a few different ways depending on who I am talking to (chuckle) because it’s so weird”* (83111).

History of Reiki

As I was conducting interviews, a shared comment made about Reiki was that there was more than one history of the origin of Reiki. It was not until then that I realized

the complexity of Reiki history in its transferal to the United States. During my Reiki I class I was given a handbook that included the two opposing histories of Reiki that practitioners had communicated to me during my interviews. This handbook also brought to light other sources regarding these conflicting histories.

In one version of Reiki history, in 1937, Mrs. Hawayo Takata brought Reiki to the United States from Japan. She practiced and taught the history of Reiki until she passed away in 1980 (ICRT “What”). Mrs. Takata’s version of the history began with Dr. Mikao Usui, who is the founder of Reiki. According to Mrs. Takata, Dr. Usui was working at the Christian College of Doshina University in Kyoto in the mid-1800s. “His students began to ask him if he believed Jesus could heal as the Bible stated” (Amador 2001:4). Dr. Usui stated he did believe in Jesus’ power to heal, which led him on a quest. This quest was to learn how to heal like Jesus, so he could get his students to believe in the power of Jesus. “As the story goes, he travelled throughout Japan and China, then studied at the University of Chicago Divinity School and eventually came back to Japan” (Amador 2001:4).

Mrs. Takata’s report continues with Dr. Usui climbing Mt. Kurama for a 21 day fasting and meditation ritual. During the last day, Dr. Usui saw a light coming towards him. “The light struck him in the forehead (third eye)” (Amador 2001:4). This hit knocked Dr. Usui unconscious. Mrs. Takata’s story continues by saying that once Dr. Usui awoke, he was shown through light bubbles each symbol needed for Reiki and how to apply the Reiki methods (Spruce and Capen 2011:8). The report continues with stories of his miraculous healings and the successors that followed him all the way until Mrs. Takata. Most of this history was undocumented, and many people do not think the

parallel between Jesus and Reiki was made until it was being practiced in the United States.

“Until the 1990s, the only information we had about Reiki came from Mrs. Takata” (ICRT “What”). With further research and more information coming to light, new versions of the Reiki legacy have arisen. The most common history mentioned to me still begins with Dr. Usui as the founder of Reiki. In this version, Dr. Usui studied “Buddhism at the school and the temple on Mt. Kurama as a child” (Amador 2001: 5). He became a scholar and businessman as an adult. Some time in the year 1914, Dr. Usui climbed to the top of Mt. Kurama to fast and mediate for 21 days. Throughout these 21 days, the Reiki energy entered Dr. Usui and he learned the gift of healing (Amador 2001:5). This is where the stories come back together with a discussion of lineage to Mrs. Takata.

Mechanics of Reiki

Reiki Training: My Experience

I paid 150 dollars to take my Reiki course with Reiki Master Martha Spruce in Brunswick at *Hearts & Hands* Reiki center. Since I had met Martha before, she gave me a hug and ushered me in on the day of training. I took my shoes off near the doorway and went right into the reception-area part of the room. I was introduced to another woman and a man named Alex. Another woman came in soon after and I was introduced to her. Everyone taking the class was older than me by at least 10 or more years.

We began the class with the passing out of papers. I was given a handbook that was made by Martha and Dar Capen, another woman who works at *Hearts & Hands*. It was called “Reiki Level One Manual.” I was also given a red folder with an outline for

the workshop, a poem, a couple of articles about Reiki, her business card, and a business card that had the five Reiki Principles: “Just for today I will let go of anger, I will let go of worry, I will show gratitude for all my blessings, and I will honor all life.” After some basic questions about whether people were comfortable, we jumped into the outline. We introduced ourselves, and explained why we were taking the class. This included our intent in taking this course: were we finding help for ourselves, looking to help others, or solve a problem, etc. This is when I learned a little about the other people in the class and myself. I went first because the other two women kept looking between us. I said I was learning Reiki to help center myself for school, get through my senior year, help deal with my family transitions, and most importantly to help me with my thesis. The man named Alex was there to make an even number (4) of students for Martha. He was already a master/teacher level who had completed his education with Martha at an earlier point. The women both came to overcome issues in their own lives. They were in crisis, as I discovered many of the practitioners had been when they found Reiki. One woman was learning how to deal with illness and all the traumatic events from her childhood, and the other woman was learning how to cope with leaving Maine. Martha was very caring throughout this introduction period. A better observation would be to say she was very caring throughout the day. She would nod, hug one of the women who looked like she needed that reassurance, respond with compassion to any story said, and overall just be soft-spoken, which had a calming effect on the group.

We then did an opening meditation. Martha directed us to close our eyes, breathe in and out slowly. During this time, she talked to us in a soothing voice and told us to recognize how busy our minds were and to watch all the ideas slowly dissipate. Once this

was complete, we began the history part of the Reiki class. Martha talked about the meaning of Reiki, how Reiki came to exist in Japan by Dr. Usui, and how it was brought to the United States by Madam Takada. We talked specifically about our “Lineage” line through Martha and how we came back to Dr. Usui. Martha said this was important to remember that we are connected to one another. For her, it is a nice feeling to know we are connected to Dr. Usui.

The next part of the education about Reiki was how it is channeled. As the outline stated, “Intention!” is what channeling Reiki is all about. Our stated intention, whether stated quietly, out loud, or just internally, is what channels the Reiki. A person needs to have intent in mind to use and channel Reiki. We went through the chakra system. Martha explained the colors, where they were in the body, how they affect us, and what they represent. It is this last part of this section with which I felt most connected and what Martha was very excited to go over: the Reiki Principles. The Reiki Principles are five points that learners and teachers of Reiki live by. She recommended that we meditate on these at least once a day. If they are hard to remember, she wanted us to repeat them as we meditated like a mantra. A person is to say “Just for today: I will let go of anger, Just for today: I will let go of worry, Just for today: I will do my work honestly, Just for today, I will honor all life, and Just for today: I will show gratitude for my many blessings.” Martha explained that these principles are important to remember because they help center a person. They remind us that everything is ok, there is still good around each of us, and that doing good brings good. Martha also mentioned that if a person gets into the good practice of saying and living by these rules, stress is reduced. I personally think this is true. If I did not worry as much as I do over small things, remember all the

good things I have, my life in general would not be as turbulent as I make it out to be. This conversation led into another break and meditation to clear our minds.

Then each of us was brought into the room where Martha does Reiki for our attunement. During this time as we waited, we were told to read our manual, talk quietly, and just relax. I was the last of the women to go in for my attunement. The bed had been moved to the back of the room, and a chair was placed over a huge stone. I think it was an amethyst. The chair faced a low table that was in the nook of the room. The table was an altar. It had four white candles (one for each student) and a larger candle to light the white ones from. There were photos on the altar of people who meant a lot to Martha, along with Mrs. Takada, Dr. Usui, and Dr. Hayashi (another historical Reiki figure). There were assorted stones on the altar as well. Previous to the workshop, we each had been told to bring a few important items for the altar. I brought a small statue of a dog, a lion, and the worry stone my mother had given me. I placed them near the front of the altar and lit my candle. I sat down. Martha asked me if Alex could come in for my attunement to watch so he could have more to compare with for his own attunements on other people. I gave consent and Alex sat to the far right of me to watch my attunement. Once we were settled in, Martha told me she was going to center herself and when she touched me on the shoulder I had to shut my eyes. I would know when to open my eyes by a chime sounding. She stood behind me, near the bed, and walked up and touched me on the shoulder. I closed my eyes. She touched my head and other chakra points as a practitioner would do in a Reiki session. Then she brought my hands from my lap into the Namaste position. During this, especially when she touched the top of my head, I felt how I do during Reiki sessions. I had a tingling sensation and it felt like a wave had come

over me. I even had a few muscle twitches as well. Once my hands were in the Namaste position, she began to speak in Japanese. She ended in English with a saying which more or less said Reiki was a gift to keep, a gift to share, and a gift between master and student. She then rang the chime and I opened my eyes. She bowed with her hands in Namaste position and I bowed too. She then asked me how my experience was. I told her and also mentioned the first color that I had thought of was purple. She chuckled at this comment. She said she wasn't surprised since I have a powerful crown chakra. She also mentioned she stumbled a couple of times because I have very close or strong spirit guides. I found this interesting because they seemed to be talked about causally; also, I always have believed in someone looking out for me and other people. Then I left the room and Alex had his attunement.

After this we had lunch, answered questions, and went over hand positions for self-treatment. I felt normal after my attunement, but one woman had gotten very cold after her attunement. Martha explained this was because she let go of a lot of pent up energy all at once. From here, we moved into setting up two massage tables. Alex and I were partnered up and the other two women were partnered up. We practiced the hand positions, and gave each other a full Reiki treatment. Once this was done, we picked up and were given our Reiki I certificates. Each of us was scheduled for a private attunement, which was our second attunement. I went the following week. It was very simple. I met Martha at the practice. We sat down and talked about my experiences so far, how I felt, if I noticed any changes. After, we finished our glasses of water; in Reiki it is important to stay hydrated. I helped set the room up to look like it did for the first

attunement. Then she attuned me. It felt like the first one. From here, we got ready to go and she told me to keep in contact often.

This apprenticeship way of teaching Reiki is consistently found to be the way practitioners are taught the practice of Reiki. I completed my Reiki I degree, which is the basic level. This gave me all the basics of Reiki from history, chakra knowledge, and how to use Reiki energy on oneself and people close to oneself. An initiation attunement is given on this level as explained above to open the channel for Reiki to flow more easily through the person. The second level of Reiki is “known as the ‘practitioner level’” (Shuffery 2007:105). This level requires a second attunement where three symbols are “transmitted along with their energy essence” (Shuffery 2007:105). The symbols taught within this level “enhance either spot or full hands-on treatment” and give the person the ability to do distant healing (Miles 2006:103). Distant healing is the ability to send healing energy from the practitioner over a distance to person who is supposed to receive the treatment. Reiki III/Master level are taught together or separately depending on the teacher, but these give more symbols and practice. This level also allows people to teach new people and open their own apprenticeship.

