Reiki in the treatment of depression : a literature review

Tilia Gonzalez

Reiki in the treatment of depression: A literature review

Tilia Gonzalez

The University of Toledo

2016

Dedication

I dedicate this paper to my family and friends.

To Tina and Julio Gonzalez, my parents, who have supported me financially and emotionally during my time in PA school. Thank you for taking every phone call and for listening to every worry. I am proud to call myself your daughter and to have such wonderful parents.

To my brother, Julio Gonzalez III, who always took time out to hangout with me on weekend when I came home. Thank you for the endless hours of video games and conversation.

Mary Westwood, thank you for taking time to read over my paper even though you are working on getting your masters and have little time yourself. I appreciate our friendship and the many times you allowed me to vent on the many stressors ranging from relationships to school. Thank you for your sound advice.

To Rachel Weems for keeping in touch everyday even though you are hundreds of miles away in another state. Our conversations helped me to keep my social skills while I was locked in my apartment studying every night.

Acknowledgments

My advisor, Walter Edinger, PhD, thank you for taking interest in my topic. I appreciate the time you took to understand my topic and allowing me to make this project my own. I also appreciate all of your valuable feedback.

Mary Westwood, thank you for taking the time to read my paper and offer feedback. Your different perspective and suggestions offered a valuable addition to my paper.

Lastly, my mother and my inspiration for my paper. She is the Reiki Master in my life who reminds me to always consider the spiritual healing of my patients.

Table of Contents

Introduction

Reiki is a form of alternative medicine developed in Japan in the mid-19th century (Lee, Pittler, & Ernst, 2008). Reiki is a combination of two Japanese words, “rei” meaning universal spirit and “ki” meaning universal life energy. The National Center for Complementary and Alternative Medicine classifies Reiki as “energy” or “biofield therapy” (Lee et al., 2008). Biofield therapy refers to therapies that are involved in the utilization of energy fields that surround and penetrate the human body (Young, 2015). Currently, interpersonal therapy is the most common form of outpatient treatment in treating depression (LaTorre, 2005). This involves no touching of the patient, Reiki serves to break this boundary by the practice of laying on of hands (LaTorre, 2005). Reiki focuses on the belief that an energy is present within the body that supports the ability to heal (NIH, 2015). The Reiki practitioner does not manipulate the body in any way while performing the laying on of hands. The practitioner lays hand on the patient and helps to facilitate the innate healing energy of the body (Nield-Anderson & Ameling, 2001). These practitioners believe that the therapeutic effects of Reiki provide strength, harmony, and balance in the body and mind (Lee et al., 2008).

Research Question: Is Reiki an efficacious adjunct therapy in the treatment of depression symptoms?

Definitions

Reiki: a healing technique based on the principle that the therapist can channel energy into the patient by means of touch, to activate the natural healing processes of the patient's body and restore physical and emotional well-being.

Major depressive disorder: is a medical illness that affects how you feel, think and behave causing persistent feelings of sadness and loss of interest in previously enjoyed activities. Depression can lead to a variety of emotional and physical problems. It is a chronic illness that usually requires long-term treatment

Biofield therapy: therapies that effect the energy fields that surround and penetrate the human body allowing for healing

Integrative Medicine: integrative medicine and health reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic and lifestyle approaches, healthcare and disciplines to achieve optimal health and healing.

Psychotherapy: the treatment of mental disorder by psychological rather than medical means

Interpersonal therapy: a brief, present-focused psychotherapy that centers on resolving interpersonal problems and decreasing symptoms. It is a highly structured and time-limited approach that follows a manual and is intended to be completed within 12-16 weeks

Methods

Search terms: Reiki, Treatment, Depression, Adults, Alternative medicine, pharmacotherapy, psychotherapy, efficacy, alternative medicine, CONSORT criteria, integrative medicine, biofield energy, biofield therapies, MDD.

Databases: CINAHL, OhioLINK, EBSCOhost Psychology and Behavioral Sciences Collection, Google

Inclusion and exclusion criteria for articles: Articles that were included in this review contained the following topics: Reiki and its effects on depression, current therapies for depression, and effectiveness of pharmacotherapy to treat depression. Articles were excluded if they were not a part of a reputable academic journal. Articles exceeding 20 years since last revision were also excluded.

Literature Review

History of Reiki

Reiki is a form of alternative medicine developed in Japan in the mid-19th century (Lee et al., 2008.). Reiki is a combination of two Japanese words, “rei” meaning universal spirit and “ki” meaning universal life energy. Mikao Usui is recognized as the founder of Reiki. He began his studies at the age of four in a Tendai Buddhist monastery (Smith, 2004). He traveled throughout China and Europe to study medicine, psychology and the art of divination (Rand, 2015). Throughout his early life, he held positions including civil servant, journalist, and also served to rehabilitate prisoners. With the connections he made through his business ventures, Usui became a very successful businessman in Japan (Rand, 2015).

