
Theses, Dissertations, and Projects

2011

When East meets West : an exploratory study of how Reiki is integrated into psychodynamic practice

Kimberly Ann Winnegge
Smith College

Follow this and additional works at: <https://scholarworks.smith.edu/theses>



Part of the [Social and Behavioral Sciences Commons](#)

Recommended Citation

Winnegge, Kimberly Ann, "When East meets West : an exploratory study of how Reiki is integrated into psychodynamic practice" (2011). Masters Thesis, Smith College, Northampton, MA.
<https://scholarworks.smith.edu/theses/1030>

This Masters Thesis has been accepted for inclusion in Theses, Dissertations, and Projects by an authorized administrator of Smith ScholarWorks. For more information, please contact scholarworks@smith.edu.

Kim Winnege: When East
Meets West: An Exploratory
Study on How Reiki is
Integrated into Psychodynamic
Practice

ABSTRACT

This study was undertaken to explore the experience of mental health professionals who use Reiki in their therapeutic practice. Secondly, the study examined clinicians' perceptions of the efficacy of Reiki in a mental health setting.

Recruitment letters were sent out via internet professional listservs to individuals who held both Reiki certification and mental health licensure. Sixteen participants, twelve social workers and four licensed mental health counselors, were interviewed regarding their views on the integration of Reiki within their practice. Narrative data was collected that described clinicians' personal experiences with Reiki, their practice and how they considered Reiki as a therapeutic intervention within their profession.

The findings of this study supported the previous literature that Reiki has been proven to alleviate tension and anxiety, decrease the perception of pain improve communication among clinician and client, and reduce emotional distress. Virtually all the clinicians in the sample noted that Reiki speeds up the therapeutic process for their clients as well as creating a body-mind awareness that may have been lacking before Reiki integration.

Findings from this research may contribute to the ongoing dialogue regarding therapeutic touch and body-based clinical social work practice. As shifting trends indicate a need for an expanded approach to healing, including holistic medicine, the following research may convey an implication for expanded education in clinical social work practice.

WHEN EAST MEETS WEST: AN EXPLORATORY STUDY ON HOW REIKI IS
INTEGRATED INTO PSYCHODYNAMIC PRACTICE

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Kim Winnegge
2011

Smith College School for Social Work
Northampton, Massachusetts 01063

ACKNOWLEDGMENTS

This thesis could not have been accomplished without the assistance of many people whose contributions are gratefully acknowledged.

I wish to thank my participants, without whom my research could never have been completed; my research advisor, Jean LaTerz, for her patient and dedicated guidance; my classmates, whose parallel processes kept me in check; my friends and family, for their continued support and humor; my cat Joan and Facebook, each for distracting me when I needed it (and sometimes when I didn't); and my spiritual mentors for their inspirational words and encouragement.

TABLE OF CONTENTS

ACKNOWLEDGMENTS	ii
TABLE OF CONTENTS.....	iii
CHAPTER	
I. INTRODUCTION.....	1
II. LITERATURE REVIEW.....	3
III. METHODOLOGY.....	15
IV. FINDINGS	24
V. DISCUSSION AND CONCLUSIONS.....	46
REFERENCES	55
APPENDICES	
Appendix A: Recruitment Letters.....	65
Appendix B: Consent Form	67
Appendix C: Approval Letter	68
Appendix D: Interview Guide	69

CHAPTER I

INTRODUCTION

The purpose of this study is to explore the experience of psychodynamically trained clinicians who utilize holistic healing, specifically Reiki, into their clinical social work practice. As the medical community expands its understanding of what is beneficial to its clients, it is important to highlight what is known and unknown about various subgroups within this domain. More specifically, it is important to know more about the history of holistic healing, the advent of its integration within clinically-based practice, and current trends to incorporate it more fully within the clinical model.

Although Reiki is gradually becoming introduced into mental health treatment as an alternative modality, insufficient research has been done on the effectiveness of such integration. Previous and current literature generally focus on holistic healing within the psychodynamic model (Adler and Mukherji, 1995; Corrigall, 2006; Mollon, 2008), therapeutic touch from a Western perspective (Hunter and Struve, 1998; Scheiber, 2000, Smith, 1998), and an increased emphasis on utilizing alternative modalities within the social work setting (Aposhyan, 2004; Totton, 2003). To date, there is little to no previous research that has explored or evaluated the integration of Reiki as a secondary treatment strategy within psychodynamic therapeutic treatment (Galland, 1997).

This gap in the previous literature warrants the need for further research on alternative treatment modalities within a clinical setting and, thus, provides a rationale for the current study question, “How do clinicians’ integration of Reiki (and other holistic healing strategies) into their clinical practice influence treatment?”

The objective of the current study was to explore the strengths and limitations of incorporating Reiki into clinical social work practice from the perspective of clinicians who are psychodynamically oriented. This project was an exploratory, descriptive study using qualitative research methods.

Qualitative data was collected through the use of semi-structured, open-ended interviews with 16 participants who self-identified as psychodynamically trained clinicians in a mental-health setting and who had at least five years of licensed work experience. Additionally, these clinicians must have achieved at least one level of Reiki training and have utilized Reiki within their psychodynamic therapy settings for at least one year. Areas of interest focused on reasons why these clinicians chose to seek Reiki training, subsequent challenges faced within the mental-health field, and their subjective experiences using Reiki during clinical practice. The intended audience for this study is clinicians interested in integrating alternative treatment modalities, especially Reiki, into their therapy.

As there has been negligible research done on the convergence of Reiki and psychodynamic practice, the findings of this study may contribute to the ongoing dialogue regarding shifting trends within the field of social work. Similar to the lack of literature related directly to the question for this study, psychodynamic social work programs do not include training and resources that address the integration of Reiki and clinical social work practice. In addition to the goal of making a contribution to the literature through an empirical investigation, I also plan to convey the need for social work programs to educate their students regarding potential integration for holistic healing within the psychodynamic paradigm.

CHAPTER II

LITERATURE REVIEW

The following literature review focuses on previous research pertaining to the study question: “How do clinicians’ integration of Reiki and other holistic healing modalities into their clinical practice influence treatment?” This chapter is divided into two major sections. The first section focuses on Reiki and holistic healing. This section begins with a definition of Reiki followed by the history and meaning of holistic healing modalities. The next sub-section examines body-mind psychotherapy and how the human body has gradually become a part of psychoanalysis. A sub-section on therapeutic touch will follow, giving a potential basis for the use of Reiki in social work practice. The second major section presents an overview of psychodynamic psychotherapy and includes how it has evolved since its inception as Freud’s “talking cure.” This chapter closes with a presentation of current empirical studies regarding holistic healing and its integration into Western medicine.

Reiki and Holistic Healing

This section opens current definitions and popular modes of holistic healing followed by a more detailed description of the history of holistic healing in general. This section includes a look at Reiki within a holistic medicine context. The next section describes embodied psychotherapy and its correlations with Reiki and holistic healing,

the history of body-mind psychotherapy, a brief overview of psychodynamic psychotherapy, and finally, the connection between Reiki and psychodynamic practice.

Current Definition and Types of Holistic Healing

Holistic healing or holistic medicine is often subsumed under the category of alternative and complementary medicine. *Holistic medicine* is a term used to describe therapies that attempt to treat the patient as a whole person by looking at an individual's overall physical, mental, spiritual, and emotional well-being before recommending treatment (Skinner, 2006). A practitioner with a holistic approach treats the symptoms of illness as well as looking for the underlying cause of the illness (Skinner, 2006). This treatment approach is thought to be more far-reaching and includes a wide variety of treatment modalities that are not usually included within a conventional medical model.

According to the National Center for Complementary and Alternative Medicine (2010), conventional medicine is also called Western or *allopathic medicine* and is typically practiced by individuals who have medical degrees and by allied health professionals, such as physical therapists, psychologists, and registered nurses. Holistic healing treatments, or *alternative medicine*, range from herbal and botanical supplements to acupuncture to meditation to yoga. Many psychotherapeutic practices already integrate alternative medicine into their practices. For instance, a mental health professional might recommend St. John's Wort, a common herbal supplement, as part of treatment for depression. Another therapist might ask his or her client to consider incorporating meditation into their daily practice to allay anxiety. As the attitudes of the current medical model shift, these complementary practices have become more prevalent.

Reiki and Its Place in the Spectrum of Holistic Healing

Before moving forward, it is important to define what Reiki is and how this practice could have a positive impact on psychodynamic treatment. Reiki works to create positive changes within the mind and body. During a session, a light touch is given on a fully clothed recipient who is either seated, lying down, or standing. A full treatment typically includes placing the hands in 12 positions on the head and on the front and back of the torso that correspond to the body's endocrine and lymph systems. The twelve positions for hand placement for a Reiki practitioner include over the face, over the head, on the posterior of the head, around the jaw line, simultaneously under the chin and over the heart, below the ribcage, over the solar plexus area, on the pelvic bones, on the shoulder blades and middle back area, and finally on the lower back area. As hands are placed on the body for three to five minutes at each position, the energy flows according to the client's needs and this energy flow is transmitted to the Reiki practitioner (LaTorre, 2005).

There are three levels to Reiki training. The first level, or *attunement*, explains the concepts and basic hand positions of Reiki. The second level expands upon the first and incorporates the use of *remote or distant healing* for Level 2 practitioners. This means that the practitioners are taught certain symbols associated with energy and emotion to incorporate in their Reiki sessions. Finally, the third level of Reiki training creates a Reiki *master*, which means the practitioner is capable of sending Reiki by thought alone and in some circumstances may teach other Reiki initiates about the process (Miles, 2008).

This method of energy healing through the use of a light touch may have implications in psychotherapy as it works to create a strong interpersonal relationship

between therapist and client (LaTorre, 2005). Wardell and Engebretson (2001) found that a client's feelings of safety and inner peace enhance a sense of connectedness towards the Reiki practitioner. Deciding to use part of a therapy session to give a Reiki treatment can do a lot to support the overall interpersonal work between client and therapist, because it can be empowering for the client. The therapist can model a coping mechanism for the client, encouraging the client to reenact it at home, instilling a sense of agency and empowerment for the client (LaTorre, 2005).