The content of training and the length of training follow a relatively consistent pattern. Twelve practitioners specifically reported that their training sessions were a one day class, and five practitioners reported weekend courses. The class length is determined by the Master/teacher and how they would like to run their class. One practitioner reported *“I did it in one day. My teacher said yes and she felt that my knowledge was sufficient because I basically memorized Diane Stein’s book. And I am a nurse and was a nurse already so I had the ethics of touch, caring, personal space, and communication so*

my teacher just took me to level III in one day” (82511). It is also important to point out that each person can choose what levels to complete.

How Reiki is Performed

The first step of Reiki is being able to move the universal energy into the client. The channeling of energy is based on intention and the desire to move energy into the person. This can be done through thinking about Reiki flowing from your head or crown chakra down through your hands, or it can be “done simply by saying the word ‘Reiki’ to yourself at the beginning of the healing session” (Rand 2000:1).

Reiki is facilitated in two ways. The first is human to human contact, where the practitioner uses the placing of hands just above or directly on a person who is receiving the treatment (NCCAM “Reiki”). The second is through distant healing. Distant healing is facilitated in many different ways depending on the practitioner and the teaching they were given. For example, Miles (2006) facilitates by calling the person and has them lie down. Once the person is comfortable, the call is ended and she concentrates on that person. After the session time is done, a phone call or email is made to make contact with the client to see how they felt after the session. However, other practitioners have different practices. One practitioner explained that she does distant healing on many people at once, *“just make a Reiki box, you just put different people’s names into the Reiki box, set your intent and send it to all of them”* (62711).

The “human-to-human contact” version of Reiki is more consistent with regard to how the process takes place. The person lies down on a flat surface. During my encounters with practitioners’ offices and during my class a massage bed was used. Two pillows and a blanket are traditionally lying on the bed waiting for the client. One pillow

is placed under the head of the client and one under the knees to allow the natural bend of the knee. A blanket is offered to keep the client warm and make them comfortable.

The placements of hands used in contact-Reiki are loosely based on the chakra system. A chakra is a center that “receives, assimilates, and expresses life force energy” (Spruce and Capen 2011:15). There are seven main chakras within the body that start near the sexual organs and end at the top of the head. They are called the root, sacral, solar plexus, heart, throat, brow (or third eye), and crown chakra. The practitioner begins with laying his/her hand on the crown chakra and uses hand positions upon all the chakras until reaching the end with the root chakra. It is important to note that the hand placement for the root chakra is the feet, which has chakras related to the root. This way nothing close to sexual contact is made. These hand positions are a guide to using Reiki. Not all the positions are used in each session, and other hand positions are sometimes incorporated as well. Moreover, other techniques can be implemented to find where blockages, imbalances, and other disturbances are present.

During both my sessions, scanning was the technique that led the Reiki practitioners to work on my shoulders. Scanning is a way for the practitioner to learn where the imbalances of the body are and aid them to know where they should concentrate during the session. The practitioner starts at the head and places their non-dominant hand a few inches above the body. If any sensations are felt that are different than the rest of the body, the practitioner “can stop and give Reiki to the area right then, or be sure to provide Reiki there during the session” (Spruce and Capen 2011:20). The areas that are found during scanning can be anywhere in the body and do not follow any

particular hand position. Scanning the body for imbalances allows for more flexibility of hand placements and for healing to be based on the individual's needs.

Discussion

My experiences with Reiki through my participant observations and interviews really enlightened me to how complicated Reiki is as a healing modality. Defining Reiki is a challenge, for the meaning of Reiki is developed from the understanding the practitioner has established through their personal experiences and research. The training of Reiki is an apprenticeship style that allows for a variety of styles to develop and the performance of Reiki varies between practitioners. The history of Reiki has changed over time as research into Reiki has been completed.

Through my research, I have discovered that Reiki is a syncretic modality that draws on a number of traditions. Syncretism is the “diffusion of culture or elements of culture from one ethnic group or cultural sphere to another ethnic group or cultural world” (Grayson 1992:200). Sered includes that these elements are “join[ed] together into one institutionally unified system” when discussing the syncretism of CAM modalities (2007:238). Acupuncture, primus, healing touch and other energetic medicines all share the idea that there is an energetic system in the human body. The energy in our bodies can become blocked, which in turn disrupts and manifests as physical illness within the body. Reiki also relates to Buddhist traditions regarding beliefs in disease etiology; “disease is viewed as the direct or indirect result of *karma* [sic]” (Birnbauun 1989:39). Karma is generated through actions and speech, which ultimately come from one's thoughts: “It is the mind especially that is seen as the root of disease” (Birnbauun 1989:39). Reiki's framework of disease etiology, as discussed further in Chapter VI, is

based on the idea that the mind causes disturbances. These disturbances are seen in the energy field, and ultimately manifest in the physical body.

Another example of Reiki's syncretism is the use of chakras. Chakras are utilized in many Asian healing practices ranging from meditation to Qigong. In addition, chakras are a part of Hindu and Buddhist scriptures. As Sered states, "Reiki is a particularly popular syncretic healing practice in the United States today" (2007: 234). Through my exploration of Reiki, I have learned "What is Reiki" is a complex and deep question with many intertwining answers.

CHAPTER IV: INSTITUTIONAL LEVEL

“A few years ago, it was assumed that CAM therapies were external to and would remain outside the mainstream conventional health care system. Today, however, there is a fair amount of discussion of the possibilities, perils, and promises of integration” (Barrett 2003:420)

The institutional level embodies the administration and outside influences upon the medical field. These components include the broader cultural concepts and views that the general public have of a modality; it also includes the “institution” of medicine, encompassing health care policies, regulations, all the levels of personnel, as well as insurance companies, government and other outside sources that have effects on all medicine and its providers. The institutional level is what dictates what is considered a CAM therapy and what is considered “integrative” medicine. Integrative medicine is when CAM therapies and conventional medicine are combined to “improve patient care” (ACAM). CAM modalities are not being used as a supplement with conventional medicine, but are a part of the examination and treatment with conventional medicine.

Stephen E. Straus, M.D. Director of NCCAM, stated in 2000 that “complementary and alternative medicine will be the conventional medicine of tomorrow,” exemplifying the on-going discussion of CAM therapies becoming integrative medicine (Rees 2001). The underlying assumption from these discussions is that integration will occur once the “potential barriers” are identified and “facilitators to potential integration” are recognized (Barrett 2003:417). In this view, integration is a black and white shift that will occur. Once a modality has moved into an allopathic setting it is integrated. One study conducted in Australia researched the benefits of the emerging integrative health care model. The researchers stated that “several contexts of integrative medicine” exist in Australia, which include “co-location of CAM and

mainstream medical practitioners in metropolitan practices and isolated examples in hospital settings and in remote and rural communities” (Grace and Higgs 2010:945). Even within the context of this study, outside CAMs were not discussed and “referral networks for CAM are beyond the scope of this research” (Grace and Higgs 2010:945). For some adherents to conventional medicine, integration is a phenomenon that simply occurs or is unimportant to look at.

My research suggests that this assumption about integration may be overly simplistic. I found that the seemingly simple shift from being unaccepted and outside the realm of conventional medicine to being integrative medicine and mainstream is very complex. My research on Reiki leads me to think that integration is based on a dynamic spectrum. Each modality is at a different place on this spectrum that can change and transition over time. The modalities can be placed anywhere between being “integrative” medicine to being an outlying CAM therapy. In this chapter, I explore the specific factors that affect CAM modalities and where they are on the integration spectrum. I will be comparing Reiki to other modalities along the integration spectrum and practitioners’ thoughts on what specifically affects where Reiki is on the spectrum. I will conclude the chapter with some of the suggestions given by practitioners to help transition their healing modality closer to the integrative end of the spectrum.

Reiki v. Other CAM Therapies

Licensure and Certifications

While dealing with the spectrum of integration, it is important to look at mainstream modern medicine to find specific factors that bring one CAM therapy closer than another to mainstream biomedicine. Licensure and certifications are the one of the

most prominent factors of biomedicine. There are strict regulations that are followed for training medical practitioners; codes to be followed; and specific licensures for each specific group of medical personnel. As a CAM modality becomes mainstream and integrated into biomedicine, these same rules become modified and transferred to “alternative” healing therapies.

I chose six CAM modalities across the spectrum to illustrate this point. The more well-known and integrated modalities include acupuncture and chiropractic care. Homeopathy, a practice that uses highly diluted substances to stimulate the body’s innate healing processes, is a healing therapy that has been used to complement conventional medicine since the 19th century (NCCAM "Homeopathy"), but has not been integrated into medical settings and used as conventional medicine. Craniosacral, an energy modality, Reflexology, a modality using pressure points, and Reiki are modalities that have become increasingly popular over the last ten years. Table 4.1 illustrates how training is typically completed for these modalities; whether there are uniform professional standards in the United States for the CAM therapy; the number of states that require licensure; and the requirements for Maine licensure, if needed in the state.

Chiropractic care is one of the most integrated CAM modalities in the United States. National professional standards and licensure have become stringently regulated to follow suit with this integration. Fifty states and the District of Columbia have state licensures. Maine requirements for initial licensure include a pre-chiropractic transcript that must include biology and English, a chiropractic transcript from an institution, scores from the National Board of Chiropractic Examiners exam, showing of all licensures previous to Maine (if any), and passing the Maine Jurisprudence take home exam

(Maine.gov "Chiropractor"). In addition, chiropractic care training is taught in a college setting or a school specific to chiropractic care.