Usui began to change his focus from business, to the spiritual journey he had yet to complete. In his research, he came across what is known as the An-shin Rius-mei, which is a state of constant peace of mind (Rand, 2015). He eventually achieved this peace by performing the ritual known as satori (Smith, 2004). Satori is the practice of reaching oneness with the divine by completing a period of fasting and meditation that lasts for 21 days (Smith, 2004). After he completed this enlightenment he journaled that he began to run down the mountain where he had completed satori, and stubbed his toe. After he had laid hands on his toe he realized it no longer hurt (Rand, 2015). In February of 1922, he moved to Tokyo and started his healing society known as Usui Reiki Ryoho Gakka (Rand, 2015). He also began to be known as Usui Sensai (Smith, 2004).

Usui created an affirmation that is still used today in modern western based Reiki practices (Smith, 2004). Reiki was introduced to western culture in 1937 by a woman named Hawayo Takata (Rand, 2015). In Usui’s practice, Reiki was a way of life. When Reiki reached

the West it was changed to become a healing ritual (Smith, 2004). A set of principles were developed based on the original affirmation created by Usui (Smith, 2004). There are variations to these principles but they all include just for today, let go of anger, let go of worry, be grateful, work diligently and be kind to others (Smith, 2004).

What is Reiki?

The National Center for Complementary and Alternative Medicine classifies Reiki as energy or biofield therapy (Lee et al., 2008). Biofield therapy refers to therapies that are involved in the utilization of energy fields that surround and penetrate the human body (Young, 2015). Interpersonal therapy is a more traditional psychotherapy in the treatment of depression (LaTorre, 2005). This involves no touching of the patient, Reiki serves to break this boundary by the practice of laying on of hands (LaTorre, 2005). Reiki focuses on a cultural stance that an energy is present within the body that supports the ability to heal (NIH, 2015). The Reiki practitioner does not manipulate the body in any way while performing the laying on of hands. The practitioner lays hand on the patient and helps to facilitate the innate healing energy of the body (Nield-Anderson et al., 2001). These practitioners understand that the therapeutic effects of Reiki provide strength, harmony and balance in the body and mind (Lee et al., 2008).

Reiki and other forms of biofield interventions hold low risk for any patient (Miles & True, 2003). Health care providers who are not aware of the biofield therapies available underutilize these low risks therapies. Patients are usually too anxious to discuss these methods of treatment with providers (Miles & True, 2003). Reiki is a non-conventional therapy and is an out of pocket expense for patients (Nield-Anderson et. al., 2001). Those that tend to receive Reiki therapy are of higher socioeconomic status. Of the patients that are able to afford Reiki

they benefit in treatment of anxiety, depression, and pain management (Nield-Anderson et. al., 2001).

Reiki is used in some urban teaching hospitals in adjunct to chemotherapy to treat pain, anxiety and depression in cancer patients. Nurses are the main driving force in Reiki treatment in the hospital. Nurses become Reiki certified and incorporate Reiki into the treatment of their patients. Three levels of Reiki are completed before a certification is given. These three levels help to enhance the healing ability and to channel the universal life force energy (Nield-Anderson et. al. 2001).

Each level of training includes an attunement or empowerment that is revealed to the student and allows them to tap into the ancient healing practice. The revelation must occur in each phase for the student to continue and become a Reiki master. The training is not about the accumulation of formal teachings but about the empowerments that the student is able to achieve (Miles & True, 2003). The student will learn the first four attunements in first degree of Reiki healing. During this phase, the student learns where to place hands, the history of Reiki and the spiritual symbols associated with the practice (Nield-Anderson et. al., 2001). Figure 2 shows these spiritual symbols that are learned by the student. The master will also perform mantras and Reiki on the student to enhance their spiritual life force. (Nield-Anderson et. al., 2001).

First degree is the only level of training with four attunements; the next two levels require only one attunement (Miles & True, 2003). Second-degree training involves a prayer like state with the spiritual surrender to a divine life force (Nield-Anderson et. al., 2001). This allows the student to perform distant healing, meaning the patient does not have to be in the room to receive the benefits of Reiki (Miles & True, 2003). In third degree, the spiritual vibration force is obtained by training directly under a Reiki Master (Nield-Anderson et. al., 2001). During the

initial training of Reiki it is recommended that the trainee undergo 21 days of self-treatment. This helps to center the mind, body and spirit (LaTorre, 2005).

What is depression?