The History of Holistic Healing

Holistic healing has existed in the world for thousands of years. Socrates warned that treating just one part of the body would not have good results and Hippocrates thought that many factors contributed to the health and well being of a person (Skinner, 2006). Aristotle believed that the heart was the center for emotional and mental processes and the entire body should be treated with that in mind (Adler and Mukherji, 1995). Holistic medicine existed in ancient Greece, China, and India, as evidenced by cuneiform writings, ancient pictographs, and hieroglyphics, but the term "holistic" did not become a part of everyday colloquial language until the 1970s, when Western medicine began to integrate it into practice (Skinner, 2006).

According to the National Center for Complementary and Alternative Medicine (2010), herbal or botanical medicines were some of the first attempts to improve the human condition. In 1991, a mummified man discovered in the Italian Alps was examined and medicinal herbs were found among his personal effects. Healers in the Middle Ages identified thousands of herbs in terms of their medicinal properties.

Throughout European history, two types of healers were prominent; professional physicians and folk healers. Folk healers were typically in a lower class and healed villagers who could not afford to go see the professional physicians. This division of healers by social class was evident in many different cultures (Cuellar, 2006).

By the mid-1900s, allopathic medicine was making great strides in treating infectious diseases and surgery was becoming prevalent in society. This caused a greater divide within the medical community, and until holistic medicine began to show its worth by treating chronic illnesses that form of healing was discarded for more modern medicine (Cuellar, 2006).

Once the scientific method began to inform the basis of healing, the intuitive and traditional forms of healing were shunned, as they were deemed uncivilized and irrational (Adler and Mukherji, 1995). It was only at the beginning of the twentieth century that the principles of holistic medicine fell out of favor with the advent of more Westernized medical practices (Skinner, 2006).

During the last 100 years, Western medicine has made significant scientific strides by producing progressive diagnostics, pharmaceuticals, and surgical treatments, all of which are supported by standardized medical training and academic research (Milden and Stokols, 2004). In the 1970s, Western practitioners began to rediscover the benefits of holistic medicine through the research of its detractors, and it has gradually become more integrated into the Western paradigm ever since. Many people began seeking holistic remedies when chronic ailments could not be treated by allopathic means alone. Because modern medicine, specifically prescription medications and surgery, are designed to attack illness, the goal of creating and sustaining optimal health for an

individual is not primarily addressed. This goal is key for holistic medicine, which makes it an attractive alternative for people seeking that type of treatment (Skinner, 2006).

Body-Mind Psychotherapy

As more clinicians become interested in expanding their psychotherapy practice to incorporate Eastern thought, body-mind psychotherapy has become important to explore. *Body-mind psychotherapy*, or *somatic psychology*, refers to psychological approaches that focus significantly on the role of the body (Aposhyan, 2004). Therapeutic interventions rely on the clinician's ability to observe and support the client's process by asking the client to listen and identify with their body and their body's desires. These observations are meant to alleviate physical or psychological symptoms that are linked to the physicality of a person (Totton, 2003). These beliefs can be linked back to Hippocrates' view that mind, body, and soul are all interconnected.

Body-mind psychotherapy recognizes there is no living human body without a mind, and therefore in approaching a human body, a psychotherapist also approaches that person's mind (Totton, 2003). This philosophy also has early roots in Freud's development of psychoanalysis. Freud's psychosexual stages and drive theory could be considered entirely body-based, as well as his incorporation of having his patient use a couch to increase bodily awareness (Apoysan, 2004).

Freud ultimately rejected the idea that touch could be beneficial for his patients, as physical contact became associated with seduction and aggression, which could potentially place the psychoanalysis with his patients in jeopardy. Additionally, touch was historically linked to religious traditions and pagan beliefs, and helped convince

Freud that rejecting touch within therapeutic sessions would be in the best interest of his practice (Fosshage, 2000).

One of Freud's students, Wilhelm Reich, disagreed with Freud's approach to sitting behind the patient who was lying on a couch. Freud had prohibited the use of touch in psychotherapy, as he instituted the "rule of abstinence" to prevent personal or sexual relationships from developing with patients -- a problem he had encountered previously (Fosshage, 2000). Reich believed that sitting apart from the patient prevented eye contact or good observation of a patient's emotional state and physical reactions, which was counterproductive to solving the patient's problems (Ventling, 2002). This created a division in thinking as mental health practitioners began siding with Freud or Reich.

Therapeutic Touch

Ever since Freud's disavowal of touch in psychotherapy and his extremely successful approach called the "talking cure," touch has been considered a taboo subject. Even as Freud renounced touch by stating that it simply gave into a client's desires rather than creating the needed frustration to move the client forward in therapy, a colleague named Sandor Ferenczi continued to advocate and explore the effects of therapeutic touch by developing a form of somatic trauma therapy (Totton, 2003). Ferenczi (1955) believed that physical contact was a valuable means of repairing early damage to the individual, especially children who had been sexually abused.

Some feel that the disagreement between Freud and Ferenczi had a considerable impact on the development of psychoanalysis, as many feared that challenging Freud's

psychoanalytic theory would cause them to be shunned by Freud himself (Hunter & Struve, 1998).

Because of the debate surrounding the advantages or disadvantages of therapeutic touch, reports vary on how clinicians use touch as a therapeutic intervention. Some adhere to Freud's abstinent philosophy and others believe it is a crucial element in psychotherapy (Smith, 1998).

Dolores Krieger first introduced the notion of therapeutic touch as a specific intervention in the 1970s. She believed that patient satisfaction, comfort and recovery from illness were improved by the use of touch (Scheiber & Selby, 2000). By the mid-1990s, Krieger had secured thousands of dollars in grant assistance to further study the benefits of therapeutic touch and this method had been professionally incorporated into several nursing associations as a skill for nurses (Scheiber & Selby, 2000).

Medically, the use of Reiki has been proven to lower blood pressure and heart rate, which in turn alleviates tension and anxiety, ultimately helping the immune system to defend against bacteria and viruses (Sawyer, 1998). By stimulating the brain to increase the production of endorphins, Reiki serves to create a deep sense of relaxation and well being, as well as decreasing the perception of pain in the body (Sawyer, 1998). Other positive effects reported by nurses who have observed this treatment on patients include less pain, more relaxation, improved sleep, and a greater appetite. A reduction in nausea, emotional distress and improved communication has also been noted (Sawyer, 1998).

As therapeutic touch becomes more accepted and used in the nursing field, it also began to have a profound impact on other medical fields.

Current Empirical Studies on Reiki within Medical Models

Therapeutic touch and Reiki are closely linked in their philosophies. The next section will examine the use of Reiki and clinical social work practice.

Since Krieger first introduced the concept of therapeutic touch in the 1970s, studies have been done on pain perception and anxiety reduction, although the results were inconclusive (Scheiber & Selby, 2000). Interestingly, a study that specifically named Reiki as a therapeutic intervention found disparate results. The study, completed by Nield-Anderson and Ameling in 2001 found that clients who are anxious, stressed, depressed, or in chronic pain seem to benefit from introducing Reiki into the therapeutic interaction (LaTorre, 2005).

Studies have been done on the use of Reiki and relaxation, where “biochemical changes in the direction of increased relaxation and immune responsivity were reported, with a statistically significant reduction in state anxiety (and) drop in systolic blood pressure” (Bowden, Goddard and Gruzeller, 2009). Another study found Reiki is effective in modulating heart rates in stressed and unstressed rats, supporting its use as a stress- reducer in humans (Baldwin, Wagner and Schwartz, 2008).

With those results in mind, clinical social work practice currently accepts somatic counter-transference as a legitimate therapeutic technique and many clinicians have been to explore mindfulness techniques in which the body is central to therapeutic interventions (Corrigall, 2006).

Psychodynamic Psychotherapy

As Freud developed psychoanalysis, the intensive investigation of how a mind works, a less intense and briefer form of therapy emerged. *Psychodynamic psychotherapy* is based on the theories and techniques of psychoanalysis and is similar in that it attributes emotional problems to the patient's unconscious motives and conflicts. However, psychodynamic psychotherapy is different from Freud's classical stance, as this form of psychotherapy does not necessarily align with Freud's views that unconscious motives and conflicts are grounded in sexual desire.

Psychodynamic theory encompasses many different theories and has to do with inner energies, based in past experiences and present reality that motivate, dominate, and control people's behavior (Berzoff, Flanagan, & Hertz, 2008). *Psychodynamic* refers to interactions between conscious and unconscious factors which result in how a person's behavior or personality may be formed. The purpose of all forms of psychodynamic treatment is to bring unconscious material and processes into full consciousness so that the client can gain more control over his or her life (De Mijolla, 2005).

The goals of psychodynamic psychotherapy may vary depending on the client's needs and the method of treatment, which can use 1) a broad, expressive lens to explore root causes in a client's behavior or 2) supportive therapy, which attempts to alleviate immediate distress (Fundukian and Wilson, 2010). Psychodynamic psychotherapy sessions may be scheduled from one to three days per week and each session lasts about 45-50 minutes per session. More sessions per week allows for more in depth treatment.

It is the therapist's job to listen and to help identify patterns of thinking, feeling and interacting that may be contributing to the patient's current struggles. Consequently,

the person becomes more aware of his or her thoughts and feelings; learns how some present ways of coping are no longer adaptive even though they may have been necessary in childhood; and discovers that he or she as an adult has a greatly expanded repertoire of resources and can use far more effective ways of dealing with problems. Deeper awareness and new insights stimulate psychological growth and change (Fundukian and Wilson, 2010).

Psychodynamic psychotherapy places great importance on the *therapeutic dyad*, which is the term for the relationship between the therapist and the patient (Fundukian and Wilson, 2010). It is within the context of the therapeutic dyad that positive changes in the patient's outlook and behaviors are able to unfold. This relationship is unique because the therapist maintains a uniform, neutral and accepting stance. This therapeutic stance makes it easier for the person seeking treatment to speak freely and to therefore provide as much information for the therapist to work with as is possible.

Because of the historical emphasis placed on Freud's abstinent philosophy, touch in most forms is not accepted in psychodynamic treatment. The definition of touch can be a complicated factor, as it can include light contact with the hand or shoulder, handshakes, or even a broad range of techniques such as body awareness and movement exercises (Kertay, 1993). Because of the wide range of definitions, discussions around touch in psychodynamic psychotherapy continue to be complex, and such therapeutic interventions like Reiki need to be individually considered under ethical and professional considerations.