Table 4.1: Comparison of CAM Modalities

CAM Modality	Training	Uniform Professional Standards in United States	State Licensure	Requirements for Maine State Licensure
Acupuncture	Specific undergraduate courses needed (dependent on school), then attendance at an institution specific for acupuncture ¹	Most states require NCCAOM ¹ exam	42 states and D.C. ⁴	1,000 classroom hours, 300 hours of clinical experience, NCCAOM accreditation, Proof of B.A. degree ⁶
Chiropractic Care	4 years of undergraduate in a biological-based major, 4-5 in professional college specifically for chiropractic care ²	Yes	50 states and D.C. ⁴	Transcripts and diploma, exam scores from NBCE ² , verification of licensure from any and all states, pass Me. Jurisprudence take home exam ⁶
Craniosacral Therapy	Completion of 10 modules and 700-hours training ³	No	None ⁴	N/A
Homeopathy	Training depending on institute or teacher ⁴	No	3 states ⁴	N/A
Reflexology	Institute/School depends on the institution ⁵	No	None specifically to Reflexology, but may fall under requirements of massage therapy ⁴	N/A
Reiki	3- 4 classes under the apprenticeship of a Master/Teacher	No	None ⁴	N/A

¹ National Certification Commission of Acupuncture and Oriental Medicine (NCCAOM)

² American Chiropractic Association (ACA)

³ Biodynamic Craniosacral Therapy Association of North America (Kern)

⁴ NCCAM “Credentialing CAM Providers”

⁵ reflexology-research.com (Kunz)

⁶ Maine.gov “Acupuncture” and “Chiropractor”

⁷ National Board of Chiropractic Examiners

Reiki is a much less regulated CAM modality, with apprenticeship-style training that is usually completed within three classes to reach the highest level of training. Many people who begin training do not complete all three levels. Level I and level II practitioners are found commonly. In addition, there are no state licensures or national professional standards for Reiki training or for practitioners. Independent practitioners are taking steps to change this lack of qualification to make Reiki a more integrated

modality. The International Center of Reiki Training is one group that has begun to reach out and make a more cohesive Reiki community. This center has also begun to have certifications that Reiki practitioners can apply for to begin to regulate this healing modality (RMA). Small changes such as these can change accreditation of Reiki, which in turn can lead to the movement of Reiki on the spectrum of integration.

Table 4.1 also looks at uniform professional standards in the United States. Uniform professional standards include whether there are central governing groups for each modality. Being highly integrated into biomedicine, chiropractic care has a main governing group named the American Chiropractic Association, which is associated with other groups educating and supporting chiropractic care such as the National Board of Chiropractic Examiners (ACA). Reiki, craniosacral, and reflexology do not have central governing associations. As integration progresses, practitioners of these modalities have begun to organize themselves into governing groups. For example, William Rand developed the International Center for Reiki Training in 1995 to begin centralization of information, create standards through membership to the ICRT, and begin to formalize Reiki as a whole (ICRT “Home”).

Connor et al. (2006) conducted a study to learn about the ethical codes used by Reiki practitioners. They performed web searches using the query: energy healing program and ‘Reiki’ and ‘US’ and ‘code of ethics.’ Hundreds of websites were looked at and ethical codes were collected. The study discovered that there were “no set standards for ethical behavior for Reiki practitioners” (Connor et al. 2006: 4). The issue is that without a clear set of codes inconsistencies in practice can result (Connor et al. 2006: 5). However, Connor et al. did mention that “many Reiki groups have organically recognized

the importance of ethics and are making attempts to develop and follow certain ethical standards” (Connor et al. 2006: 4). Until there is uniformity in professional standards and ethical codes, Reiki will be further away from “integrative” than other modalities.

Insurance and Costs

Insurance coverage is a sign of the progression towards the “integrative medicine” side of the integration spectrum. One practitioner during her interview stated *“Insurance doesn’t cover Reiki... but for the most part insurance doesn’t cover healing modalities. Unless you consider chiropractic. Chiropractic and acupuncture sometimes and those are more mainstream and into the medicine [biomedicine]”* (713111). Insurance coverage for a medical procedure is one sign a CAM modality is closer on the spectrum to being completely integrated compared with other modalities.

Table 4.2: Insurance Coverage for CAM Therapies

CAM Therapies Covered by Insurance:	CAM Therapies Not Covered by Insurance:
Acupuncture ¹	Reiki * ³
Chiropractic ²	Craniosacral
	Homeopathy* ⁴
	Reflexology

*Insurance coverage is possible under certain circumstances

¹acufinder.com

²American Chiropractic Association

³International Center for Reiki Training

⁴University of Maryland Medical Center

When comparing the same six CAM modalities discussed earlier, the quote from the practitioner above is especially relevant. Acupuncture and chiropractic care were the only two CAM therapies covered by insurance providers in the United States. I found that Reiki and homeopathy have some conditions covered when treatment is carried out by certain providers. According to the International Center of Reiki Training, nurse

practitioners, nurses, and holistic nurses have a billing code: 1.8 - Energy Field Disturbance. The billing code can only be used by nurses (ICRT "Insurance"). Homeopathy has insurance codes that can be used by conventional medicine to cover costs, but these codes are rarely used. Craniosacral and reflexology are not covered by insurance. Chiropractic care and acupuncture have completed this step of integration, as Reiki and homeopathy work towards insurance coverage slowly through specific codes and regulations on coverage.

Barriers Specific to the Integration of Reiki

While interviewing Reiki practitioners, there were many reports on other various “barriers” that kept Reiki on its particular place on the spectrum compared to other modalities. Out of the responses, I was able to place the barriers practitioners mentioned into two basic categories: questions of efficacy and cultural restraints.

Questions of Efficacy

“On the conventional medicine side, the stickin’ point is the evidence based medicine” (62111). Skepticism around the effectiveness of Reiki and other CAM modalities is a huge factor in the progression toward integration: “Unconventional treatment methods that have not been extensively investigated probably initially meet with scepticism [sic]” (Ditte et al 2011:234). Furnham and McGill’s study found that skepticism and other negative thoughts of unconventional healing modalities were positively correlated with the length of time in medical school (2003:282). They suggested that correlation was related to the number of patients seen who found CAM practices not effective, being in contact with older skeptical clinicians, and increased

medical knowledge that may allow for assumptions to be made about all alternative healing therapies (Furnham and McGill 2003:282).

Many Reiki studies have found very ambiguous results dealing with its efficacy. Even practitioners have realized the ambiguity of Reiki: *“Results have been umm either ambiguous, sometimes positive or negative (when) a standard umm random-controlled trial is applied”* (62111). One research group stated that future research would need to determine if *“benefits attributed to Reiki in this study may have been due to touch”* (Olson, Hanson, and Michaud 2003:990). Evidence of Reiki benefit is hard to differentiate due to many confounding factors, which create a barrier for full integration. Some of these factors are related to the relaxation response, placebo effect, and the lack of ability to have a double blind test. These will be discussed further in Chapter VI. As the practitioner stated before, *“Evidence base is a sticking point”* (62111).

Cultural Restraints

“People called me the voodoo lady and things like that” (62211), *“It is still voodoo crap as my mother still calls it”* (52911), and *“They still call it the voodoo”* (7811) are just a few reports from practitioners on the names they have been called for themselves and the Reiki practice. Negative views on Reiki from individuals or sectors of the population have created barriers that have left Reiki less integrative than other modalities.

Practitioners mentioned trying to avoid religious connotations of Reiki. As mentioned above, many practitioners have heard the word “voodoo” used synonymously with their practice. Others discussed how religious beliefs have contributed to preventing Reiki in particular hospitals and physician settings: *“I am not sure that you are aware of*

this...He [the Pope] was misinformed and I don't know where he got his information, but he decided that Reiki was close to the occult... he forbade any of the Catholic hospitals to have anything to [do] with it" (7211). This particular practitioner was no longer allowed to post her Reiki classes or treatments in the hospital in her community because of this change. Other practitioners shared that the term "comfort touch" was the name that was permissible to be used in the hospitals.

"You don't have to be a guru or an organic guru. You don't have to dress the part. You can be a regular person on a regular journey and be a Reiki master" (81111). Practitioners discussed the "hippie" stigma that is found around Reiki and other energy work. The biggest concern expressed in the interviews about this hippie stereotype was related to being taken seriously by the public. One practitioner stated she was not *"Quote un-Quote 'out of the closet' with it [being a Reiki practitioner] yet because of the stigma"* because of the concern of losing respect (81511). Another practitioner commented on not being taken seriously *"Umm you know I am a professional, I have a bachelor's degree, I didn't make this up"* (81111). These stigmas about being a hippie healing modality or doing *"the devil's work"* make it difficult for Reiki practitioners to come forward as being practitioners and make it hard to be taken seriously as a practitioner (81511).

Practitioners mentioned the difference in the Reiki and conventional medicine approach to medicine: *"We culturally will struggle with that in America. We are a 'get it done and fix it after' society. We are really good at improvising; we are not big on planning"* (62111). Conventional medicine is based mostly on tertiary prevention (Straub 2007:163), which means care that occurs after the disease or illness has begun to affect the body. Reiki is a preventative practice. It is a healing therapy that is used before

disease or illness manifests to correct the energetic imbalances that are assumed to cause the manifestation of disease and illness.

Additionally, the timing of care was brought up in terms of how long an appointment lasts, as well as how long treatment takes: *“Reiki takes time... You aren't fixing it in a week or two. It takes days and days of doing this to get your system back. You can't have one Reiki session and be all set for the rest of your life. It doesn't work that way”* (52911). In the United States, a typical doctor's appointment takes an average 18.7 minutes (Glottschalk and Flocke 2005:488). The average time length of a Reiki session ranges from 30 to 90 minutes (NCCAM "Reiki"). The difference in appointment times can range from 11.3 to 71.3 minutes. As one practitioner stated, *“it's not necessarily a quick fix”* (91311).

The cultural norms of the United States may have created some conflicting interests between Reiki and integration into biomedicine, but as one practitioner stated: *“I like to present it to physicians is that Reiki is a cultural choice... So, if we support people's cultural choices and cultural diversity [then] we need to support their requests for integrative medicine services”* (82511).

Improvements in the Relationship between Biomedicine and Reiki

If integration is a spectrum, steps can be taken to move Reiki and other healing modalities closer to becoming integrative medicine. Reiki practitioners gave me suggestions as to what improvements could be made to strengthen the relationship between biomedicine and Reiki. I classify the two broad categories that these suggestions fall into as: more medical setting integration and tolerance of Reiki.

More Medical Setting Integration

Many Reiki practitioners reported that one way to improve the relationship between Reiki and biomedicine was through having them interact more in a professional medical setting. Integration of Reiki into medical settings has begun throughout the nation. For example, Reiki practitioners have the ability to volunteer at many health clinics. There are hospitals and outreach health clinics in Maine that ask for Reiki volunteers to come in and work with their patients. Comments on this volunteering status were made by practitioners: *“I know they have volunteers go into hospitals, which is nice. But they don’t get paid, they just volunteer their time. I feel that we should get paid for this. It’s good. It’s a service”* (7811). One way practitioners would like to improve relationships is by making Reiki a legitimate service within the medical community. Some practitioners clarified that they are not looking for financial reimbursement that is equal to a medical professional, *“but in terms of a little acknowledgement could go a long way”* (71911). Payment for Reiki services would be an avenue to legitimization and a foundation base for integration into the medical setting.