Major depressive disorder (MDD) is a combination of genetic and environmental interactions that produces a deficit in monoaminergic transmission within the brain (Hernández, Coronel, Aguilar, & Rodríguez, 2016). The pathophysiology of MDD is characterized by hyper-metabolism of the Cg25 area, lower expression of serotonin 1A receptors and enhanced expression of monoamine oxidase (Hernández et al., 2016). Due to the multifactorial components that make up MDD it is difficult to individualize treatment for patients (Hernandez et al., 2016). Other neurotransmitter deficits include serotonin, tryptophan (a precursor of serotonin), noradrenaline and dopamine (DynaMed). Depression can be commonly perceived as a chemical imbalance, which refers to the monoamine deficiency hypothesis (DynaMed). Currently the only way to treat the chemical imbalance is by medications that inhibit the reuptake of the neurotransmitters (DynaMed).

The monoamine hypothesis suggests that depressed patients somehow become deficient in the synthesis of serotonin, norepinephrine and dopamine (Ruhe, Mason, & Schene, 2007). This is derived from the understanding that patients with depression exhibit serum deficiencies in one or more of these neurotransmitters (aan het Rot, Mathew, & Charney, 2009). Studies have not been able to determine if it is the true cause of depression or an outcome of being depressed (aan het Rot et al., 2009). In one study, depressed patients were given a tryptophan deficient amino acid mixture, which would later decrease their serotonin levels. By doing this, patients experienced a relapse in their symptoms however in non-depressed patients given the same

mixture, did not experience any depressive symptoms (aan het Rot et al., 2009). This reveals an unclear etiology of MDD, along with the large variability in the disease it is unclear at this point the best route for treatment (aan het Rot et al., 2009).

MDD is very closely associated with repeated stressful events, these events can cause increases in cortisol (Miyata, Hattori, Shimizu, Ito, & Tohyama, 2015). This is described as the inflammatory and oxidative stress hypothesis (DynaMed). Elevated levels of inflammation and peripheral blood biomarkers are found in patients with depression (DynaMed). The activated inflammatory pathways begin to decrease neurotrophic support, alter glutamate activity and oxidative stress which leads to glial loss and excitotoxicity (DynaMed). The elevation of cortisol activates the expression of serum/glucocorticoid regulated kinase (SGK1) which causes arborization of oligodendrocytes which is suspected to increase depressive symptoms (Miyata et al., 2015).

The DSM V is used currently to diagnose someone with MDD. Criteria for the DSM V include experiencing five of nine of the symptoms listed that must include depressed mood or pervasive loss of interest or pleasure (Zimmerman, McGlinchey, Chelminski, & Young, 2006). Other symptoms include significant change in weight, insomnia or hypersomnia, fatigue, loss of energy, psychomotor agitation or retardation nearly every day, feelings of worthlessness, indecisiveness or decreased ability to concentrate and recurrent thoughts of death or suicide (DynaMed). Depression is variable among patients and can make the diagnosis and treatment difficult due to this heterogeneity (DynaMed).

Current Treatment of Depression

Depressive disorders are associated with decreased quality of life and increased mortality and suicide (Burnett-Zeigler, Zivin, Islam, & Ilgen, 2012). Major depressive disorder is a growing public health concern with an estimation that by 2050 there will be a 35% increase in the lifetime prevalence of MDD in adults (Burnett-Zeigler et al., 2012). Depression is associated with significant disability and economic costs, and according to the World Health Organization it will be the second most common cause for disability by 2020 (Castro et al., 2015). Most depressed patients are diagnosed and treated in primary care (Dunlop, Scheinberg, & Dunlop, 2013). Psychotherapies are not provided in a primary care setting and many of these patients will be placed on maintenance antidepressants (Dunlop et al., 2013). However, a study done by Uher and Pavlova (2016) suggest that the use of certain antidepressant medications including tricyclics and SSRIs are not efficacious after one year of use.

Pharmacotherapies are the most common form of treatment for depression in a primary care setting even though relapse is high after cessation of medication (Castro et al., 2015). Patients are often non-compliant with their medication which may be due to the limitations found in primary care in offering psychotherapy options (van Schaik et al., 2004). In primary care, 73% of patients will be diagnosed with depression during their first visit and placed on anti-depressants. Out of these patients, 50% will stop taking their medications by the sixth week of treatment (van Schaik et al., 2004).

Pharmacotherapy is very limited in the treatment of depression due to the heterogeneity of the disease (Malhi et al., 2013). There are many antidepressants available for treatment with the same amount of efficacy. For each individual being treated for depression there will be a difference in the tolerability and response to antidepressants which makes choosing the correct antidepressant for a patient difficult (Malhi et al., 2013). Serotonin reuptake inhibitors (SSRIs)

account for 53% of antidepressants that are prescribed in the United States and much of Europe (Johnson et al., 2014).

Safety for the use of an antidepressant is determined by the number of adverse effects experienced by the patient while using antidepressant therapy (Malhi et al., 2013). Safety is among one of the largest concerns for physicians and patients when beginning a regimen of antidepressants (Malhi et al., 2013). Among the antidepressants SSRIs tend to have the highest safety level with lower risk of adverse effects (Malhi et al., 2013). Even with this information many patients would prefer to be treated using psychotherapies (van Schaik et al., 2004).