Summary

The current literature views therapeutic touch as a contentious area in regards to psychodynamic psychotherapy, as it has been since Freud condemned it from his practice. The relationship between holistic and allopathic medicine has evolved from a class issue with folk healers tending to lower classes, into a new divisive issue of goals for treatment. Western medicine generally aims to attack existing illnesses or medical conditions from a purely physical and biological level, whereas holistic medicine intends to treat individuals on a variety of different levels, contending that the mind and body both needed to be treated for an individual to be healthy. A number of holistic practices have remained the same over the years, as traditions and rituals have been passed on through generations.

As holistic healing has recently seen a reemergence into Western medical models, it is important to study the advantages or disadvantages of using complementary and alternative treatment into allopathic medicine. Psychodynamic relationships in which therapeutic touch has been introduced are becoming more common (Scheiber & Selby, 2000).

Therapeutic touch has begun to be empirically researched, as have other types of integrative theories into clinical practice. However, the therapeutic processes in which Reiki has become an additional mode of intervention has not been fully investigated. Therefore it is necessary to examine if and how clinicians perceive the effects of Reiki in psychodynamic clinical sessions.

CHAPTER III

METHODOLOGY

The objective of this qualitative study was to explore the strengths and limitations of incorporating Reiki into clinical social work practice from the perspective of clinicians who are psychodynamically oriented. The specific objectives of this study were to gather information about: 1) the nature and history of social workers' integration of holistic medicine into therapy sessions, 2) how social workers evaluate the appropriateness of holistic modalities for their clients, 3) the rationale and conceptual framework for social workers' integration of Reiki in their psychodynamic practice, and 4) the barriers or training issues that need to be addressed.

A more in-depth understanding of this topic might be an important development for social work practice, as Eastern medicine becomes more frequently integrated into psychodynamic practice. The findings of this study might lay the groundwork for social workers and social work students to develop a conceptual, theoretical and practice-oriented map of how to integrate alternative treatment modalities into their clinical skills.

Data was collected through semi-structured interviews composed of closed ended questions focusing on demographic characteristics, education/training, etc., and open-ended questions which should have allowed the participants to provide opinions, information or understanding about this phenomenon. Allowing individuals to explore

their ideologies at their own pace is important because they had the opportunity to reflect and offer in-depth responses.

Characteristics of the Participants

The participants were comprised of a non-probability sample of individuals who were trained as both Reiki practitioners and licensed mental health clinicians. Sixteen psychodynamically trained clinicians participated in the study. Clinicians were defined as social workers, psychologists, psychiatrists, and licensed mental health clinicians who had at least five years of work experience and hold an accredited license to practice in their state. Additionally, these clinicians must have achieved at least one level of Reiki training and have utilized Reiki within their psychodynamic therapy settings for at least one year. Reiki practitioners undergo a series of attunements, which are sessions with Reiki masters that teach the basic methods of energy healing. Several organizations provide resources for Reiki training, up to four levels of attunements.

Exclusion criteria included those clinicians with no involvement in Reiki training or were currently undergoing their first Reiki attunement, clinicians with less than five years of licensed work experience, and those not conversant in English.

Recruitment Process

.I contacted several individuals through an Internet search who have explicitly stated a positive bias on the integration of psychodynamic practice and Reiki. These individuals have responded enthusiastically about the nature of the study and have expressed an interest in helping recruit individuals for the sample. I used a snowball sample of convenience utilizing the assistance of those individuals.

A flyer (Appendix A) that included information about the study, including risks and benefits associated with participation, and details related to the purpose and justification for the study was sent via email to those clinicians who had agreed to help with the recruitment process. This flyer was also posted on public web sites accessed by clinicians and Reiki practitioners (i.e. local Reiki message boards and mental health websites, etc.)

If feasibility problems arose (i.e. cannot obtain enough sample subjects), I planned to broaden my selection criteria to include licensed mental health clinicians, psychologists and/or psychiatrists as well. Were I still unable to recruit enough subjects, I might have altered my study to examine the how holistic healing modalities in general have affected clinicians' perceptions of how treatment with clients has been achieved.

Nature of Participation

Once I recruited the participants and received an informed consent letter (Appendix B) from each, I contacted each individual by telephone or Skype for their hour-long interview. If they preferred to meet in person, we arranged for a place that was private and comfortable for the participant. The data from these interviews was not collected or published until a letter (Appendix C) from the Smith College School for Social Work's Human Subjects Review Board was received.

Demographic data such as length of time working with a license to practice psychotherapy and length of time working with Reiki certification were collected at the beginning of the interview. Participants were also asked to describe their integration of Reiki into their social work practice and to identify the parameters for deciding a client was a good fit for this treatment modality.

During the interview, I utilized a list of interview questions (Appendix D) that served as a guide as I asked the participants both closed and open-ended questions. I assumed that the open-ended questions (such as: “Why did you become interested in the practice of Reiki?” and “Please describe how you integrate Reiki into your work.”) would allow participants to be able to communicate their thoughts and experiences more authentically and with fewer constraints, and that a more comprehensive understanding of their narratives will result.

The interviews were audio taped using a digital recorder. Notes were taken during the course of the interviews with participants. These notes became part of the data collected and analyzed. I transcribed the data and analyzed the transcriptions.

Risks

Minimal risks from participation in this study were anticipated. Participants may have experienced some mixed feelings when reflecting on their experiences using an alternative treatment in a psychodynamic setting. Participants may have been uncomfortable expressing their thoughts about this topic.

I did not distribute a list of referral sources to this particular group as 1) they are adults who have made a choice to participate in this group, 2) they know this topic and have agreed to the content of the discussion, and 3) this is a topic that is not geared to reflection about internal states or attitudes.

Participants had the right to not answer any question during the interview without any repercussions. They had the option to withdraw from the study at any time before, during, or after the completion of the interview until April 1, 2011, when the report was

being written. In addition, removing names from the data and holding the data in a locked location protected participants' confidentiality.

Benefits

Participants may have gained new insight into their work with Reiki that might be useful for their direct work with clients. The information participants provided about their experience may prove to be invaluable and may generate some good questions to posit for future research regarding holistic healing within the mental health field. This information might also benefit individuals seeking therapy and clinicians interested in expanding into a complementary medical model like Reiki. Participants were not paid for their involvement in this group.

Informed Consent Procedures

Once it was determined that a person was interested in participating in the study and meets the selection criteria, an informed consent form was mailed to the participant for signature. Participants were advised to keep a copy for their records. No interview took place until the signed informed consent form had been returned to the researcher.

Precautions to Safeguard Confidentiality

Participants' confidentiality was protected in a number of ways. Data in the final report was presented without reference to identifying information. All identifying information on the demographic questionnaires or in my records was removed from the data. Signed informed consent forms are kept separate from recordings and transcripts, and I am the main handler with the collection of data including transcripts.

As a student, my research advisor did have access to the collected data after identifying information was removed. Illustrative vignettes and quotes were disguised to protect a participant's identity. Any quantitative data that are reported will be presented in the aggregate.

Data Collection

I recorded the narrative data during interviews using a digital recorder. In addition, I took notes during interviews. After interviewing, I transcribed the interviews verbatim from the digital recorder.

Data was collected via telephone or Skype using a semi-structured interviews guide and lasted approximately 1 hour. I chose interviewing as a way to collect data because it is a flexible method for research and is generally employed to investigate a phenomenon that has not been previously studied or has been poorly understood (Anastas, 1999, p. 353). Considering that there is a major lack of literature on the integration of Reiki into clinical practice, interviewing seemed to be the most appropriate method for data collection for this study. The interview was semi-structured so that I could ask certain questions that elicited information around themes, while keeping the questions open-ended enough so that respondents could discuss their own individual experiences, reactions, and responses to whatever extent they chose.

My interview guide began with a few questions that collected data regarding professional development, specifically: professional degree, level of Reiki certification, and years of experience. My questions were broken down into the following themes:

- feelings/thoughts regarding integration of Reiki into mental health practice

(i.e. How do you determine if a client is suitable for Reiki?);

- extent of training in both holistic healing and Western medical models (i.e. How many years of experience do you have as a clinician? and In what level of Reiki training have you been certified?);
- how clinicians determine suitability for Reiki integration (i.e. In general, what types of presenting problems would you consider suitable for Reiki integration within the therapeutic setting?);
- how Reiki is incorporated into a clinician's work (i.e. How do you introduce Reiki into a session with a client?);
- if a clinician's perception of acceptance regarding alternative treatments has influenced their caseload (i.e. Do you advertise Reiki as part of your mental health specialties? If so, why? If not, why?);
- what clinicians believe results of this type of dual treatment have been for their clients (i.e. What benefits have you seen within clients whom you've utilized Reiki treatment with? and Please describe any disadvantages or negative experiences for clients?)

Finally, I ended the interview section with a few questions regarding race, religion, socioeconomic status, gender, and age, as I was interested to see if there were any trends among these subgroups. The sample was too small to examine these demographics with any systemic confidence, but trends might have been pervasive enough to suggest further study.

In order to enhance the study's credibility, I had two licensed and experienced (two years or more in the field) clinical social workers review my interview guide and provide feedback on the clarity and relevance of the questions. Piloting the interview guide with one subject (not part of the sample) enhanced clarity, consistency and flow of questions..

In order to establish the study's trustworthiness, I attempted to avoid several threats including reactivity and respondent bias (Anastas, 1999). I planned to ease into the interview with participants in a relaxed and supportive way, to decrease the chances of reactivity and respondent bias (Padgett, 2004). During data collection, I would have preferred to enlist the help of several coders who could have analyzed the data so that themes are confirmed by consensus, a process known as *analytic triangulation* (Padgett, 2004). I also examined data that might have disconfirmed my working assumptions (negative case analysis) to develop a thorough understanding of my thesis topic. Finally, I kept a detailed record of my thesis process and materials for the purposes of creating an audit trail.

Data Analysis

Data collected during recorded interviews was transcribed, organized and analyzed for common and divergent themes based on words and phrases as the unit of measure. As I took notes during the interviews and then reviewed the transcriptions, I noted both common and varied themes as well as atypical and remarkable responses. Data was coded and reduced into distinct categories based on themes within the responses to the questions asked.