Another form of integration mentioned by practitioners was referrals from doctors: *“The gold standard would be if an MD would write a referral or a prescription umm the same way they have done for physical therapists and massage therapists”* (62111). The stipulations on the referrals varied among practitioners. *“I would like to see some of the doctors sending their patients a couple times of year to a Reiki practitioner. Maybe it would be for maintenance”* (52911). Another suggestion was to have physicians refer patients that *“they want to get rid of... because they don’t know what to do [with them]”* (81011). The ideas for referrals and why they are given to patients are different

for different practitioners. The main idea is that referrals would improve the relationship between Reiki and biomedicine, which would be a step closer to integration on the spectrum. One study asked CAM practitioners “whether they would respond to a referral letter from a physician regarding a mutual patient” and asked physicians whether they would respond to a CAM provider’s referral; 69.3 percent of physicians replied yes, while 92 percent of CAM providers replied yes to the question (Schiff 2011:191).

Referrals to and from health care providers have had positive responses but have not been implemented. Soklaridis et al.’s study suggested that a lack of understanding of each other’s “scope of practice could create embarrassment or potential conflict if an inappropriate referral was made.” To counteract this potential mistake, practitioners’ “defense mechanism” is to avoid the issue: “they simply did not refer to a practitioner they were unfamiliar with” (2009:664).

“I think our goal will be met when the Reiki person is in the same practice as the medical person and, you know, with the physical therapist person. You know, the whole team approach” (6711). The last idea presented to integrate Reiki into the medical setting was to staff Reiki practitioners in all health settings. Volunteers or paid practitioners coming into the health settings would be replaced with on-staff Reiki practitioners. This change that Reiki practitioners would like to develop would change how Reiki is perceived. Soklaridis et al.’s study found that the “lack of consistent presence” that CAM providers have in a particular clinic leads to a lack of understanding of their “scope of practice” which in turn leads to the lack of referrals from personnel of the biomedical field (2009:655). *“Ideally, having an integrated practice with doctors, nurse practitioners ... and Reiki people and all these different modalities”* (62711).

Tolerance of Reiki

When I asked what could be done to help improve the relationship between biomedicine and Reiki the discussion of tolerance and respect was also a major point made: *“And I am not saying, well it would be nice to be seen as equals, but that’s a whole lot to ask, but at least respected. And an accepted part of the healing process and the accepted part of a treatment plan”* (91311). The suggestions about how respect could be attained from conventional practitioners were grounded in openness, *“continuing dialogues,”* and education (81211).

“I think as far as Western medicine, I would love to see more practitioners be more open to the idea that umm it is not just some out there idea. That really does help” (82411). The openness suggested by practitioners was directed to the idea of an open relationship between Reiki and biomedicine. Allopathic practitioners would be open to the idea of Reiki, and Reiki practitioners would be *“a little more upfront with doctors about what Reiki can and cannot do”* (62711). The majority of the practitioners conveyed the idea that openness would allow conversations between healing approaches and for each group to learn from one another. One practitioner who was a Reiki practitioner and Psychiatrist (or specialist in physical medicine, rehabilitation, and pain management) stated, *“I think the most important area that I would like to see is a sense of humility about how much about what we do not know. And openness to what other traditions can offer”* (713113).

Communication in the medical field between all participants is important, but does not happen that often. “Consequently, low patient disclosure rate of CAM use and poor physician- CAM provider communication combine to create a ‘Bermuda Triangle’

phenomenon, where valuable information disappears somewhere among the three parties” (Schiff et al. 2011:189). The lack of communication between the parties, particularly between CAM providers and biomedical physicians leads to “professional, legal, and ethical” implications, including safety issues and “respect for autonomy” (Schiff et al. 2011:189). Communication improvements that practitioners mentioned would have beneficial influences on integration.

Schiff et al. found that many CAM practitioners and physicians could come to a consensus on who should initiate communication: “Estrangement, language barriers, and content barriers lead to hesitancy” (2011:191). To help alleviate this boundary, education has been suggested by Reiki practitioners: “*Education: I think that is a primary point*” (81911). The idea being expressed is that education would give awareness of Reiki to the larger biomedical community. This awareness would give more physicians a relationship with Reiki or at least open them to the idea of it as a healing therapy. “Educational initiatives that address the communication gap are starting to emerge in both camps” (Schiff et al. 2011:191). I found that many practitioners did not know how, or could not explain how, this education process would work. One practitioner discussed “*offering sessions to doctors so they can understand*” Reiki and what place it has in a patient’s healing process (62711). Schiff et al. suggested that the education to reduce the communication gap take place in class settings that teach about the other healing practices, how to develop collaborations, and work on other projects to bring more knowledge about each group to the other (2011:192). Ditte et al. state that integration is further impeded by the lack of education for medical students who form negative views on CAM from the lack of education and will become less likely to “be interested in future

developments in the field, e.g. medical treatment” (2011:234). They explain this impediment comes from the lack of exposure to CAM therapies. Very few medical students “had made use of complementary medical treatment before the survey” (Ditte et al. 2011:235). Education becomes a tool for exposure and a way to understand CAM modalities.

Integration of Reiki and other modalities is on a spectrum with many factors affecting the position each has on the continuum of integration. Licensures and certifications of healing modalities are indicators of the progression of integration. As can be seen from the comparisons made, as government and private health care policies move to stricter regulations and training procedures, a healing modality moves closer to the side of integrative medicine. Through my interviews with Reiki practitioners, some of the specific factors that are affecting Reiki in its process of integration can be learned. Through the acknowledgement of barriers and the implementation of changes that may include the improvements suggested by practitioners, Reiki’s position on the spectrum can adjust over time. As one practitioner stated, “*Well, I think some of its improved already, but I think... real respect, acknowledgement would go a long way*” (71911).

CHAPTER V: PRACTITIONER LEVEL

“Almost all CAM practitioners use more than one healing modality.” (Sered 2007: 229)

The practitioner level is the middle level in medicine which interacts directly with both institutions and patients. At the practitioner level, a researcher can look specifically at the practitioner and at the practice itself. I investigated a number of questions, including why people decided to become practitioners, what practitioners’ thoughts are on their training/teaching, and their views on Reiki. I also was interested in practitioners’ perceptions of institutions, the practice, and the patient as well as their own role in affecting the practice.

Through my research with Reiki practitioners, I acquired a lot of information on all aspects related to the practitioner level. I realized there were a lot of differences among practitioners that may affect the integration of Reiki. Most of the practitioners reported a desire for Reiki to become an integrative medicine, but I found there were many actions that suggested otherwise. “Separated but integrated” was the theme.

This chapter explores practitioners, their views on their practice, and how some of the differences between practitioners are affecting the integration of Reiki. I begin by looking at what drew particular people to become Reiki practitioners, personal mantras of practitioners and the different origin stories of Reiki. I then explore the professional lives of the Reiki practitioners, including main sources of income and mixing of healing modalities. Last, I examine the vocabulary of practitioners and how certain words are used.

Why Did You Become a Reiki Practitioner?

The first question I asked during my interview sessions was, “Why did you become a Reiki practitioner?” I was given many reasons why Reiki drew in people to become practitioners. I was able to categorize these responses into three overarching themes: encouragement from peers, own inclination, and traumatic event.

“I am a body worker other than this and one of my teachers forced me. ‘You have to study Reiki. You will feel how much stronger your work will become when you do your craniosacral work so I was really directed into [Reiki]” (81011). Encouragement to become a practitioner came from various peers. As seen in the previous quote, that practitioner was “forced” to become a practitioner from her teacher of another CAM modality. Another woman discussed her experience with her massage therapist mentor: *“So I went to school in Cambridge and I had an internship. And the internship I had was with a woman who was a massage therapist and a Reiki practitioner”* (83111). As one of the MD/Reiki practitioners stated, patients of conventional medicine give encouragement to their doctors to learn Reiki: *“So one of my patients has experience with Reiki and suggested to me that it was something I might want to learn and she lent me a book. I read it and thought this was really interesting. I would like to learn this”* (713113). A majority of the encouragement to become a Reiki practitioner came from friends: *“One of my friends mentioned Reiki as an alternative and complementary to traditional medical services”* (81911).

Practitioners’ reports that I classified as “own inclination” were reasons that were not based on others suggesting Reiki or on a traumatic event occurring that caused a search for a healing modality. Intuition led some people to become practitioners: *“I had a*

dream that led me to [Reiki]" (62111), while others had a desire sparked: "I had read a book on it and I wanted to and I kept talking about Reiki" (81511). Others were looking for an energy modality that could help with the supernatural or "to help channel all the energy I have" (52911). This group of practitioners was drawn through a need that Reiki was able to solve. As one practitioner stated "Reiki chooses you" (71911).

The last category of reasons for joining Reiki is tied to traumatic events. These experiences I term traumatic, and include illness, disease, and other health related issues that cause distress. These events could be emotional, physical, mental, or a combination: *"I had some emotional and physical problems of my own. And I wasn't finding any solutions. I was diagnosed with incurable irritable bowel and I was quite depressed and anxious" (62211). What makes all the traumatic events tie together is that Reiki was the solution they found.*

*When my mother died I was a wreck. I was just a complete wreck. Umm I ended up going to a craft fair...a week after she died and 'cause my daughter was doing a booth project. And there was a woman doing chair Reiki and so... [I had] 10 minutes of chair Reiki *laughs*... And it felt wonderful so I went back to that same woman and got a longer session. And then became interested in that because it seemed to be a wonderful healing therapy. (71911)*

Practitioners who fall under this group were looking for solace, aid, or a solution to their personal crisis and Reiki was able to provide that care.

These responses give insight why the interviewees decided to become practitioners. The reasons for becoming practitioners influence some of the difference between practitioners. One practitioner exemplified this point: *"I am very interested in trauma and all levels that it affects the body... I think what it means to me is that a lot of people store trauma and don't even know they have it...Just trauma from everyday*

human experience. And when they are given the opportunity to be in a safe, nurturing, quiet environment, they seek self-healing” (81110). Specialization within Reiki in itself can lead to differences between practitioners. These forms of specialization make it difficult for a modality to come together as a cohesive group and move into integration since each practitioner is looking for something specific to happen and a place for Reiki cannot be established.