In recent decades, there have been an increased discussion to incorporate psychotherapy in primary care. This has failed due to the amount of training that would need to be incorporated into primary care physicians. There is also concern that this would create conflict in professionalism among psychiatrists and primary care physicians (Castro et al., 2015).

Patients diagnosed with dysthymia, postnatal depression and depressed infertile women tend to benefit most from pharmacotherapy. Patients diagnosed in any other category of depressive disorders have equal benefits from pharmacotherapy and psychotherapy (Cuijpers et al., 2012). There is increased benefit in receiving long-term psychotherapy for the treatment of MDD (Zimmerman et al., 2015). Long-term psychotherapy is defined as 50 sessions or more of psychotherapy (Zimmerman et al., 2015). The highest rates of improvement happen within the first 10 sessions of psychotherapy, but to reach a response of 75% or higher a patient must comply in completing 50 sessions (Zimmerman et al., 2015).

Explanations for Non-Compliance with Current Depression Treatment

Most patients diagnosed with depression will be treated through primary care (Dunlop et al 2013). Among those that are diagnosed with MDD only 30-60% receive care within the first 12 months, with many not receiving care until four years later (Burnett-Zeigler et al., 2012). By being treated in primary care setting much of the underlying issues, differential diagnoses and alternative treatment options are often missed (Dunlop et al., 2013). Non-compliance occurs in 21% to 60% of patients that are on maintenance antidepressants such as serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants (TCAs) (Balikci et al., 2013). Non-compliance is defined as patients not following the recommended treatment plan given to them by their physician (Balicki et al., 2013).

Non-compliance is partly due to the lack of communication between patient and provider. In a primary care setting due to the lack of time, proper education such as potential side effects, expected period of improvement and duration of therapy will not be explained to the patient and therefore patients may have unrealistic expectations for their treatment (Dunlop et al., 2013). Antidepressant medications can be efficacious in the treatment of depression as initial therapy however can cause non-compliance due to their adverse effects and the lack of patient education about these effects (Balicki et al., 2013).

Another cause of non-compliance is due to the variability in treatment. This variability can make a patient feel ultimately discouraged (Balicki et al., 2013). Antidepressant treatment is highly variable between patients due to the site of metabolism (Hodgson et al., 2015). Antidepressants are metabolized by P450 enzymes found in the liver. Due to the genetic variants of this system, treatment becomes difficult to individualize (Hodgson et al., 2015). Genetic testing may prove to be valuable in dosing of antidepressants for patients, although this has yet to be applied (Hodgson et al., 2015). The variations in metabolism cause patients to have varying

levels of medication in their blood serum (Hodgson et al., 2015). Depending on the amount of circulation metabolites in the blood stream accounts for the side effects that occur with antidepressants (Hodgson et al., 2015). Side effects of antidepressants include weight gain, anxiety, sexual problems, dizziness, insomnia, nausea, sedation, pruritius, increased appetite and constipation (Balicki et. al., 2013).

As depression becomes harder to treat due to its complexity, some patients will fail many treatment options. Some patients suffer from treatment resistant depression (TRD). This condition increases their risks for cardiac events (Rizvi et al., 2014). TRD is associated with hyperactivity in the anterior cingulat cortex, striatum and amygdala. TRD usually develops after a delayed diagnosis of MDD or a poor treatment of MDD. As mentioned previously, many patients will visit their primary care physician instead of a psychiatrist, due to the ease of access (Rizvi et al., 2014).

Why people seek integrative medicine?

Integrative medicine is defined as the combination of modern medicine with ancient healings (Brown, 2015). People tend not only to seek this for the decrease in side effects from taking modern medications, but also to align their body, spirit, and mind (Brown, 2015). A US study found that almost 20% of people with depression made an effort to incorporate alternative medicine to their treatment plan (Joyce & Herbison, 2015). Around 5% of these patients decided to incorporate energy therapies (Joyce & Herbison, 2015). Combining therapies is not a new concept and turns out to be a need in a modern treatment plan (Brown, 2015). In psychology, the matching law describes the need that a person has for seeking alternative forms of healing to yield the highest result. Matching law falls under the concept of operant conditioning, that if the

subject views something as good or the treatment relieves his or her suffering, he or she will continue with this treatment (Brown, 2015).

It is also important to understand the difference between health and well-being of a patient. Well-being is better understood as the wellness of someone's soul, freedom and pleasure (LaTorre, 2005). Some Reiki practitioners explain that Reiki can be used to nurture acceptance of a patient's current state of being and reach acceptance (LaTorre, 2005). Health is defined by the World Health Organization as "a state of complete physical mental and social well-being and not merely the absence of disease or infirmity." Reiki has the advantage in doing all of this by promoting holism in a cost effective manner (Kryak & Vitale, 2011).