Content analysis codes responses according to a conceptual framework. This means that I attempted to base my judgment on a broad range of information and observations, as I aimed for depth during the interviews (Rubin and Babbie, 2010).

Additionally, qualitative research allowed me to be flexible and reflexive, both considered strengths in this type of research. Because qualitative research relies on perception to determine nuances in behavior and attitudes of the participants, my research design might have shifted slightly through modifications to my research design (i.e. additional probes and follow-up questions). Qualitative research also demands that the researcher become aware of her own biases and perspectives (Rubin and Babbie, 2010). These biases are described in the final chapter.

Discussion

Expected findings, drawn from the related literature, were as follows: 1) Reiki used in a psychodynamic clinical setting was beneficial to clients; 2) a clinician's experience and level of Reiki training were commensurate with their perceptions of benefits and 3) reasons for using Reiki in a clinical social work setting relied on relational and interpersonal goals for the client.

A possible unexpected finding might have been that therapists used Reiki as a therapeutic intervention with clients who had been referred for a number of different presenting problems. The literature suggested that Reiki has been beneficial in reducing stress and anxiety in clients, increased mindfulness, alleviated depression, and treated clients who have experienced trauma.

CHAPTER IV

FINDINGS

Introduction

This chapter contains the findings from interviews conducted with sixteen licensed social workers from the United States and Canada who have had a minimum of five years experience as a licensed mental health clinician. All clinicians practiced using a psychodynamic treatment approach with their clients and integrated Reiki in their practice.

The first set of interview questions were designed to elicit information regarding participants' experiences with Reiki, ways they incorporated holistic healing into their work, and what it meant to them. The next set of questions pertained to how the participants developed an interest in Reiki and how the use of Reiki pertained to their clinical social work practice. Open-ended questions on the topic of the clinicians' experiences, the determination of suitability for clients, and integration within their practice followed. A section focused on the clinicians' perception of acceptance of Reiki in their profession followed, including the possibility of marketing holistic healing as a treatment modality within the mental health profession. Finally, participants were asked what benefits and/or disadvantages they have observed while incorporating Reiki, and if they would like to share further information which could benefit future social workers interested in utilizing holistic healing in the field.

The data from these interviews are presented in the following sequence: demographic data of participants, determination of client suitability for Reiki, the use of Reiki in session, perceptions of acceptability within the field, and outcomes of Reiki integration within practice.

Demographic Data

The sample for this study was comprised of sixteen licensed social workers: fifteen women and one man. Geographic locations included: California, Connecticut, Massachusetts, North Carolina, New York, Ohio, Ontario, and Washington. The age range was between 37 and 67, with twelve participants 50 or over. One person self-identified as Asian, and the remainder (n= 15) identified as Caucasian.

The following section offers information pertaining to the clinicians' training and background. The range of practice experience was from 9 to 35 years, with 8 participants reporting they had 20 years or more of clinical experience. The majority of participants (n= 12) held independent licenses to practice clinical social work (LCSW); the other four participants identified as licensed mental health counselors (LMHC).

Most participants (n= 14) stated that they had obtained masters level training in Reiki. Two participants were level two Reiki practitioners. The range of experience practicing Reiki was from 2 to 26 years.

Interest in Reiki

This section details the clinicians' responses to questions pertaining to their interest in Reiki. The data are presented in the following sub-sections: personal reasons, incorporating the concept of energy, and expanding treatment modalities.

Personal Reasons

Participants were asked: Why did you become interested in the practice of Reiki? In responding to the question, a few participants (n= 4) stated that they were drawn to Reiki for personal reasons. One participant said she became interested “during a stressful time in my life.” Two participants referenced experience of being around a terminally ill relative. One person described her experience in the following manner:

It was because my stepfather was dying and my cousin was a Reiki master. She came down when he was staying at home as he was approaching his death. She came and visited him and did Reiki on him and we all got to the point to where we were completely fried. She called from where she was in a different state and told us to go to three different rooms and she sent Reiki to us. We each had similar experiences of hands touching our bodies. At that point, I knew I’d be a Reiki practitioner.

Participants who sought Reiki training for personal reasons stated that they had a spiritual focus. One participant stated, “I’m very spiritual. So in my own mental health, if I’m feeling very stuck, and like nothing else is working, I go to spirituality and Reiki is a very spiritual practice.” Another said “It [Reiki] was offered to me as a support during that time from a spiritual perspective.” A spiritual perspective was not the only reason that drew individuals to the practice of Reiki. Learning more from a conceptual standpoint in terms of how energy impacted healing was also a major incentive for participants.

Incorporating the Concept of Energy

Half of the participants (n= 8) felt that understanding the influence of energy in Reiki could be important to their clinical practice. Some clinicians stated that energy could be “transformative,” “interesting,” and “curious”. One participant framed it in the following way:

I had a spontaneous experience. A friend had hurt her knee and I spontaneously got up and put my hand on her knee where she had hurt it. And there was a phenomenon where I had pulled the pain out of her knee, and her knee felt better. It got me really curious. I went online to try to figure out what had happened, and Reiki kept coming up on the searches, so I figured I would try a Reiki class and see if it would get me somewhere.

One participant felt that taking a class on Reiki was important in order to “to find out about the energy fields I was experiencing as I got into being a clinician.” One person said that “the first time I noticed Reiki experientially is when I was outside and I felt this energy flowing from my hands, and I felt compassion.” Three clinicians were engaged in other holistic practices, including Aikido, massage and yoga; and they became aware of energy fields through them. They reported that “my yoga teacher was a Reiki master. She convinced me, she said I’d be perfect at it,” and “the massage therapist was a Reiki master. I could feel the energy and I asked her what she was doing, and she told me what it was. I had never heard anything like that before.”

One participant became interested in the concept of energy from an academic perspective. The following passage describes her process of becoming interested in Reiki:

I became interested in understanding energy. Part of my work was about understanding Karl Jung's archetypal psychology. He really talked about how the psyche is an open system of energy and how our emotions are like frenetic energy. Also, my own experience occurred - 20-some years ago - after having an awakening with spiritual energy and how restorative it was. That began a 25-year quest to understanding energy and what kind of energy is transformative. I've been studying various levels of energy for many years. Reiki was something I was really drawn to, it was comprehensive, had a long lineage. I was really connected to it.

Although participants' responses varied regarding why energy was a factor in incorporating Reiki in their practice, two themes emerged: 1) a better understanding of energy within a therapeutic setting and 2) meaning-making. Several participants alluded to a need to expand their treatment modalities to better serve their client population.

Expanding Treatment Modalities

Some clinicians (n= 4) reported that they felt their professional training in mental health was insufficient in meeting their clients' needs. One clinician shared that, "after counseling for about 20 years, I really did not feel that it was a strong enough method to be able to affect changes in my clients. I decided to add a more holistic piece to it and that has worked tremendously well." Another participant said that she began exploring Reiki as a treatment option after learning about a peer clinician who had successfully introduced Reiki into her own practice. Yet another clinician learned about Reiki as a treatment option in a peer supervision group, wherein a social worker who had been

trained as a Reiki master taught it to the group for its therapeutic intent. This participant went on to say:

The thing that really made me continue was that one of the social workers in the group got leukemia. She asked us if we would give her daily sessions, either through distance healing or hands on. She did very well with her treatment, and went into complete remission. It was a great experience. It was certainly an undeniable, powerful experience.

Finally, one clinician shared that she originally was interested in Reiki as a treatment option for herself, as she was working in a stressful and emotional field. Once she experienced the benefits of Reiki, she began utilizing the modality in her profession. In her words, “I found it just a nice way to relax and deal with the difficult work of working in cancer care. So it was sort of like my support system. And then I started practicing it because it seemed to fit really nicely with (my) patients.”

Acknowledging a client’s individual needs is often encouraged in order to provide the best care, as illustrated by the common therapeutic adage, “Meet the client where they are at.” As indicated in the last comment, this awareness should be addressed throughout one’s career in social work. The following section further examines clients’ suitability for Reiki as a treatment modality.

Determination of Client Suitability

The second set of questions asked how the therapist determined a client’s suitability for using Reiki within their therapeutic process. This section is divided into three subsections: clinicians’ use of Reiki during therapy, common presenting problems of clients, and clinical determination of client suitability.

Clinicians' Use of Reiki

Most participants (n= 13) indicated that it would be difficult to say how many times they have incorporated Reiki into their clinical social work practice. Six out of the 16 participants responded that they could not quantify or specifically answer this question. Some participants (n= 4) noted that they used Reiki in their practice in each session. Two participants stated that they had incorporated Reiki at least one hundred times within a therapeutic setting. Another clinician explained that she “couldn’t give a simple answer.” One participant reported that she used Reiki with about half of her clients on a weekly basis. Only one respondent was able to give a specific answer, stating she had used Reiki with 36 clients. Another stated, “one time, very directly, otherwise, very frequently.”

Participants were then asked how many clients received Reiki treatment in their practice. Again, many interviewees stated that it would be difficult to estimate, and answers ranged from 2 clients to 20,000. The participant who estimated she had given Reiki to thousands of clients said she had been in practice for 20 years and said that 90 percent of the time, she was able to incorporate Reiki in her work. Six participants reported a range of clients, such as “at least 30 a year,” “between 5 and 10,” and “about 25 to 30”. One respondent said it varies from year to year. Another subject stated “I can’t say (for) my whole practice.” Only two clinicians were able to provide exact numbers, both reporting integrating Reiki with two clients.

Common Presenting Problems of Clients

Participants were then asked what types of presenting problems they would consider suitable for Reiki integration within the therapeutic setting. The majority of

participants (n= 10) named anxiety as a suitable concern to address with Reiki. One respondent recalled an experience where, “a person who had been raped, had been going through extreme anxiety and this felt like a way to calm her. There was nothing else at that time that felt as contained and soothing to her as Reiki.” Another interviewee emphasized “it’s pretty much good for anything, but especially with anxiety, I’ve found it wonderful.”