Personal Mantras

The individualization of practitioners was also exemplified through the use of personal mantras and philosophies that each person had. Mantras for Reiki practitioners are the words or sayings or sounds that are habitually used around the usage of Reiki. For example during my Reiki I class, Alex stated he stated his intention for healing by saying, *“As I let go, Reiki flows.”* Philosophies of practitioners are just personal held beliefs that revolve around Reiki and its usage. The mantras and philosophies of Reiki usually were stated during my questions regarding how to define Reiki and the mechanics of Reiki. Practitioners would make a statement about how this belief was a philosophy or mantra connected to their understandings: *“so that is almost not a definition, but a philosophy”* (62111).

In addition, each mantra a practitioner lives by individualizes their practice and their potential training of future practitioners: *“But I learned something from my first Reiki master, which was his mantra”* (713112). These philosophies can cause divides in how each practitioner performs and teaches Reiki, making it harder to present as a cohesive CAM modality. This lack of cohesion can slow the progression of integration. The spectrum that Reiki covers in mantras and philosophies may make it too broad and

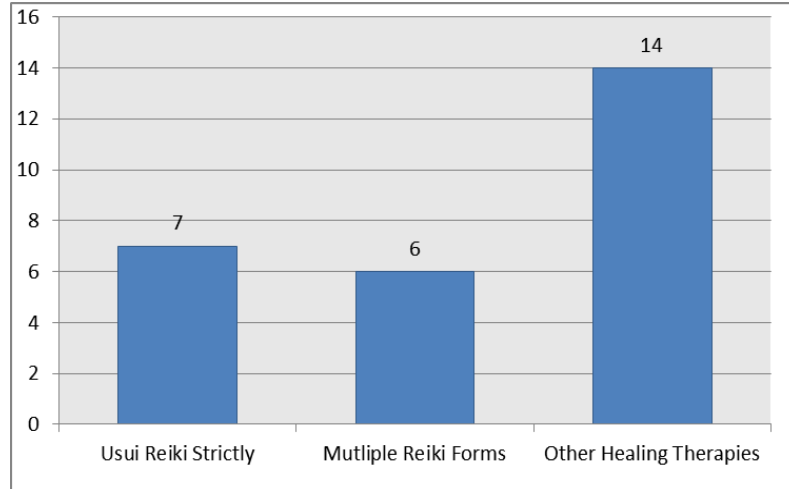
varied to be acceptable to a general public from the institutional standpoint. As well, because of these divides, practitioners do not have a common ground to work with one another.

Professional Lives

As I interviewed practitioners, I learned a lot about their experiences with Reiki and its place in their occupational and professional lives. Out of the 27 practitioners interviewed, 12 utilized Reiki as a main source of income, while the other 15 had other sources of income, including western medicine, dance studios, teaching, and other various jobs. The experience was from 2½ months to 20 years as a Reiki practitioner. I learned how practitioners are utilizing Reiki, and how this process is being presented to the general public.

From the interview information, I classified practitioner training into three types: strictly Usui Reiki, multiple Reiki forms, and other CAM modalities (see Figure 5.1). It is important to note that Usui Reiki is the traditional type that originated with Dr. Usui. This form of Reiki is the foundation training needed before a practitioner can learn other forms. The “other healing modalities” category includes other complementary and alternative methods, which include spiritual healings.

Figure 5.1: Practitioner Training



Of those interviewed, seven practitioners stated they were trained solely in Usui Reiki. Six were trained in multiple Reiki forms. These practitioners with training in multiple forms of Reiki presented them as additional Reiki trainings and not as an individualizing factor: *“And before we had taken the Reiki III we had taken the Shamballa [Reiki], which was a weekend thing where they did I and II in one day”* (81511). As I collected business cards and flyers during interviews, I found that practitioners did not explicitly state if they knew or would utilize more than one Reiki form. One business card did state that the practitioner would provide: *“The Full Reiki Experience”* (Appendix B).

Fourteen of the practitioners used other healing modalities in addition to Reiki. Practitioners’ usage of other healing modalities had a great variety. Hypnosis, development circles, breath-work, Qi Gong, polarity, sound therapy, and massage therapy are a few of the therapies being utilized by practitioners. This group was particularly interesting in the extremely individualized way they utilized and presented Reiki. Practitioners reported other CAM therapies equally with Reiki and in combination: *“I am*

going to be a massage therapist and be a Reiki practitioner” (83111). Others acquired Reiki to complement another healing modality and to expand healing repertoire: “I am a certified hypnotist. I was certified in 2002 so [I’m] doing Reiki as kind of like um you know a way to expand that kind of healing that I was already doing” (82311).

Sered and Agigan’s study of CAM practitioners’ views on breast cancer and its etiology found that their original research design had to be redefined because of the mixing of CAM modalities (2008:619). “The interview team quickly learned that most practitioners utilize [sic] several CAM modalities, and that the modality listed on a practitioner’s business card or web site may not be only one practiced” (Sered and Agigan 2008: 619). Furthermore, Sered found that practitioners “also would often list on their business card or in CAM directories a particular modality that in reality they rarely used” (2007: 229).

Over 50 percent of the practitioners interviewed had individualized ways of utilizing and presenting Reiki; this disparity creates small niches within the Reiki community. Integration of Reiki into biomedicine is affected by these personal niches. Having individual practitioners providing different sets of services or an amalgamation of services creates difficulties. It can create confusion for the public in understanding what they are receiving. It can cause complications at the institutional level since the description of Reiki would never completely be correct for the patient. In addition, the efficacy tests become more complicated. Insurance companies would have difficulty coming up with codes for Reiki as well for additional services being billed. For the insurance companies in particular, codes for billing are highly categorized, so a combination therapy would be difficult to code.

Sered's study suggested that the reason mixing of modalities occurs is related to the "lower cost of training in marginal trainings" (2007:230). Moreover, CAM modalities are a "more easily exploited process" because of the "fewer regulatory or enforcement mechanisms" which in turn exemplify the "minimal power" of these CAM modalities to "enlist institutional enforcement of boundary protection" (Sered 2007: 230). Practitioners may state an ideal of integration, but their actions create separations from each other and biomedicine.

Terminology of Practitioners

Reiki practitioners' specialization among themselves and difference from biomedicine can be seen even on the minute level of terminology. Vocabulary etiquette of practitioners varied for two main reasons: practitioners' differences in using words that have stigma-provoking connotations, and the wish to disassociate from biomedicine terminology.

"I don't use the word 'channel' because I think that brings up a lot of different things for people" (7611). The word channel was a concern for some practitioners because of the connotations related to psychics, telepathy, and other supernatural abilities that have stigma around them for not being believable. Respondents wanted to avoid those stigmas in order to legitimize their practice. Even with this drive to become more substantial and taken seriously, there were just as many practitioners who used the word channel freely: *"Reiki is umm channeling energy. It is a way to channel energy all around us"* (81211).

Another word that had the same differences in use was “healer.” Some practitioners made it clear that he or she was personally not a healer: *“I don’t call myself a healer”* (7611). Others corrected what they felt were public misconceptions: *“They call us healers but I guess it is because they don’t know what else to call us. We are practitioners, you know we aren’t healers”* (80211). And still other practitioners used the word healer without a second thought: *“A person attuned as a Reiki healer has had his/her body’s energy channels opened and cleared of obstruction by the Reiki attunement”* (7311). Words carrying a stigma, and their usage, were varied between practitioners, as did the words they felt were appropriate to use.

The disassociation from biomedicine terminology occurred more commonly between practitioners. The three words that had a huge avoidance by practitioners were “curing,” “diagnosis,” and “patient.” ‘Curing’ was a term that not a single practitioner interviewed used except to state, *“But... what we are doing is healing, we don’t talk about cure”* (80211). As practitioners would explain, their goals are related to preventative care and healing, *“but sometimes in healing we can cure”* (80211). *“Western medicine is completely disease focused. And its whole philosophical framework is curing disease or preventing disease”* (713113). Curing was left to biomedicine. The word ‘diagnosis’ was not widely used by practitioners, for as this practitioner said, *“I am not a medical practitioner at all. I never diagnose. I never treat; that’s entirely outside my realm, my scope of practice”* (62211). These two terms may disassociate Reiki from biomedicine linguistically, but this separation is based on what Reiki can provide versus what conventional medicine provides. The term ‘patient,’ however, is a personal choice of practitioners to distinguish themselves from terminology used by biomedicine. The

word “client” is the widely accepted term used by practitioners. Only Reiki practitioners who had a connection to biomedicine through physical therapies, such as being a nurse, doctor, or EMT actually used the word “patient.” The absence of this term creates a boundary between Reiki and Western medicine.

Overt terminology plays a role towards integration. Not using common terminology may make Reiki practitioners less cohesive as a group. It is important to note that as integration progresses, word choices may change to accommodate the movement that is occurring, but as of now these choices may play a role in the initial speed of that movement. Terminology cohesiveness has been studied as a barrier of CAM integration once entering medical settings. Soklaridis et al.’s study found that CAM practitioners found it was frustrating to be expected to understand acronyms and biomedical language that “biomedical practitioners seemed to take for granted” (2009:660). They suggested this was a “defence [sic] mechanism used to maintain biomedical control over patients” (Soklaridis et al.2009:664). This of idea of a defense mechanism could be translated to CAM practitioners. The avoidance of biomedical terminology may be done to defend their practices from the possibility of being completely lost to biomedicine.

As the desire for integration grows or is established more, there are nonetheless actions creating individualized practices and countervailing movements away from integration: *“The biomedicine looks at this whole diversity mob of alternative practitioners and see a whole range of series or speculations... that are outright wrong or...don’t have any intersection with what we know from science”* (62111). This may be the result of individualizing terminology to disassociate from biomedicine, or the combining of many CAM modalities to offer unique sessions that not all people can

provide. And not all Reiki practitioners want or are striving towards integration with biomedicine. Overall, practitioners have a great effect on the integration of Reiki into biomedicine. Practitioners may vocalize the desire for integration with biomedicine, but their actions demonstrate their need to separate themselves from biomedical influences.