Canada spent almost $6 billion dollars in out of pocket expenses to incorporate Complementary and Alternative Medicines (CAM) into the mainstream of healthcare in 2006. A study conducted in Canada found that incorporating integrated complementary therapy enhanced symptom management, and increased the comfort of their patients (Berger, Tavares, & Berger, 2013). Mackenzie Richmond Hill Hospital performed a pilot program where they incorporated aromatherapy, massage, Reiki and therapeutic touch to the care given to their residents (Berger et al., 2013). The study showed that after receiving these complementary therapies residents reported a 62% improvement of overall symptoms, which included depression and anxiety (Brown et al., 2013).

These patients rated their level of discomfort on a scale of 0 to 10, 10 being the worst level of discomfort. After one or two sessions, the patients were asked to rate their discomfort level again. The study marked a 61% overall improvement in patient discomfort and 62% improvement overall. A paired sample t test was conducted for each symptom. Each p-value for the symptoms were less than 0.05 indicating significance with 95% confidence (Berger et al.,

2013). Symptoms included pain, discomfort, depression, anxiety, stiffness, restlessness and then total improvement was also measured (Berger et al., 2013). Patients were also asked to rate their level of inner stillness and peace on a scale of 0 to 10. In this case 10 being the best and 0 being the worst. This revealed a 66% increase of inner stillness and peace after treatment with alternative therapies including Reiki (Berger et al., 2013).

The Center for Reiki Research shows promising effects in the alleviation of pain, depression and anxiety and are much supported by the American Holistic Nurses Association (Kryak & Vitale, 2011). Some facilities have already begun implementation of Reiki by use of licensed nurses (Kryak & Vitale, 2011). These include facilities located in Ohio, North Carolina, Michigan, Illinois, New Hampshire and New York (Center for Reiki Research, n.d.).

Does Reiki provide a significant treatment effect?

The concept of Reiki is to heal the whole person versus focusing on a single ailment (vanderVaart, Gijsen, de Wildt, & Koren, 2009). The efficacy of Reiki is still widely inconclusive (vanderVaart et al., 2009). Measurement of the efficacy of Reiki was studied using a modified Criteria for Herbal Interventions (CONSORT) while also measuring the quality of these test using the Jaded Quality score (vanderVaart et al., 2009). When performing studies of the efficacy of Reiki many trials fail to adequately outline their randomization and assessments. Many studies will also tend to only report the findings of the test group and not the controlled group (vanderVaart et al., 2009).

The CONSORT criteria was developed in order to give more credibility to research based in CAM (Gagnier et al., 2006). Included in this checklist is description of allocation or randomization of subjects, precise methodology including specific objectives and hypothesis,

descriptive sample size and blinding or masking details of the trials (Gagnier, 2006). In the literature review conducted by VanderVaart in 2009, it was noted that in reference to specific methodology and statistical methods many Reiki studies lagged behind.

Deborah Bowden in an effort to increase the reliability of her studies repeated her study on undergraduates. In this study, she and her colleagues assigned students to a Reiki and non-Reiki control group. Students with high depression (high mood) and with low depression (low mood) were randomly placed in either the appropriate control or experimental groups. The trials lasted from 2-8 weeks. In order to measure the efficacy of Reiki on mood in these subjects the Depression, Anxiety and Stress Scale (DASS), Pittsburgh Quality of Sleep Index (PSQI), Illness symptoms Questionnaire, and Activation-Deactivation adjective checklist (AD-ACL) were used. The conclusion of the study found that overall improvement was found in the high mood group while there was not much change in the low mood group (Bowden, Goddard, & Gruzelier, 2011). This demonstrates the effectiveness of Reiki for patients with higher levels of depression.

Many Reiki studies fail to create the proper format of a study that gives a placebo Reiki to patients the control groups usually do not receive any form of treatment (Mansour, Beuche, Laing, & Leis, 1999). This gives many false findings. A study done by Mansour designed a placebo Reiki and determined that if 25% of their subjects could tell a difference between Reiki and the placebo Reiki they would deem it a successful study. A study done by Taylor Ford found that there was no difference between groups that were given “sham Reiki” versus true Reiki (Clark, 2013).

In certain organic causes of depression secondary to an acute stroke, Reiki showed no significant benefit in treatment (Lee et al., 2008). Reiki was provided for subacute stroke patients and showed no significant improvement in the Center for Epidemiologic Studies-Depression

(CES-D) measure. Patients underwent a double blind study where a group of participants received sham Reiki and the other group received treatment from a Reiki master (Lee et al., 2008). Neither group showed significant difference in CES-D measure. Reiki is effective for some forms of depression. When treating MDD Reiki seems to be a good adjunctive therapy. However, in cases of more organic causes like stroke Reiki is not as effective (Lee et al., 2008).