Depression was also identified by most participants (n = 9) as a suitable issue for Reiki integration. Four participants named trauma or post-traumatic stress as presenting problems for using Reiki within a therapeutic setting. One interviewee stated that “with the post-traumatic stress, more from a stabilization point of view, the person is able to get more present in their body.” One participant said the process of Reiki was helpful in moving forward in the therapeutic process for depressive, fearful, or anxious clients. Her example follows:

I think when I have a client who is especially anxious or depressed or afraid, when there’s a high level of that, I like to put my hands on them for a few minutes, on their shoulders or on top of their head, just to slow them down, to get them to be part of their body, so we can move forward.

Two subjects said they rule out certain diagnoses such as borderline personality disorder or psychosis. However, another participant noted that she had successfully treated a borderline client.

The majority of participants (n= 9) believed that Reiki integration was suitable for most clients, with one subject explaining, “if someone is stable enough, regardless of presenting issues, I will do Reiki with them.” Another participant echoed that sentiment

by saying, “I think you can apply Reiki or energy work into a therapeutic, traditional setting pretty much for anything.”

Another interviewee recalled, “I work on the person as a whole being. Whatever their particular symptoms are, just presenting themselves. What methodology I use depends on what they’re open to. You have to work with where people are at.”

One subject said, “I’d say it applies to everything I can think of, any kind of situation in which a person’s body is becoming agitated and turned around. And assuming that they are able to switch hats with me and let me offer that and then switch the hat back to a therapist role. For me, it’s a maturation question.”

Another respondent went into more detail about her experience. Her explanation follows:

Reiki is wonderful for a number of things. It’s wonderful for trauma. I really find it useful in every way. It’s really whether if the client themselves are ready for Reiki. I think the clients need to be in a certain place before they can think about that kind of treatment. You have to be in a certain place in your journey. You have to kind of know the therapeutic process, know how it works. And in a way sometimes not, sometimes people are really open to it. It depends on the person really.

Finally, one subject summed it up concisely, stating, “There’s really nothing that would not lend itself at least to a session on a table.”

Clinical Determination of Client Suitability

Participants were then asked how they determine client suitability for Reiki integration within a therapeutic setting. Most respondents (n= 10) said clients need to

express an interest in Reiki, using phrases such as, “the person has to be open to receiving it,” “they need to be interested in Reiki and desire it and ask me about it,” and “as long as they give me permission, if they’re open, pretty much anyone (can be suitable).”

Several respondents believed that suitability was determined if a client approached them with Reiki as a treatment modality. For example:

In my private practice, they come to me. The person is self-identifying. They know they’re coming for Reiki. The fact that I’m a clinician trained in psychotherapy is kind of a side benefit. People don’t look for psychotherapy and shifting into Reiki, it’s kind of the other way around.

Yet another interviewee said, “People come to me specifically for Reiki and then I’m like, okay, fine, that’s a no-brainer. Because I’m a social worker I do a lot of talk therapy in a Reiki session, no matter who it is.”

Several respondents identified those types of clients they would not consider suitable for Reiki integration, including individuals with dissociative features, “a brand new client,” and clients who need strong boundaries. One participant said, “I guess I would not probably use it with personality disorders. Not that I don’t think that somebody who’s borderline doesn’t need it, but I just think that the boundaries there need to remain pretty strong.”

Going even further into eligibility criteria, a female subject said she would be hesitant to work with a man. “I wouldn’t do it with a man as easily. I would be afraid of the boundary issues. It would be too risky.” She went on to identify an appropriate client as “someone I know pretty well, someone who knows me and knows my style and would be comfortable being touched.”

Another respondent reported that she rarely uses Reiki in her practice, as she considered it an ethical violation in her profession as a licensed clinical social worker.

Her statement follows:

With my license, you're not allowed to touch. The board of ethics, you're not allowed to touch clients, period. That's actually a violation. Within my therapy session, if I incorporate Reiki, I'm actually violating a code of ethics. So when it comes to deciding which clients, that's a tricky question. Some people might sue for sexual harassment. It's tricky. I wouldn't do Reiki with someone I didn't know for a long period of time. I would have to be really sure. It's something that you handle with care and you don't do with every client. Especially with extremely mentally ill clients, it changes the transference and may be perceived in a sexual way and it's not at all. So I'm very careful and I don't advertise it and I don't do it with most clients.

Overall, there was not a common theme for selecting clients for Reiki incorporation. One participant stated, "It's not perfect for everybody." Another respondent echoed that statement, noting, "It depends on the person. It can be overwhelming if you're not one to want to process your feelings. You have to feel your client out."

The next question in this section asked how these mental health clinicians introduced Reiki to their clients. Most participants said that their clients will ask them about it directly and from there, a brief description of Reiki as a form of energy work may follow. One participant said:

If someone comes to me because I'm a social worker, I do regular treatment with them and there comes a point in the therapeutic process where it doesn't seem that talk therapy is enough or movement isn't quite where it could be. At that point, they're pretty comfortable with me so I will talk to them about this kind of treatment, adding Reiki.

A few participants said that, by the nature of their website or the setup of their therapeutic space, clients may come in with questions about Reiki without the clinicians having to introduce the topic. Some respondents (n= 6) went into detail about how they might describe the practice of Reiki to a prospective client. Several interviewees said that they mention Reiki as one of the therapeutic services they provide during an intake session or within the first few meetings with a client. Another participant recalled that she might simply explain to a client that Reiki can be seen "as a complement to what we're doing, as a complement to mental health work."

The next question in this section asked participants to describe how they integrate Reiki in a session with a client. Most participants (n= 8) mentioned that they used a massage table as part of their Reiki sessions. Several participants (n= 4) said that they incorporated distance healing in their sessions with clients.

For some participants, delineating a distinction from talk therapy was important in their process. As one respondent noted:

I do it quite separate. Either it's a hands-on healing session or a counseling session. Occasionally what I'll do is just talk for the first half and then do hands-on healing for the second half. The first half I check in and see where people are

going, and what they need, what their head needs, and then the second half. Some people I'm sure do both together, but I don't.

Another subject said that separating talk therapy from Reiki was done by moving to another room where the massage table was present. Yet another interviewee said "the Reiki part of the therapy is typically silent. There's no conversation...That allows the Reiki to flow so that it supports the integration of any insight gained during the talk therapy."

For some participants, the Reiki session is usually silent. For others, talking is optional. One respondent recalled how she shifted her method of Reiki integration to meet her clients' needs:

The way that I was trained was my Master teacher said you absolutely don't talk when you're doing Reiki. It has its benefits because the person can be in a real meditative space. But what started happening was that things would come up for people. So what I started doing was say that if something was to come up or if you have a memory or you're feeling something in your body that you need to talk about with me, please feel free to let me know while you're on the table. That ended up to leading to a lot of really wonderful things that happened during the session that was very awareness-raising for people.

Another participant stated that, after a Reiki session, she would close up the talk therapy portion. However, she noted, "Sometimes when they become so relaxed, they may just want to stay silent." Although several interview subjects reported a structure to their Reiki integration, one respondent said that, ultimately, "it depends on what they want."

Acceptance and Marketing of Reiki

The third set of questions asked clinicians to consider if and how they marketed Reiki as an alternative treatment modality within their psychodynamic practice. This section is divided into two subsections: clinicians' determination of how to advertise Reiki within their mental health field, and if they felt Reiki was accepted in their profession.

Clinical Determination of Marketing Reiki

Participants were asked if they advertised Reiki as part of their mental health specialties. The majority of participants (n= 14) said that they did advertise Reiki. Of those 14 participants, 11 of them identified using a website to market Reiki as a treatment modality. One respondent said that although she had created a space for Reiki on her website, she does not advertise it on her business card. Another interviewee stated she designed a brochure to give adequate attention to Reiki as a therapeutic modality, in addition to a link of her website. One participant said she markets Reiki online, but with a caveat: "I didn't put my state license on the top of the page; one of my colleagues said you want to be careful putting your license on there with alternative methods."

Several participants responded that the decision to advertise Reiki was not easy. As one respondent said, "I do. I don't know how I could without [advertising]. I wouldn't be true to myself, I wouldn't be true to my clients. But it's taken a long time. Those first few years of mental health counseling, I had to really sneak it in. I wasn't comfortable with it. Now, everybody does it."

Another subject said that initial discomfort caused her to waver including Reiki in her advertising for many years. Her response follows:

It took me a long time to decide to do that. The reason I decided to do that is because I wanted to use Reiki more in my practice and I think it's beneficial to clients. The reason I hesitated so much is that I think the introduction of touch in psychotherapy is obviously very controversial and I think for me in my practice I find it essential to really do a good assessment with people before I introduce touch. I don't mind that some people think energy work is bogus. That doesn't really bother me. I've seen it work. I think it's starting to be a little bit of research on it. My concerns are about how I would be viewed by other therapists as someone who is willing to introduce touch into my practice. So it took me a few years.

Another participant echoed that she was concerned how other people in her field would view her as a mental health professional. She recalled, "I would feel terrible if I didn't let people know that I do that. I felt that it was important to offer it. I have struggled with it, though. It's on my business card, too. I really suffered a lot of angst about putting psychotherapist and Reiki practitioner on my cards, but it's on there. I think I worried what fellow social workers would think." Several (n= 3) participants mentioned that they advertise Reiki to make it clear to prospective clients that they are open to holistic or alternative treatment modalities.

Two interviewees said they do not advertise Reiki at all. One participant said he originally put psychotherapy Reiki as part of his specialties on the professional development site, LinkedIn.com. After a colleague questioned its relevance as part of a mental health specialty, the respondent said he began to doubt his security about the practice. He added that insurance companies have also impacted how he advertises Reiki

as part of his mental health work. He stated, “I felt I was better off for myself and for my clients to traditionally offer psychotherapy and then offer Reiki classes pretty separate. The managed care piece is big too; because of that influence, I really wanted to keep my approach pretty conservative with those clients.”

Another participant said she did not market Reiki due to the social stigma attached to the practice. In her words:

I find that Western medicine isn't really open to it. Some doctors are, but for the most part, you tell people you do Reiki and they look at you like you're not smart anymore. Unfortunately, there is still a stigma about it. Because I want to be taken seriously as a psychotherapist, I don't advertise it right now. Maybe in ten years from now, it'll be fine.