CHAPTER VI: PATIENT LEVEL

“The divinely inspired Reiki energy is coming in and you are directing it to that person. And they are going to do whatever they need to do. And so it’s a matter of trusting that” (7211).

Patient level is the lowest level of analysis. Topics of interest include how patients interact with their health care, what drives them to choose certain health care, and how they affect integration of healing therapies. Patients’ views on particular health care practices are also included in this level of investigation.

I did not interview patients in my research, except for those practitioners who had also been Reiki clients. Patient-level information presented here comes from practitioners’ points of view on their clients, their views on their own experiences as Reiki clients, and how Reiki is being presented to potential clients. From this research, I have learned that clients and potential clients are not given a clear-cut understanding of Reiki. The information practitioners provided to clients was client-dependent and ambiguous at points. The lack of clear information leaves the public to make assumptions and decisions that may not be accurate for Reiki. This ambiguity may lead to dissatisfaction or confusion that may affect integration in intrinsic parts. A supply is only fulfilled when demand exists, and that demand may not occur if there is too much uncertainty about a practice.

This chapter explores the points of ambiguity and mixed information given to clients. I will discuss the mindset and spiritual requirements of a Reiki client and how practitioners approach both these requirements. Finally, I will explore some of the possible ways Reiki can heal and the kinds of conditions Reiki is being utilized to heal.

Client Requirements

An individual's approach to any medical experience is important to healing. For Reiki, I explored two aspects of individual experience: mindset and the religious/spiritual requirements of Reiki.

Mindset

I was curious to find out if there is a common pattern in what the client is thinking or expecting when they come to a Reiki session. I found that 20 of the practitioners interviewed said that a client did not have to be in a mindset for receiving Reiki. Many of these responses came with a statement such as *"Nope. No, it doesn't matter"* (62211). The response given dealt with being open to Reiki: *"Obviously the more you embrace and are open to it [Reiki], in my mind, the more the benefits"* (81110). Ten practitioners explicitly stated how being open to Reiki helped the Reiki energy move into the body: *"I think that if you have a belief or if you are open minded that you're more likely to absorb more and get more out of the treatment"* (82311). These practitioners expanded on this point to include, *"The more they are vested in it, the more effective it will be"* (81211). I think it is important to state that this condition was a preferable trait for a client to have, but was not required. Many practitioners would have similar responses as this one's: *"Even if a person doesn't believe in it and isn't particularly open to it, if they have given their permission to receive it amazing things can happen"* (7311).

The seven other practitioners had various comments on what the patient mindset should be for a Reiki treatment. These responses had a more concrete view on the idea of being open to Reiki:

Yea, [they] should not expect me to do a miracle...My wife sent me: [she said] I should get Reiki. It is hard to get vibrations there. The mindset should, at least, be I heard about [Reiki]. It helps people. I would love to try it out. They don't have to believe in it. That is nonsense, but at least a little open... If not, it is a waste of time and money. (81011)

Practitioners are conflicted on how important mindset is to a patient, which can lead to different responses to the clients. Where one practitioner will take a client on even when Reiki is not acceptable to the client, others would not. This gives mixed messages to clients and potential clients of Reiki. The particular point of being open and in a positive mindset about Reiki also ties into the power of belief. The power of belief and its contribution to the placebo effect will be discussed later in the chapter, but it is important to see that belief can play a role in healing and the perceptions of Reiki by clients.

Religious/ Spiritual Requirements

During my interviews, I asked practitioners if a person had to be religious or spiritual to have Reiki performed on them. This question led to identical responses for the religious aspect, but a variety of responses pertaining to spirituality. *“Reiki is not religious,”* (52911) was the type of response given unanimously by practitioners. Reiki is a religion-less modality. A nurse Reiki practitioner stated, *“Reiki practitioners umm welcome and accept people of all faiths all religions anyone. You can be any religion to practice Reiki”* (82511).

There were a much broader range of responses regarding the spirituality aspect of Reiki. Practitioners were not in agreement regarding how spirituality and Reiki fit together. Some reported that Reiki is spiritual: *“I think it is a part of the spiritual practice and I think it is a part of the mind-body-spirit umm that it falls in uh spirit umm and mind-body too. Well I think primarily spirit, so I do think it helps”* (82511). Another said

that *“I don’t think a person has to consider themselves spiritual to benefit from Reiki”* (713113). Others used similar wording to the mindset question by saying that being spiritual was not a requirement, but that it helped with Reiki: *“I think if you are spiritual you are more open to Reiki and likewise if you are not spiritual Reiki can open you up to a more spiritual life”* (82411) or *“Mind is like a parachute, it works best open”* (71411).

What I found from the responses of practitioners was that the information provided to clients on the spirituality of Reiki was ambiguous and mixed. One person explained that he explains Reiki depending on the person and what he feels they would want to know, *“And I think that would open up the dialogue and then depending on what direction the person is [pause in conversation] you can gauge what the person really wants to know about”* (81911). Some practitioners who were not tailoring their responses about spirituality and other aspects about Reiki made statements that seemed to contradict themselves when explaining Reiki. For example, one practitioner was asked to define Reiki. Her response included that Reiki was a *“God-consciousness (Rei) guides the life energy (Ki)”* making it seem as if this healing modality was based on a god or faith, but when asked if a person has to be religious or spiritual for Reiki, this respondent stated *“absolutely not”* (7311). The practitioner may have not meant that Reiki was religious when giving the meaning of “Rei” and “Ki.” However, as a potential client not familiar with Reiki it could be interpreted this way. Contradictory, ambiguous, and specific responses created for a patient create issues in the relaying of information from person to person. It causes issues when one client is taught that Reiki is one way in practice, but then goes to another practitioner to learn it is different. Having clients without complete

information affects integration about a modality, and such clients may not seek it out for their personal care.

At this point, I would like to point out there are some practitioners who were very clear about the religiosity and spirituality of Reiki: *“So as a Reiki practitioner what I do I focus universal energy. So if you believe in God, it’s God. Otherwise it is light. It’s purity. It’s oneness. It’s a higher power that comes from my head down and out through my arms into the body”* (7811). This response, along with others, explains that Reiki can be spiritual or not depending on the client. This response and similar ones allow the client to know that Reiki has spiritual implications, but that it is what the client personally takes from it that matters. This is a way to cover all the bases while leaving ambiguity about the spiritual side of Reiki.

How Reiki Heals

Patients seek health care that provides an answer to a specific ailment. In Western medicine, a cardiologist is seen when a heart problem is a concern. These desires to search out a healing modality that will cure a specific ailment come from the *“get it done”* aspect of our culture (62111). Reviewing practitioners’ reports of healing patterns of Reiki, there were not many specific answers given regarding what Reiki was an effective treatment for. Practitioners reported that patients sought Reiki out for many different reasons: nausea, pain, and preventative care were a few of these reasons. One of the more common uses reported was the use of Reiki to heal emotional and mental issues that cause distress for patients: *“What happens is emotionally-based . . . 90 percent from my teaching and travels etcetera, umm about what I learned was that 90 to 95 percent of what goes wrong with us is emotionally based”* (80211). Practitioners did emphasize that

Reiki is not intended to heal a specific ailment: *“Reiki will pick up the pickup stick on the top of the pile first. So, if a person has a problem with their knee, but there’s some emotional pickup sticks that are on top of that pile, probably that knee is not going to get treated until the emotional pickup stick on top gets the treatment first”* (62211). The process of healing was based on the idea of universal energy healing in its own accord: *“Reiki is in charge of the healing. The energy knows where to go and what the individual needs. I do not determine what will be healed or where the energy will go”* (7311). Reiki can heal what needs to be healed without direction: *“I understand Reiki as an intelligent energy and the only thing is I am facilitating is becoming a funnel, a hose”* (713112).

With the few specific reports given by practitioners and literature research, I wanted to explore what clients were seeking to heal through Reiki and Reiki’s possible effectiveness on the individual client’s level. This exploration led me to two main topics: stress/anxiety relief and pain management.

Reduction of Stress and Anxiety

Reduction of stress and anxiety is one way that Reiki may potentially be working to help clients heal. One practitioner described why Reiki would aid in the reduction of stress, explaining that stress is connected to thought and *“thought is energy. Thought creates form. So, that creates reality”* (80211). She continued by explaining the thought, the energy of stress, especially *“when the stress is not attended to... it starts to create an obstruction” in the energy field. This obstruction ultimately turns into a manifestation of disease and illness as it takes form”* (80211).

Freud’s theory of personality relates very closely to what this practitioner stated. Freud explains that the “human organism is a complicated energy system” (Hall 1954).

Energy specifically related to thought, perception, and remembering is named “psychic energy.” Freud believed that psychic energy could have effects on “bodily energy” or energy pertaining to any bodily function, such as respiration, digestion, muscular, etc. As Hall explains “One can speak of the transformation of bodily energy into psychic energy as well as the transformation of psychic energy into bodily energy... just how these transformations take place is not known” (1954:36-37). Freud’s theory is based on the idea that psychological well-being has effects on the biological well-being of a human.

Reducing stress and anxiety in one’s life has been shown by health psychologists and medical tests to affect a person positively. Stress helps to create or plays a role in many of common illnesses today, ranging from hypertension and depression, to lower back problems, bleeding ulcers, and death (Straub 2007). Research into the effects of Reiki on reducing stress and anxiety is being carried out by the medical community. Richeson et al.’s (2010) study on the usage of Reiki to reduce stress found that Reiki reduced anxiety significantly (194). Blood pressure and heart rate studies on laboratory rats showed a significant reduction in heart rates, but not in blood pressure while Reiki was being conducted (Baldwin, Wagers and Schwartz 2008: 422). Studies on humans regarding these biological markers of stress have shown more mixed results. Richeson et al. (2010:194) found no statistically significant differences in heart rate and blood pressure, while other studies such Diaz-Rodriguez et al. did find statistically significant differences in blood pressure and heart rate with the use of Reiki (2011:1136). These studies and others reported mixed results about the effectiveness of Reiki, due to the inability for double-blind study; the placebo effect; biased willingness to participate; and the use of small groups in studies (Richeson et al. 2010: 197).