Reiki in the hospital setting

The trend of integrating CAM services into hospitals has been rising since the Affordable Care Act of 2010 (Vitale, 2014). Hospitals are beginning to become more interested in consumer satisfaction and are willing to spend more money on CAM programs (Vitale, 2014). In order for the integration of Reiki into a hospital setting, Vitale provides a list of the necessary steps to have a successful program. There must be an understanding of the need for Reiki, a proper business plan development and stakeholders.

In the development of a program, it must be decided who will be in charge on performing Reiki in the hospital (Vitale, 2014). This can be either trained Reiki specialists or nurses trained in Reiki (Vitale, 2014). Nursing students earning their BSN's in central Maine were offered an elective course in Reiki (Clark, 2013). The application of Reiki performed by nurses gives the benefit of additional healing for the patient and allows nurses to create a presence, which has become scarce in the nursing practice (Clark, 2013). The practitioner also has to have basic training and a self-treatment commitment. It is imperative that anything experienced by the patient be experienced by their therapist first (LaTorre, 2005).

A pilot study was done in central Connecticut in a hospice and nursing home facility where patients would receive a combination of massage and Reiki for one year and would be monitored for any signs of improvement (Vandergrift, 2013). After one year, the study showed

that 99% of subjects exhibited a reduction in stress and depression, and 76% experienced a reduction in pain (Vandergrift, 2013). Similarly, chronically ill patients who received Reiki showed significant improvement versus patients who did not receive Reiki or received false Reiki (Dressen & Singg, 1998).

It has become a growing interest in the nursing community to incorporate healing touch holistic methods to the care of patients (Kryak & Vitale, 2011). These practices are part of the founding practices of holism envisioned by Florence Nightingale who believed in the healing effects of the energetic environment (Kryak & Vitale, 2011). This practice is not limited to the nursing field. Other professionals such as psychologists, physicians and volunteers have also taken on administering Reiki to those patients seeking holistic care (Herron-Marx, Price-Knol, Burden, & Hicks, 2008).

In the United Kingdom Reiki has been administered within many fields of medicine. In the United Kingdom they only allow masters of Reiki to practice on patients making their treatment more effective (Herron-Marx et al). While in the U.S., level I Reiki healers are permitted to give treatment to patients which can lead to the treatment being ineffective (Herron-Marx et al., 2008).

Reiki and Depression

Depression is becoming increasingly more difficult to treat. A subset of patients with MDD go on to develop treatment resistant depression (TRD) after failure of antidepressant, psychotherapy and electroconvulsive therapy (Kallmunzer et al., 2016). It has become common practice to prescribe antidepressant therapies to patients, however many patients can fail multiple rounds of pharmacotherapy due to the lack of homogeneity among depression (Popa-Velea,

Gheorghe, Trutescu, & Purcarea, 2015). The challenge of non-compliance due to antidepressant side effects further complicates the treatment of depression (Balikci et al., 2013). This is particularly true for SSRIs and TCAs which are two of the most commonly used drug classes of antidepressants (Balikci et al., 2013). By incorporating Reiki therapy to the overall treatment of depression side effects and treatment resistance can be decreased (Vitale, 2014).

In the treatment of depression it is imperative to understand the needs of the patients. In considering a treatment plan a healthcare provider must consider the predisposing factors, lifestyle, and the treatment options for each individual patient due to the heterogeneity of the disease (Malhi et al., 2013). Treatment is not made easier by the vast choices of pharmacotherapy available. Patients now will go through many failed attempts before finding an effective treatment regimen (Popa-Velea et al., 2015). Anti-depressants may act effectively at the neurotransmitters that they are targeting but data shows even if this direct effect is adequate physiologically it may not give the desired outcome for the patient (Popa-Velea et al., 2015). During the weeks that it takes for anti-depressants to begin to work a patient may suffer weeks of side effects (Popa-Velea et al., 2015).

Reiki is an excellent addition to psycho and pharmacotherapies due to the little time it takes on to become properly Reiki certified and that it brings in gentle touch which is not incorporated in other psychotherapies (LaTorre, 2005). By using Reiki it helps to give patients a sense of warmth, peace, well-being and an overall increase in awareness of the life around them (LaTorre, 2005).

A study conducted by Shore on older adults showed a statistically significant reduction in symptoms ($p<0.05$) after 6 weeks of Reiki treatments (Richeson, Spross, Lutz, & Peng, 2010). One in five older adults suffer from depression, with their increased risks of comorbidities due to

age and polypharmacy it is difficult to find an antidepressant medication that is safe for these individuals (Richeson et al., 2010). These patients continued to see effects of hands on Reiki a year out from treatment (Lee et al., 2008). For most clients that experience high stress, depression and anxiety, Reiki is a beneficial intervention to introduce to their overall care (LaTorre, 2005). By introducing Reiki, it adds a feeling of empowerment and connection with their therapist (LaTorre, 2005).