Acceptance in the Mental Health Profession

Many participants indicated that their decision to include Reiki in marketing was underscored by a general sense of how their colleagues might view the treatment modality. The next question asked participants to consider, in their geographical location, if they felt Reiki was accepted within their profession.

Most respondents (n= 9) felt that Reiki was not accepted as part of their mental health peers.. Several participants said that Reiki was still considered “woo-woo” in their line of work. One participant said, “They [colleagues] think it's kind of weird. It's not really understood. It requires more of a paradigm shift for people.”

Another clinician stated, “I don't want to be thought of as a flake. I don't want to be taken less seriously. Having Reiki tacked onto my name makes me worry that people

might not take me seriously as a therapist, at least, other therapists who I respect might not.” Another respondent echoed that sentiment, saying, “I don’t think enough counselors have really considered pushing the envelope on it. I don’t feel enough people are actually making use of it. They’re afraid to. They think it’s woo-woo. They’re afraid their clients are going to be upset, they’re afraid their work is going to be upset, they’re afraid the schools are going to be upset.”

Another respondent said that a strong push for evidence-based practice has created a backlash for holistic medicine. He stated, “Because a lot of the funding services are from state and federal agencies, they have to position themselves really conservatively. The push for evidence-based practices is really heavy. I would never be able to use Reiki directly as an intervention in that setting (at a child welfare mental health agency).”

For participants who asserted that Reiki was an acceptable form of mental health work, their reasons varied. Two interviewees considered the fact that the National Association for Social Workers (NASW) had offered continuing education credits on the subject of Reiki. Another respondent recalled observing articles in her chapter’s NASW newsletter about Reiki, indicating that she felt the practice is becoming more accepted in the profession. Several interviewees felt that a change in the general population’s view on holistic healing was having a positive influence on the mental health profession at large.

Benefits and Disadvantages of Using Reiki

The next section asked participants to reflect on their clients' experiences with Reiki as part of their mental health work. Clinicians were first asked to identify benefits or advantages for incorporating Reiki within the therapeutic setting.

Benefits to Reiki in Mental Health Work

All participants identified at least one benefit to using Reiki in their work. Many participants stated that Reiki increased awareness for the client, whether of physical symptoms that were exacerbated by emotional issues or simply more understanding of their mental health concerns. As one participant stated:

I've seen a greater awareness of what their presenting problems are - a greater insight. They're more relaxed. They actually become more body-centered and mind-centered. They come from more from their heart. The clients have told me they prefer that. They get more clarity about decisions they have to make.

One respondent recalled, "They [clients] become aware of certain patterns that they're playing out, what they need to stop doing, what is bothering them at a deeper level that they weren't able to put words to." Another interviewee stated, "People have become clearer about what's going on within [themselves] individually." Yet another subject said, "A lot of what I see is increased awareness, the "Aha" moment. It's nice to be there for those moments. People have more awareness of their body."

Another benefit that some participants (n= 6) noted was the client's ability to work through presenting problems more quickly. As one respondent noted, "It speeds up the process of psychotherapy. It requires less sessions. People make the changes needed

in a shorter period of time with less upheaval. The timing- it helps people integrate change more fully in their life instead of just the mental process.” Another interviewee said Reiki created “more of an immediate effect.”

Another participant agreed, stating:

They [clients] just seem to move through their presenting problem a lot faster. I think that’s because sometimes in traditional talk therapy someone can have an intellectual understanding of what the behavior is, why they do the behavior, the history and the root, but there’s still a disconnect with being able to shift out of that, even with all that awareness and insight. I find that integrating the body-mind consciousness into the session really helps them to release it, not just intellectually but energetically. It’s been embedded in their body.

Other benefits noted by the therapists for using Reiki in a mental health setting included: a deeper sense of relaxation for the clients, empowerment, and more energy. Decreasing anxiety was a common benefit, according to half of the participants (n= 8).

One participant stated:

When I first started using Reiki, you could have knocked me over with a feather. I did not realize anxiety was so treatable. It was so frustrating to see so much panic after a year and a half of treatment. So pretty quickly I saw the progress for people who have anxiety or panic. And people can self-treat between sessions. I was seeing a lot of reduction with symptoms. I noticed that right away.

Disadvantages to Using Reiki

All participants said that there was minimal risk to integrating Reiki within their mental health practice. Several respondents stated there were no disadvantages to using the modality. A few subjects mentioned that clients might experience a “healing crisis.” As one participant put it, “they develop some physical or emotional reaction. They might get tired, they might feel drained or they might get a headache. They might bring up some emotions or feelings that might need to get integrated into their sessions.”

Another interviewee said, “Your body could be releasing certain feelings, you may feel intense grief or intense anxiety. I tell them that beforehand, so that if they do feel some intense emotion working through, they aren’t scared.” Yet another participant noted, “Maybe, and this could happen in a regular counseling session, they’ve gone deeper than they were ready for or expecting and maybe had pretty profound results. And then they maybe just aren’t ready to start that process.”

Another subject said that a healing crisis just underscored the importance of creating space for a psychotherapist to include Reiki as a mental health specialty. Her response follows:

I’ve had patients get to a very - when you’re treating them - you might hit a part of their body that for some reason, some sort of trauma or sadness or grief is locked in there, and some people might have an outpouring of grief. It’s usually crying or sobbing. That’s certainly where I was glad I was trained therapist as well. Having only been trained in Reiki, I’m not sure that I would be equipped for that.

One participant noted that a disadvantage to incorporating Reiki into a session is that it could have a negative effect on the Reiki practitioner. “I know that one client was so severely depressed that I actually picked up some of her depressive energy. That’s when I realized to be careful.” Another interviewee mentioned, “I have seen negative impact only when the person practicing handled it unprofessionally, without training and knowledge.”

Other Findings

This final section presents some other findings from the interviews, including answers to a question regarding different types of holistic medicine. Participants were also asked at the end of the interview to share additional insights if desired, and some of those comments are presented here.

The first question in this section asked if the participants used different types of holistic healing techniques in their practice. All (n= 16) participants identified at least one other form of holistic medicine that they used in treatment, in addition to the practice of Reiki. Five interviewees stated that they had used hypnotherapy in their practice. Seven respondents mentioned incorporating meditation or breath work with their clients. Other holistic modalities included emotional freedom technique (EFT), eye movement desensitization and reprocessing (EMDR), Shamanic healing, and crystal healing.

Finally, participants were asked to share other comments regarding the integration of Reiki and mental health. Some participants (n= 3) did not have anything else to add. One respondent stated, “When I first started doing this work, I felt like I had to tiptoe around it. People would think it was strange, people would think it was weird. It’s been opening up in the past 15 years, which I think it is great.” Another participant echoed that

sentiment, saying, “I want to believe that in 10 years for now, I will be able to publicly use my Reiki in public practice and not have to pretend it’s not there.”

Another subject noted, “I think that the social work field is wonderful in terms of incorporating a little bit more alternative healing. The more we can empower our clients, the better it is.”

Another respondent stated, “It seemed against the rules, because I was trained psychodynamically. I felt like I was doing something wrong. I find myself shying away from it, it feels awkward to do it in the context of psychotherapy. I find myself using it more as a hospice social worker instead of a psychotherapist.”

Finally, a comment from another participant follows:

One of the reasons why I love being an MSW is because we were revolutionary. We had revolutionary ideas that people were valuable no matter where they came from. So I think we should continue to be revolutionary and radical, go back to our roots. That’s where Reiki comes in. I choose to walk in a radical way because that is the nature of the origins of the roots of being an MSW. We said even though people totally disagreed with us, people deserve food, people deserve shelter. I believe people deserve access to all the healing modalities that an MSW can offer to them on behalf of their needs.

CHAPTER V

DISCUSSION

The objective of this qualitative study was to explore the integration of Reiki into clinical, psychodynamic social work practice. The experiences, benefits and disadvantages of holistic healing were explored through interviews with mental health clinicians who utilized Reiki in their sessions. This chapter discusses the findings in the following order: 1) key findings, 2) implications, 3) limitations, and 4) recommendations for further research.

Key Findings

The results showed that all participants found Reiki to be a useful component for clients, particularly those experiencing high levels of anxiety and depression. This finding was in accordance with Nield-Anderson and Ameling's (2001) study on Reiki's calming benefits as a therapeutic intervention, and a study by Bowden, Goddard and Gruzeller (2009) showing that biochemical reactions through the Reiki process correlated with a significant reduction in anxiety and an increase in relaxation. All participants in discussing their client's presenting problems reported at least one issue in which they would find Reiki a suitable intervention.

A second finding showed that the majority of interviewees stated that integrating Reiki sped up the therapeutic process. This finding concurs with a qualitative study by Wardell and Engebretson (2001), who found that feelings of safety and inner peace

enhanced a sense of connectedness towards the Reiki practitioner. By creating a safe space with clients, clinicians may be able to work with clients on a deeper level due to Reiki integration.

Methods of incorporating Reiki varied, including whether or not a clinician used touch, which is at the opposite end of the longstanding debate whether to follow to Freud's abstinent philosophy (Smith, 1998). Some clinicians in this study believed using touch-oriented Reiki was a key element in a therapeutic setting. One interviewee said touch was crucial to the Reiki experience, as that is how she was taught by her Reiki master. Another respondent noted that the sessions depended on the clients' needs, and if they preferred a traditional talk therapy session instead of an integrative session, she would respect that choice.

Some clinicians decided, based on personal experience or the advice of their Reiki masters, that using distance healing was a safer, more ethical way of integrating Reiki into session. A clinician reported sending Reiki into the room to create a healing space for the therapy process. Another interviewee said she incorporated energy symbols for mental and emotional health during the psychotherapy component of a session, echoing the former respondent regarding the healing energy she would send out to the room. And yet another interview subject said using touch in psychotherapy is forbidden due to the code of ethics of social workers. Because of this, she is very careful about selecting clients for Reiki integration.

In addition to discussing how the therapists decided if a client was suitable for Reiki, participants also described how they introduced holistic healing into a session, how it was integrated, and how it augmented and/or superseded psychodynamic talk therapy,

which expanded upon the findings of Scheiber and Selby (2000) who found that as therapeutic touch becomes more integrated into psychotherapy, clinicians are entering new territory. Since the subject of therapeutic touch continues to be highly contested, many of these clinicians are pioneering a field where there is not a definitive model for how to incorporate therapeutic touch into their mental health work.