The reduction of stress and anxiety from the use of Reiki has been connected to the “relaxation response” (Richeson et al. 2010: 197). The relaxation response is the “opposite of the flight-or-fight response” and when the body goes into a deep state of rest (Bowling 2009: 48). Deep relaxation has been shown to aid in the reduction of heart rate, blood pressure, and other stress symptoms and reactions, very similar to what Reiki has been shown to alter.

Pain Management

One particular practitioner, who was also a physiatrist MD, worked with patients with pain and used Reiki in his practice to help with pain management. Other practitioners mentioned that Reiki was used for pain management for clients of theirs as well: *“And you just uh it’s a way of helping their bodies to balance... basically allowing them to unblock things that are blocked to get past fear or pain”* (71911). The effectiveness of Reiki and the treatment of pain has been studied by many academics. Olson, Hanson and Michaud (2003) conducted a study of participants who were on a standard opioid management plan for pain. Patients were assigned into groups that received either Reiki or rest. The results showed that Reiki was more beneficial than rest alone, but as many other studies showed, confounding factors played a role. These included the effect of touch that Reiki uses, the placebo effect, and the human interaction that occurs between practitioner and patient. As the physiatrist stated, *“For the clients of complex chronic pain problems that I see it (Reiki) has not been a treatment that has replaced all other treatments. It’s umm one useful treatment modality among many”* (713113).

The Placebo Effect

It is important to consider the placebo effect mentioned by the Richeson et al. (2010) and Olson, Hanson and Michaud (2003) studies and many other studies. The placebo effect is when a result occurs for the patient or a participant expects certain results from a treatment. These expectations of a result manifest themselves as actual patient responses, even if the treatment itself is found to be ineffectual (Straub 2007). The placebo effect may play a role in the effectiveness of Reiki, since the expectation of feeling better from an ailment is there. As Miller and Brody's research emphasizes, the placebo effect has a clinical significance within medical practice (2011:70). The aim should be to understand "how to improve the context of medical care so that physicians can learn new strategies to enhance dimensions of the context to optimize therapeutic outcomes" (Miller and Brody 2011: 77). It is important to note that the placebo effect may be playing just a part in Reiki healing. It is hard to distinguish what is really occurring, so the mechanisms of Reiki healing are all speculative. Reiki may work in all these levels because the "energy" may really be working to create a healthier body from the inside out.

Not knowing how Reiki works does a play a role at the patient level for clients who are not sure about a product, and who will not pay for it. This can lead to a lack of need for integration at the institutional level.

CHAPTER VII: CONCLUSION

“Yet, there will come a time when we will be able to say that all the little change have added up to a substantial mass and health care has become qualitatively different than it was.” (Ruggie 2004: 202)

As popularity grows for CAM modalities, the demand for integration grows.

Wayne B. Jonas M.D. stated, “Alternative medicine is here to stay. It is no longer an option to ignore it or treat it as something outside of the normal processes of science and medicine. The challenge is to move forward carefully, using both reason and wisdom, as we attempt to separate the pearls from the mud” (Rees 2001: 1).

Breaking down the process of integration into three levels, the institution, the practitioner, and the patient, allows us to gain important insights about how these levels affect integration. It suggests how patterns of assimilation are occurring for CAM modalities. Through my research about the healing therapy Reiki, I learned that integration can be viewed on a spectrum. Healing therapies are at different places on this spectrum, depending on how integrated they are into biomedicine. The institutional chapter (IV) explicitly explored how outside factors influence integration, such as insurance coverage, efficacy of a healing modality, and the demand for certifications, particular trainings, and a central organization. Further, I explored practitioners’ reports of the barriers specific to the integration of Reiki and the improvements in the relationship with biomedicine.

At the practitioner level of analysis (Chapter V), I discussed how practitioners affect the integration of their particular healing modality. For Reiki, practitioners are performing actions that are creating more barriers for integration and separation between themselves and biomedicine which in turn causes barriers in integration. Practitioners

affect the integration of their healing modality by not being uniform on information provided to clients; individualizing their skills and mixing healing practices; and by using particular terminologies to separate themselves from biomedicine and other practitioners. I think it is important to point out that sometimes these separations are unintentional or are created through the progression towards integration.

Each practitioner has his/her own variation of one or both of the “histories” discussed in Chapter III. Looking at the “histories” as origin myths shows how Reiki practitioners are inventing themselves. An origin story helps create legitimacy, being a basis from which a practice arises, and becoming a common ground for practitioners. Mrs. Takata created legitimacy for Reiki in the United States during World War II, a time when Japanese practices were looked down upon, but “the U.S. government had complete control over Japan for a time and banned all Eastern healing methods in Japan and required that only Western medicine be practiced there” (ICRT “History”). Origin myths can “help explain and legitimize a community or group as well as provide a charter for social actions, from theory building to daily practices” (Gaines and Juengst 2008: 304). As the history has been researched and discovered, new remarks on Reiki history are being stated. Having different stories and speculations is another factor blocking Reiki practitioners from creating a cohesive group. Reiki practitioners want legitimacy for their healing modality, but keep their own individualistic concepts of the history. This affects the stride towards legitimacy and the progression towards integration. It is important to point out the term “myth” is not intended to suggest that the histories of Reiki and other modalities are “fanciful and/or untrue,” but to separate the origin history “from individuals’ personal history” (Gaines and Juengst 2008: 304).

I learned at the patient level of analysis that patients' demands for a healing modality can create a push for integration of a CAM modality. Specifically from my research, I found that the demand for Reiki integration is possibly affected by lack of or ambiguous information provided to clients, as well as prospective clients not being able to see the need for a modality. For Reiki and other healing modality research, interviews and more research specific to patients would give more insights as to what is affecting patients' decisions to use Reiki and other modalities. This information would make clearer how modalities are being represented to patients, what patient perceptions are of particular therapies, and how these perceptions are affecting the demand and integration of that particular healing modality.

The factors that are affecting Reiki are likely affecting other CAM modalities, such as scientific exploration of efficacy and individualization of practitioners. Other modalities most likely have specific aspects or influences affecting their movement toward integration as well. For example, Reiki is affected by not having specific communications regarding what Reiki can do or the effects it has. By contrast, a modality such as meditation has been found to have the specific effects of stress reduction, lower blood pressure, and other positive effects (NCCAM "Meditation"). More research using the three levels of analysis with other CAM healing modalities would give more insights as to what factors affects integration.

Even though there are factors working to progress or inhibit integration of CAM modalities, integration is still steadily occurring. In 1990, 427 million visits to CAM practitioners were made. By 1997, 629 million visits took place, which exceed physician visits (Rees 2001). Complementary and alternative medicine use keeps growing with

each year. Rees (2001) stated “medical therapies can no longer be solely based on one methodology in that no single modality can serve as an effective treatment for all people in all circumstances.” This type of outlook is creating a movement that only the future can tell will occur for biomedicine, complementary and alternative medicines, and how or if both will come together.

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Appendix A

Explorations in the Practice of Reiki

Submitted May 2011

Principal Investigator: Heather White

Faculty Sponsor: Ann Acheson

APPLICATION FOR APPROVAL OF RESEARCH WITH HUMAN SUBJECTS
Protection of Human Subjects Review Board
 114 Alumni Hall, 581-1498

PRINCIPAL INVESTIGATOR: Heather Marie White
EMAIL: heather.white@umit.maine.edu **TELEPHONE:** 207-212-2950
CO-INVESTIGATOR(S):
FACULTY SPONSOR (Required if PI is a student): Ann Acheson
TITLE OF PROJECT: Explorations in the Practice of Reiki

START DATE: May 20 2011 **PI DEPARTMENT:** Anthropology
MAILING ADDRESS: 1151 Richmond Road Litchfield Maine 04350
FUNDING AGENCY (if any):
STATUS OF PI:
 FACULTY/STAFF/GRADUATE/UNDERGRADUATE Undergraduate

1. If PI is a student, is this research to be performed:

<input checked="" type="checkbox"/>	for an honors thesis/senior thesis/capstone?	<input type="checkbox"/>	for a master's thesis?
<input type="checkbox"/>	for a doctoral dissertation?	<input type="checkbox"/>	for a course project?
<input type="checkbox"/>	other (specify)		

2. Does this application modify a previously approved project? (Y) If yes, please give assigned number (if known) of previously approved project: (N)

3. Is an expedited review requested? (Y) (N)

SIGNATURES: All procedures performed under the project will be conducted by individuals qualified and legally entitled to do so. **No deviation from the approved protocol will be undertaken without prior approval of the IRB.**

Faculty Sponsors are responsible for oversight of research conducted by their students. By signing this application page, the Faculty Sponsor ensures that the conduct of such research will be in accordance with the University of Maine's Policies and Procedures for the Protection of Human Subjects of Research.

4/27/11 _____
 Date Principal Investigator Faculty Sponsor
 Ann Acheson

 Co-Investigator Co-Investigator

FOR IRB USE ONLY Application # 2011-01-14 Date received 4/28/2011 Review (F/E): E
 Expedited Category: _____

ACTION TAKEN:
 Judged Exempt; category 2. Modifications required? Y (Y/N) Accepted (date) 5/16/2011
 Approved as submitted. Date of next review: by _____, Degree of Risk: _____
 Approved pending modifications. Date of next review: by _____, Degree of Risk: _____
 Modifications accepted (date): _____
 Not approved. (See attached statement.)
 Judged not research with human subjects

Date: 5/9/11 Chair's Signature: Cynthia A. Erdley 10/09

1. Summary of Proposal:

The research for my Honors thesis aims at exploring the reasons why spiritual therapy is being integrated into the biomedicine community. To accomplish my research, I will engage in ethnographic research regarding Reiki, a specific form of spiritual therapy, to gain a better understanding of this integration. My project will entail interviewing Reiki practitioners to better understand the practice of Reiki and the degree to which it is or isn't becoming integrated with biomedicine. These questions will be open-ended to allow the interviewee to provide a fuller explanation for their responses, in their own words. (Please see attached sheet for the interview questions.)