Another study conducted by Bowden and colleagues demonstrated that when Reiki is performed by a Master Teacher of the field that effects on mood and well-being are significant with a p value of <0.5 (Bowden et al., 2011). College undergraduates with a Hospital Anxiety and Depression Scale score of greater than 10 were labeled as high stress and below this level were considered low stress (Bowden et al., 2011). Those students who were experiencing high stress levels underwent 2 to 12 weeks of Reiki therapy and noticed a significant improvement (Bowden et al., 2011). The HADS score of the high stress individuals' posttreatment dropped by an average of 2 points (Bowden et al., 2011).

Conclusion

The purpose of this paper was to determine if Reiki would be a viable option as an adjunct therapy to the current treatment of depression. Reiki allows for patients to explore the option of Complementary and Alternative medicine in their treatment plan for depression. By incorporating Reiki, patients are able to receive treatment without the fear of adverse side effects. The current treatment of depression is to be placed on an antidepressant therapy, which is still the number one treatment option but can still have a patient feeling discouraged because adverse effects tend to precede the benefit of antidepressants. This is one of the many reasons for non-compliance.

Reiki can be made accessible to patients and can be easily integrated into a hospital or primary care setting through long distance Reiki via the phone, and with additional funding from the Affordable Care Act. Vitale offers a clear format and business plan to successfully integrate Reiki into the hospital setting. By carefully laying out the purpose of Reiki, training nurses or hiring Reiki masters to be a part of the healthcare team allows for patients to have another option for treatment outside of drugs and risking the side effects that may be experienced that would lead to non-compliance.

In Maine, they are beginning to offer Reiki as an elective course in some nursing programs. This allows for easy integration to the hospital setting. It expands the responsibilities of the nurse and helps to affirm their connection with their patients. Giving a patient better sense of well-being by allowing for the healing of their spirit versus just physical healing. By integrating the elective courses into nursing programs, it will also allow hospitals to save money on budget costs that could come from hiring outside Reiki masters and also allows to have Reiki masters that are already trained in a hospital setting.

Reiki is effective in a wide range of age groups as shown by Vitale's research. Vitale et al. have done extensive research in the field of Reiki. Their study conducted on college students with high stress levels showed impressive results. Students were able to become more tranquil through six weeks of Reiki therapy. By doing this, students are able to avoid the adverse effects of antidepressants at a younger age and avoid antidepressant use later in life. A similar study by Shore conducted on elderly patients living in assisted nursing home facilities. Incorporating Reiki into their care allowed for these patients to be treated for many ailments and avoid the symptoms that are associated with polypharmacy.

A systemic review conducted by Herron-Marx et al. concluded that Reiki is a viable option to be initiated in the hospital setting. Not only in the treatment of mental illness but also for physical ailments particularly related to post operative care after surgery. In this matter, more research could be conducted in the efficacy of Reiki during post operative rehabilitation. These studies could be focused on the pain and stress that patients experience after major surgery and if Reiki helps in their rehabilitation affiliated with mood and pain. Herron- Marx also commented on the need for further evidence-based research in the field of Reiki. Plenty of anecdotal research has been collected but not enough randomized controlled trials. vanderVaart et al. who also conducted a systemic review of Reiki treatments concluded similar results. More randomized trials need to be held for more accountable evidence based practice.

LaTorre believes in the integration of Reiki into traditional psychotherapy because of the incorporation of touch that could be beneficial in developing a bond with depressed patients. By incorporating Reiki, you are able to heal the spirit along with the mind, creating an increased calming effect during psychotherapy treatments. This could be easily incorporated as nurses or practitioners could become certified in Reiki and perform during appointments.

Reiki can be used as a valuable adjunct to current therapy for MDD. Reiki can improve symptoms of anxiety and depression while increasing a sense of tranquility and relaxation. In cases of patients that are in a high stress environment such as college or end of life care, Reiki is a valuable resource to help these subjects align their spirits and have a sense of being able to cope with what lies ahead of them. Those patients suffering from depression from an abnormality in neurotransmission it has been proven that antidepressant therapy must be used in order to treat these patients. Reiki can be used during the early treatment stages of antidepressant therapy to help alleviate some of the adverse effects that usually present first before a therapeutic range is met with pharmacotherapy. Reiki does have a place in the medical field, it can help patients who want a more complete sense of care, and it can help those in high stress environments such as college, assisted living or post-surgery.