The majority of respondents noted that to consider if a client is suitable for Reiki integration, several factors needed to be considered. These factors included whether or not the client appeared open to the idea of energy work, if the client proactively asked about Reiki integration, or if the client's presenting problems would appear to benefit from Reiki. No prior studies addressed client suitability, so this finding could not be compared with the previous literature.

Many respondents said that individuals experiencing anxiety, depression, and some trauma symptoms were appropriate candidates for Reiki sessions. How Reiki was introduced in the session varied depending on a client's interest. Several clinicians noted that clients were referred to them specifically because of their expertise in Reiki and holistic medicine. Other respondents stated that the introduction of Reiki was part of an organic process between the clients and themselves, as the client may have indicated a curiosity about the therapist's treatment modalities or the possible presence of a massage table in or near the therapy room. No previous literature exists indicating how Reiki is formally introduced to clients in a psychodynamic setting.

The way in which Reiki was integrated into the therapeutic process also varied, based on the client's needs or the therapist's beliefs regarding touch in psychotherapy. Many interviewees separated the two processes, either by verbally indicating a shift in

process while in the room, or by physically moving from a traditional therapeutic room into one with a massage table. All of the respondents reported receiving permission from their clients to engage in Reiki with them, whether at the beginning of the session or through an informed consent form that the client had signed. A few clinicians reported that clients began to prefer one form of therapy over the other, and sometimes a Reiki session would take the place of talk therapy. Other clinicians indicated a mix of the two modalities, although even that response varied as clinicians reported whether or not they utilized psychotherapy while a client was receiving Reiki. As there has been minimal research done on Reiki integration, no previous studies exist to compare the efficacy of Reiki use in within a psychodynamic talk session.

Half of the clinicians reported they became interested in the concept of Reiki due to its connections to energy work or holistic medicine in general. All of the clinicians indicated having an interest in holistic healing modalities, and noted at least one additional area in holistic medicine in which they have been trained. The majority of clinicians also stated that clients found them primarily through their websites, where Reiki was noted as an area of interest for the clinicians. There were no previous studies to be found on this particular topic of marketing and advertising Reiki as a therapeutic intervention.

An area of overlap in the findings was that interviewees described many of the same presenting problems such as anxiety and depression as described in the previous literature. In discussing the participants' experiences with clients while using Reiki in a therapy session, findings were consistent with the writings of Ferenczi (1955), Sawyer (1998) and Corrigan (2006) that a client's experience with Reiki shows an

intersectionality among physical and emotional responses. Corrigall found that within clinical social work practice, many therapists have begun to consider mindfulness techniques that incorporate the body as a central therapeutic intervention. Fernenczi's earlier work examined the effective use of therapeutic touch on survivors' childhood trauma, including sexual abuse. Finally, Sawyer (1998) found that Reiki serves to create a deeply relaxed state for an individual, including decreased pain perception, improved sleep and communication, and a reduction in nausea and emotional distress.

Several clinicians mentioned a sense of *embodied emotion*, where a particular area of the body might house a traumatic experience or an emotion. In exploring themes in which integrating Reiki was beneficial for the client, topics included: increased embodied awareness, an ability to go deeper into the therapeutic process, a sense of clarity, increased relaxation, a decrease in depressive or stressed symptoms, and a greater sense of empowerment. All participants identified at least one benefit to using Reiki in their work. Totton (2003) examined the concept of body-mind psychotherapy as one in which the human body and mind cannot be separated, therefore, a psychotherapist approaches the human body just as he or she would that person's mind. Clients who identified as anxious, stressed, depressed, or in chronic pain seemed to benefit from introducing Reiki into the therapeutic interaction was noted by LaTorre (2005).

When asked about the disadvantages of Reiki, responses included: going too deep into their clinical issues too quickly and instances of healing crises, wherein the client might experience a physical ailment after a Reiki session. When these patterns were explored, an unexpected finding emerged where participants described how they provided corrective experiences with more relational work during the therapeutic process.

LaTorre (2005) explored the overall interpersonal relationships between therapist and client where Reiki treatment has been integrated and found that Reiki can serve as a sense of support and empowerment within the therapeutic process. Additionally, Wardell and Engebretson (2001) found that a client's feelings of safety and inner peace may create a sense of connectedness towards the Reiki practitioner.

A main source of concern for clinicians was a feeling of disconnection from the mental health profession at large. Many participants described feeling isolated or alienated due to using a treatment modality that was not "ordained" by their profession. Several respondents said that they sought support in their communities in the form of peer supervision with likeminded clinicians. Previous research (Riva & Cornish, 1995) has shown that *group cohesion*, interpersonal relationships within groups, trust, and giving and receiving feedback are all important components of group supervision.

Significant commonalities existed between the findings that emerged by this study and the existing findings found in some studies pertaining to the importance of incorporating Reiki in clinical social work. Many clinicians felt Reiki was an underutilized modality, called upon by clients who self-referred or by agencies where Reiki has been documented as a modality, such as hospice care. This finding was consistent with the data presented by (Scheiber & Selby, 2000), who found that psychodynamic relationships in which therapeutic touch is being introduced have become more common. However, negligible research exists on the type of agency in which Reiki is typically used as a treatment modality. Previous findings regarding this topic were not found.

The range of personal experiences that respondents described went from feeling completely alone in this field to having a strong sense of community in the holistic healing field. Most participants expressed joy, confidence, and an expanded view on their treatment modalities due to Reiki. Most participants indicated that they felt that Reiki integration was increasing in the mental health field as more clinicians become aware of its benefits.

Among the findings, participants described a broad range of training and experience, with most of their training in Reiki and holistic healing obtained on their own initiative after completing a Masters degree in a clinical program. All participants continued their Reiki training beyond the initial level, and the majority went on to become Reiki masters. The vast majority of therapists noted that training in Reiki was not offered or included in their Masters degree program.

Implications for Social Work Practice

The overall objective of this study was to explore and document the utilization of Reiki within clinical social work practice, with the hope that it may guide larger, future studies on the integration of Reiki in the mental health community. Although there were divided opinions involving the ethics of therapeutic touch in psychotherapy, all the participants reported discussing the topic to some degree with their clients. As clinicians are required to adhere to the code of ethics mandated by their profession, it is crucial that clinicians consider the benefits and/or risks of touching their clients within a therapeutic setting. It is imperative that mental health clinicians who seek to integrate Reiki or other holistic healing modalities document the informed consent procedures with their clients, as well as a thorough clinical formulation that would support the use of therapeutic touch

within their settings. Several clinicians spoke about being hindered by the constraints of public community mental health agencies, or by the federal regulations that government-funded agencies must adhere to. Additionally, it is important for clinicians to take precautions to understand how insurance companies or managed care might affect the use of Reiki in mental health practices.

Finally, participants commented on the speeding up process that Reiki elicited during the therapeutic process. It would be of interest to compare these results with what other clinicians have observed in this area and if similar results would be yielded in future studies.

Limitations

One major goal of this study was to recruit participants with a variety of training and mental health licensure. Only two participants noted that they were not Reiki masters. The level of experience seems to have great importance on the type of Reiki treatment a practitioner may provide. Further research on specific levels of Reiki training could enhance the interpretations noted here.

Also, the generalizability of these findings cannot be assumed. The sample size was relatively small, with 16 participants. Although it was hoped that nation-wide recruitment would yield a diverse sample, a representative sample of clinicians from different ethnicities or genders was not obtained. Additionally, although the recruitment materials asked for clinicians with a psychodynamic focus, none of the screening questions or questions in the interview guide confirmed and/or elicited information regarding this focus. Lastly, prospective participants were turned away due to timing of

the study. Thus, it is possible that those who volunteered for the study and were denied could have provided a range of answers not shown in the research results.

Reliability of measurement and validity must also be considered. The interview questions were self-developed. Therefore, there is likely to be a certain amount of bias involved. This researcher's own experience and Reiki training may have also created bias in this study. Finally, setting up the interview involved an initial screening call, followed by mailing an informed consent and then setting the hour-long interview. This was a time-intensive process for both this researcher and the respondents, and required an amount of trust and timeliness, which may have affected the recruitment process. Time was a factor, as I received many follow-up e-mails from prospective participants that I simply had to turn down due to the limited timeframe set for my research. Although I was fortunate enough to have 16 participants, if time was not an issue, I could have conducted research with a larger sample.

Recommendations for Future Research

Future research might benefit from a larger and more diverse sample, as the majority of the sample was female and licensed in social work. Interviewing clinicians from other mental health disciplines such as psychology, psychiatry and nursing, would be important to gain further insight on Reiki integration.

An exploration of the cultural implications pertaining the use of Reiki is also warranted as all the clinicians in this sample were white, Caucasians. Further investigation in terms of gender differences for both clinicians and clients might also be useful. Participants in this sample were situated in areas of the U.S. that are considered more progressive and holistic in their treatment approaches. Additionally, when looking

at the sample based in the United States, people from the Midwest or South should be sought for future research, as the sample focused primarily on individuals located on the West and East Coasts.

It would also be important to survey clinicians based on the level of Reiki training, rather than years of experience with Reiki. With each Reiki level, the practitioner gains additional skills or methods to use Reiki, and a Reiki master may have a very different view than Reiki Level 1 or 2 practitioners. This was an unexpected finding as the interviews took place. Finally, comparing the length of treatment for clinicians incorporating Reiki with those who are not could yield interesting results, and is recommended for further research.

Conclusion

Overall, the present study provides additional data about how Reiki can be integrated into treatment and what methods have proven to be most beneficial for clients. The narrative responses in this study also offer the perspectives, both positive and negative, that some mental health clinicians have had when incorporating holistic healing into their work. The purpose of the study was for clinical social workers to consider the narratives of licensed mental health clinicians who introduce Reiki into treatment.