Through my preliminary research, the key concepts of costs, accessibility, and notions of holism have arisen. Spiritual therapy can be a cheaper source of treatment than biomedicine. On top of this, new government laws have begun to be put into place across the country to make them even more affordable (Goldstein 2002). Individuals who are seeking a more holistic outlook on their care do not want to be treated as a number or disease. They want to be treated as a complete person. The term "holistic care" embodies the smaller concepts of mysticism, Vitalism, and personal empowerment that may play roles in the popularity of spirituality (Barrett et al. 2000). Accessibility relates to economic interests but also relates to the physical availability of spiritual therapy. Globalization has made the search for alternatives substantially easier by setting up public access to a variety of complementary and alternative medicines (CAM) and from this social acceptance has developed (Barrett 2003). The mainstreaming of many CAM practices can be seen in all corners of the United States, including Maine.

Through my preliminary research, I have learned that advancements in biomedicine have made the process of diagnosis and treatment, as well as the patient-practitioner interaction, into a streamlined capitalist business model that has led to inflation of costs with less time in the doctor's office. This model has come under scrutiny by the public and left them searching for alternatives, such as spiritual therapy. The significance of my research relates to this trend. How can Reiki, along with other spiritual therapy alternative treatments, be integrated into biomedicine? And what are the implications of this? These complementary and alternative medicines are going to be affecting the future of biomedicine.

2. Personnel

The personnel who will be in contact with the participants and/or will identifiable data will be Heather White, Ann Acheson, and Constanza Ocampo-Raeder. Heather White is the principal researcher in the study and will be conducting the interviews. I (Heather White) have taken the "Social and Behavioral Responsible Conduct of Research Curriculum," "Social & Behavioral Research- Basic/Refresher Course," "CITI Health Information Privacy and Security (HIPS Curriculum Completion)," and "Responsible Conduct of Research for Students Curriculum Completion" exams and passed all of them early this April. I have not any previous experience with human participants. Ann Acheson has many years experience working with human subjects in both qualitative and quantitative research. She has served as faculty advisor for three Anthropology Honors students whose projects have been subject to IRB approval: Janna (Duym) Jensen (2003-05); Autumn Demaine (2004-05); and Kristen Kuhns (2009-10). Her recent projects at the University of Maine that have gone through the IRB approval process include:

"Coastal Stakeholders Wind Power Study" (current); "Evolution of Norms and Conservation Laws in Two Fisheries" (current); "Evaluation of the 2003A Grant Program of the Maine Health Access Foundation" (completed); "Survey of Those Who Have Left the Katahdin Region" (completed, C. Morris, PI); "Building Statewide Capacity to Assess and Monitor Gang Involvement in Criminal Activity" (completed; M. Sorg, PI). She is also authorized by the Office of the State Medical Examiner as a national reporter for confidential drug-related death information.

3. Participant Recruitment

The participants for this research are not of a specific gender, age, ethnic group, etc. No specialized groups will be used in this study. The characteristic that the participants need is to be a Reiki practitioner within the State of Maine. My aim is to interview 20-30 practitioners. I will be searching for practitioners through advertisements for their practices and at holistic fairs. Once I start the interview process, I will attempt to do snowball sampling to find more participants by asking interviewees for names of others they know who are Reiki practitioners. The participants will be contacted by phone or an email to ask them to participate in the interview. (Please see attached sheet for recruitment letter.)

4. Informed Consent

A written letter will be given to the participant to be read before the interview is conducted. Consent will be obtained when the principal investigator meets the participant before the interview begins. (Please see attached sheet for informed consent letter.)

5. Confidentiality

Interviews will be conducted at a private site chosen by the interviewee. The identity of all informants is kept confidential at all times. Interview responses are identified by a code assigned to each individual participating, the key to the code is kept separately and under lock at all times, and the key will be destroyed after approximately two years. The key will be kept at my home. The information gathered through the interviews will be through note taking and microphone recording. The microphone recordings and notes will be kept on a password-protected computer that only the principal investigator will have access to. Any printed materials will be kept in a lock-box, which will be kept at home. The microphone recordings will only be kept long enough to fully transcribe the information then be destroyed so the voices will not be able to be identified with the information. The interview notes and transcriptions will be kept up to 2 years then destroyed. In reports and publications, the participants will be kept anonymous.

6. Risks to Participants

There are minimum risks that can occur with my study. There is a chance that a person may find some of the questions personal but not any greater than ordinarily encountered daily. Inconvenience would be most prominent risk. The time it will take for the participant to complete the interview (1-2 hours estimate) may affect other obligations such as possible Reiki appointment times.

7. Benefits

a. State the benefits of research to the participants:

There are no known direct benefits.

b. State the benefits of research to society at large or others:

This study will provide valuable information in gaining understanding about the practice of Reiki. Society will benefit from this research through having supplement research on a specific spiritual therapy that has begun to be integrated into the biomedicine field. This research may possible lead to answers on how Reiki and other spiritual therapies can be integrated in the future into biomedicine field more easily through learning how to approach Reiki as a treatment.

8. Compensations

Not applicable to this study

Inquiry Letter:

Hello,

My name is Heather White, a student from the University of Maine. I am conducting research for my Honors thesis on complementary and alternative medicines and their integration into biomedicine. I am particularly interested in learning more about Reiki and its practitioners. I am looking for people who are willing to be interviewed for 1 to 2 hours to learn more about this topic. If you have any questions or are interested in being interviewed, please contact heather.white@umit.maine.edu or call at (207)212-2950.

Thank you for your time,

Heather White

4th Year Anthropology and Psychology Major

INFORMED CONSENT FORM

Title: Explorations in the Practice of Reiki

Project Directors:

- Heather White, *Principal Investigator*- Student of University of Maine, Department Anthropology and Psychology
- Ann Acheson, *Faculty Advisor*- University of Maine- Margaret Chase Policy Center

Purpose:

The purpose of this study is to gain a greater level of understanding about the practice of Reiki. The study's purpose is also to learn how Reiki is, and can be, integrated into biomedicine.

What you will be asked to do:

If you decide to participate in this study, you will be asked to answer questions that will be microphone recorded. These questions will be general ones about your practice, your experiences with Reiki as a practitioner, and your perspectives on health and the integration of Reiki with other medical treatments. A few examples are: How would you like the relationship between Reiki and western medicine to improve? Why did you become a Reiki practitioner?

The interview will be conducted in a mutually agreed location and time. The interview will take approximately 1-2 hours to complete. With your approval, the session will be microphone recorded. The recordings will be destroyed once fully transcribed. If you prefer not to be microphone recorded, the interviewer will take notes as you speak. These documents will be destroyed within two years of the interview.

Risks:

The risks with this study are minimal and include your time and any inconvenience.

Benefits:

Although this study may not have any direct benefits to you, this research will provide valuable information in constructing a greater understanding about the practice of Reiki. This project will be beneficial in providing supplementary research on a specific spiritual therapy that has begun to be integrated into biomedicine. This research may possibly lead to answers on how Reiki and other spiritual therapies can be integrated in the future into biomedicine more easily through learning how to approach Reiki as a treatment.

Confidentially:

All the information gathered will be held in confidence. Interviews will be given code numbers, so your name will not appear on the interview notes or transcriptions. The key linking your name and number will be kept separately from all other information. The key will be destroyed within two years. The audio-tapes will be destroyed once fully

transcribed, which will be within one year. The transcriptions and other written data will be kept on a password protected computer and printed material in a lock box at my home. The transcribed, deidentified data will be destroyed within two years of the interview. Your name and identifying information will not be published or be reported in any form.

Voluntary:

Participation is completely VOLUNTARY. If you choose to take part in this study, you may stop at any time during the study. You may also skip questions or stop the interview at any time.

Contact Information:

If you have any questions about this study, please contact Heather White at (207)212-2950 or at heather.white@umit.maine.edu. You can also contact Ann Acheson at ann.acheson@umit.maine.edu or at (207)581-1567. If you have any questions about your rights as a human participant please contact, Gayle Jones, Assistant to the University of Maine's Projection of Human Subjects Review Board, at (207)581-1498 or gayle.jones@umit.maine.edu

Interview Questions:

Years Practicing:

1. Why did you become a Reiki practitioner?
2. How were you trained?
3. Can you define Reiki?
4. What was your experience with attunement?
5. Why did you choose the type of Reiki you did?
6. What is the meaning of health to you from your experiences of Reiki?
7. When performing Reiki, how are you healing the person?
8. Where do you usually carry out the treatment?
9. Why is Reiki different from Western medicine?
10. What is your relationship with western medicine and practitioners?
11. How would you like the relationship between Reiki and Western medicine to improve?
12. Is Reiki a supplement or complete treatment?
13. Do people come to get treated regularly?
14. Does a person have to be in a certain mindset to have Reiki performed?
15. Do you have to be spiritual or be a certain religion to have Reiki performed?
16. How much does it cost for a Reiki session? Does insurance help cover the costs?
17. Do you have more male or female clients? Do you think there is a reason?

Appendix B

Examples of Reiki Practitioners Business Cards:

This appendix shows selected business cards to exemplify the different ways Reiki Practitioners advertise their healing services.

Reiki
 The full reiki experience

██████████
 Reiki Practitioner
 Mid Coast Area
 call for an appointment

██████████

Holistic, natural, gentle therapies that promote health, healing, and wholeness.

LMT
 Integrative Massage Therapies
 Body of Waters - Newcastle, Maine





REIKI

Martha Spruce
 Reiki Master Teacher

8 Lincoln Street
 Brunswick, ME 04011

Phone: (207) 751-5339
www.hearts-n-hands.com



REV. ██████████
 Interfaith Minister * Reiki Master

Reiki Training * Development Circles * Hypnosis
 IET * Breathwork * Readings * Qi Gong * CDs
 "Wholistic Healing – Connect to Spirit within"

Life Unlimited, Inc. ██████████



Epona Energy Therapy

Biological Therapy for the Body, Mind, Spirit

Author's Biography

Heather Marie White was born on March 26, 1990 in Portland Maine. She grew up in Litchfield, Maine, a small farming community. In 2008, she graduated valedictorian from Oak Hill High School and subsequently entered the University of Maine. During her freshman year, she declared her first major, Anthropology, and in her sophomore year declared Psychology as her second major. Heather graduated in 2012 Summa Cum Laude and as a member of Phi Beta Kappa. Heather will be attending Boston University for a M.A. in medical anthropology, where she anticipates continuing to research complementary and alternative medicine (CAM) modalities and where they can fit into biomedical healthcare.