References

- Adler, L. and Mukherji, B. (1995). *Spirit versus scalpel: Traditional healing and modern psychotherapy*. Westport, CT: Bergin & Garvey.
- Anastas, J. (1999). *Research design for social work and the human services* (2nd ed.). New York: Columbia University Press.
- Aposhyan, S. (2004). *Body-mind psychotherapy: Principles, techniques, and practical applications*. New York: W. W. Norton & Company.
- Baldwin, A., Wagner, C., and Schwartz, G. (2008). Reiki improves heart rate homeostasis in laboratory rats. *The Journal of Alternative and Complementary Medicine* 14(4), 417-422.
- Berzoff, J., Flanagan, L.M., & Hertz, P. (2008). *Inside out and outside in* (2nd ed.). New York: Jason Aronson.
- Bowden, D., Goddard L., and Gruzeller, J. (2010). A randomised controlled single-blind trial of the effects of Reiki and positive imagery on well-being and salivary cortisol. *Brain Research Bulletin* 81(1), 66-72.
- Corrigall, J. *About a body: Working with the embodied mind in psychotherapy*. London & New York: Routledge.
- Cuellar, N. *Conversations in complementary and alternative medicine: Insights and perspectives from leading practitioners*. Sudbury, MA: Jones & Barlett.
- De Mijolla, A. (2005). Psychoanalysis. In *The international dictionary of psychoanalysis* (Vol.3, pp. 1362-1366). Detroit, MI: Macmillan Reference USA.

- Ferenczi, S. (1955). Confusion of tongues between adults and the child. In *Final contributions to the problems and methods of psycho-analysis* (pp. 156-167). London: Hogarth.
- Fosshage, J. (2000). The meanings of touch in psychoanalysis: A time for reassessment. *Psychoanalytic Inquiry*, 20(1), 21-43.
- Fundukian, L., and Wilson, J. (Eds). (2008). Psychodynamic psychotherapy. In *The Gale encyclopedia of mental health* (Vol. 2, pp. 927-929). Detroit, MI: Gale Virtual Reference Library.
- Galland, L. (1997). *The Four pillars of healing: How the new integrated medicine- the best of conventional and alternative approaches- can cure you*. New York: Random House.
- Hunter, M., and Struve, J. (1997). *The ethical use of touch in psychotherapy*. Thousand Oaks: Sage Publications, Inc.
- Kertay, L., and Reviere, S. (1998). The use of touch in psychotherapy: Theoretical and ethical considerations. *Psychotherapy* 30(1), 32-40.
- LaTorre, M. (2005). Integrative perspectives: The use of Reiki in psychotherapy. *Perspectives in Psychiatric Care* 41(4), 184-187.
- Milden, S.P., and Stokols, D. (2004). Physicians' attitudes and practices regarding complementary and alternative medicine. *Behavioral Medicine* 30(2), 73-82.
- Miles, P. (2008). *Reiki*. New York: Penguin.
- Mollon, P. (2008). *Psychoanalytic energy psychotherapy*. London: Karnac Books.
- National Center for Complementary and Alternative Medicine (2010). What Is Complementary and Alternative Medicine? Retrieved from <http://nccam.nih.gov>.

- Padgett, D. (2004). *The qualitative research experience*. Belmont, CA: Wadsworth/Thomson Learning.
- Riva, M. T., & Cornish, J. A. E. (1995). Group supervision practices at psychology predoctoral internship programs: A national survey. *Professional Psychology: Research and Practice*, 26, 523–525.
- Rubin, A., & Babbie, E. (2010). *Essential research methods for social work*. Belmont, CA: Brooks/Cole.
- Sawyer, J. “The first Reiki practitioner in our OR-operating room.” *AORN Journal* 67 (1998): 674-677.
- Scheiber, B., & Selby, C. (2000). *Therapeutic touch*. Amherst, N.Y.: Prometheus Books.
- Skinner, P. (2003). Holistic medicine. In *The Gale encyclopedia of medicine* (Vol. 3, pp. 1824-1827). Detroit, MI: Gale Virtual Reference Library.
- Smith, E. W. L. (1998). Traditions of touch in psychotherapy. In *Touch in psychotherapy: Theory, research, and practice*. New York, NY: Guilford Press.
- Totton, N. (2003). *Body psychotherapy: An introduction*. Buckingham: Open University Press.
- Ventling, Christa (2004) . *Body psychotherapy in progressive and chronic disorders*. Switzerland: S. Karger Ag.
- Wardell, D.W. , and Engebretson, J. (2001). Biological correlates of Reiki touch therapy. *Journal of Advanced Nursing* 33(4): 439-445.

Appendix A

Letters for recruitment

When East Meets West: Integrating Reiki into Mental Health Practice: A Thesis Study

I am a graduate student at the Smith College School for Social Work and am conducting a research study for my thesis.

The study involves a tape-recorded interview that will last no longer than one hour, either in person or online, with interview questions exploring individuals' experiences with their use of Reiki in psychodynamic mental health practice. Strict confidentiality will be maintained throughout the project.

You will receive no financial benefit for your participation in this study. However, you may benefit from knowing that you have contributed invaluable information to the study of holistic healing within a Western medical paradigm, and your input may generate good questions to posit for future research regarding Reiki and the mental health field.

It is my hope that this study will help mental health clinicians gain a better understanding of the integration of Reiki into a standardized medical practice, and to appreciate the reasons how this integration has developed.

Participants for the study would include individuals who (a) have achieved at least one level of Reiki training, (b) are licensed as a mental health professional with a psychodynamic focus, (c) have at least five years of professional, licensed experience as a mental health clinician, (d) and have incorporated Reiki practice within your mental health work at least one time.

If you are interested in participating in this study, please contact Kim Winnegge at kwinnegg@smith.edu or (413) 774-6252, extension 110.

Letter for Organization Assistance in Recruitment

Dear (Organization Name),

For a Smith School for Social Worker MSW thesis project, I am interested in exploring the integration of Reiki into clinical mental health practice. This would be a telephone interview lasting approximately one hour, consisting of interview questions exploring individuals' experiences with their use of Reiki in psychodynamic mental health practice. Strict confidentiality will be maintained throughout the project.

I am writing to inquire if your organization would be able to provide me with any of the following: 1) access to databases, that I could query to obtain contact information for this type of

mental health clinician; and 2) access to any listserv, websites, etc, where I could post electronic recruitment materials.

I would be happy to provide in advance any materials related to the study design and purpose, as well as the study instrument approved by the Smith College School for Social Work.

Please let me know if you are able to assist me. If there is someone else within the organization in addition to yourself to whom this letter should be forwarded, please feel free to do so. And please do not hesitate to contact me through either the phone number or email listed below with any questions.

Thank you in advance for your time and consideration. I greatly appreciate any assistance you can provide.

Sincerely,

Kim Winnege
kwinnege@smith.edu
(413) 774-6252, ext. 110

Appendix B

Informed Consent Form

January 2011

Dear Participant:

My name is Kim Winnegge and I am a graduate student at the Smith College School for Social Work in Northampton, Massachusetts. I am conducting a study exploring the integration of Reiki into psychodynamic clinical practice. Perspective is important and valuable to further the development of research on the use of complementary and alternative medicine into the Western model. This study is being conducted for my thesis at the Smith College School for Social Work, and may be used for future presentation and publication on the topic.

As a participant, it is understood that you (a) have achieved at least one level of Reiki training, (b) are licensed as a mental health professional with a psychodynamic focus, (c) have at least five years of professional, licensed experience as a mental health clinician, (d) and have incorporated Reiki practice within your mental health work at least one time.

If you choose to participate, please return one copy of the consent form with your signature in the stamped, self-addressed envelope included with this form. Please retain the second copy for your records. In order to conduct the interviews, I will then arrange to meet you at a mutually agreed-upon location that is private and convenient for you, or we may schedule a phone interview.

Risks are minimal. The questions asked may make you feel uncomfortable related to your experience of using an alternative practice in a mental health setting.

You have the right to not answer any question in the interview. You may choose to withdraw from the survey at any time before April 1, 2011, when the report will be written. If you decide to withdraw, all materials related to you will be immediately destroyed.

There will be no financial payment for your participation in this research project. However, the information you provide about your experience will be invaluable and may generate some good questions to posit for future research regarding holistic healing within the mental health field. This information may also benefit individuals seeking therapy and clinicians interested in expanding into a complementary medical model like Reiki.

Your confidentiality will be protected in a number of ways. All identifying information in my records will be removed from the data. My research advisor will have access to the data collected, but not until identifying information has been removed. I will keep the

transcripts and questionnaires for three years, consistent with federal regulations. During this time, questionnaires and transcripts will be kept in a locked cabinet. After the three year period has expired, all material will be destroyed. The information given by you will be used in a way that cannot be identified with you. Any data that are reported will be presented in the aggregate in possible future publications and/or presentations..

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION; THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION AND YOUR RIGHTS; AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

I thank you for your time, attention, and willingness to consider participation in this study.

Signature of Participant

Signature of Researcher

Date _____

Date _____

If you have any questions, please contact:

Kim Winnegge
(413) 774-6252, ext. 110
kwinnegg@smith.edu

or

The Smith College School for Social Work Human Subjects Review Committee: 413-585-7974

Please keep a copy of this for your records, and thank you again for your participation.

Appendix C

HSR Approval Letter

January 11, 2011

Kimberly Winnegge

Dear Kim,

Your second set of revisions has been reviewed and they are fine. You have filled in the gap and spelled out your recruitment process. We are therefore now able to give final approval to your very interesting study.

Please note the following requirements:

Consent Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.

Chair, Human Subjects Review Committee

CC: Jean LaTerz, Research Advisor

Appendix D

Interview Guide

Questions

1. Why did you become interested in the practice of Reiki?
2. How many times have you incorporated Reiki into your mental health practice?
3. About how many clients have you used Reiki with in your practice?
4. In general, what types of presenting problems would you consider suitable for Reiki integration within the therapeutic setting?
5. How do you determine if a client is suitable for Reiki?
6. How do you introduce Reiki into a session with a client?
7. Please describe how you integrate Reiki into your work.
8. Do you utilize other holistic healing techniques in your practice? If so, please describe.
9. Do you advertise Reiki as part of your mental health specialties? If so, why? If not, why?
10. In your geographical location, do you feel that Reiki is accepted in your profession?
11. What benefits have you seen within clients whom you've utilized Reiki treatment with?
12. Please describe any disadvantages or negative experiences for clients?

Demographic questions

1. How do you identify in terms of race and ethnicity?
2. What is your gender?
3. What is your age?