References

aan het Rot, M., Mathew, S. J., & Charney, D. S. (2009). Neurobiological mechanisms in major depressive disorder. *CMAJ, 180*(3), 305-313. doi:10.1503/cmaj.080697

Balikci, A., Uzun, O., Erdem, M., Doruk, A., Cansever, A., & Ates, M. A. (2013). Drug side effects that causes noncompliance to antidepressants drugs at outpatient treatment. *Klinik Psikofarmakoloji Bulteni-Bulletin of Clinical Psychopharmacology, 24*(1), 69-75. doi:10.5455/bcp.20120827114140

Berger, L., Tavares, M., & Berger, B. (2013). A Canadian experience of integrating complementary therapy in a hospital palliative care unit. *Journal of Palliative Medicine, 16*(10), 1294-1298. doi:10.1089/jpm.2013.0295

Bowden, D., Goddard, L., & Gruzelier, J. (2011). A randomised controlled single-blind trial of the efficacy of Reiki at benefitting mood and well-being. *Evidence-Based Complementary and Alternative Medicine, 2011*, 381862. doi:10.1155/2011/381862

Brown, C. G. (2015). Integrative medicine in the hospital: Secular or religious? *Society, 52*(5), 462-468. doi:10.1007/s12115-015-9929-8

Burnett-Zeigler, I., Zivin, K., Islam, K., & Ilgen, M. A. (2012). Longitudinal predictors of first time depression treatment utilization among adults with depressive disorders. *Social Psychiatry and Psychiatric Epidemiology, 47*(10), 1617-1625. doi:10.1007/s00127-011-0465-6

Castro, A., Garcia-Palacios, A., Garcia-Campayo, J., Mayoral, F., Botella, C., Garcia-Herrera, J. M., . . . Gili, M. (2015). Efficacy of low-intensity psychological intervention applied by ICTs for the treatment of depression in primary care: A controlled trial. *BMC Psychiatry, 15*, 106. doi:10.1186/s12888-015-0475-0

Center for Reiki Research. (n.d.). *Hospitals and clinics that offer Reiki*. Retrieved from http://www.reikihospitals.org

Clark, C. S. (2013). An integral nursing education experience: Outcomes from a BSN Reiki course. *Holistic Nursing Practice, 27*(1), 13-22. doi:10.1097/HNP.0b013e318276fdc4

Cuijpers, P., Reynolds, C. F., 3rd, Donker, T., Li, J., Andersson, G., & Beekman, A. (2012). Personalized treatment of adult depression: Medication, psychotherapy, or both? A systematic review. *Depression and Anxiety, 29*(10), 855-864. doi:10.1002/da.21985

Dressen, L. J., & Singg, S. (1998). Effects of Reiki on pain and selected affective and personality variables of chronicaly ill patients. *Subtle Energies and Energy Medicine, 9*(1), 51-82.

Dunlop, B., Scheinberg, K., & Dunlop, A. (2013). Ten ways to improve the treatment of depression and anxiety in adults. *Mental Health in Family Medicine, 10*, 175-181.

Gagnier, J. J., Boon, H., Rochon, P., Moher, D., Barnes, J., Bombardier, C., & Group, C. (2006). Recommendations for reporting randomized controlled trials of herbal interventions: Explanation and elaboration. *Journal of Clinical Epidemiology, 59*(11), 1134-1149. doi:10.1016/j.jclinepi.2005.12.020

Joyce, J., & Herbison, G. P. (2015). Reiki for depression and anxiety. *Cochrane Collaboration, 3*(4), CD006833. doi:10.1002/14651858.CD006833.pub2

Hernández, H., Coronel, P., Aguilar, J., & Rodríguez, E. (2016). Neurobiología de la depresión mayor y de su tratamiento farmacológico. *Salud Mental, 39*(1), 47-58. doi:10.17711/sm.0185-3325.2015.067

Herron-Marx, S., Price-Knol, F., Burden, B., & Hicks, C. (2008). A systematic review of the use of Reiki in health care. *Alternative and Complementary Therapies, 14*(1), 37-42. doi:10.1089/act.2008.14108

Hodgson, K., Tansey, K. E., Uher, R., Dernovsek, M. Z., Mors, O., Hauser, J., . . . McGuffin, P. (2015). Exploring the role of drug-metabolising enzymes in antidepressant side effects. *Psychopharmacology, 232*(14), 2609-2617. doi:10.1007/s00213-015-3898-x

Johnson, C. F., Dougall, N. J., Williams, B., MacGillivray, S. A., Buchanan, A. I., & Hassett, R. D. (2014). Patient factors associated with SSRI dose for depression treatment in general practice: A primary care cross-sectional study. *BMC Family Practice, 15*, 210. doi:10.1186/s12875-014-0210-9

Kallmunzer, B., Volbers, B., Karthaus, A., Tektas, O. Y., Kornhuber, J., & Muller, H. H. (2016). Treatment escalation in patients not responding to pharmacotherapy, psychotherapy, and electro-convulsive therapy: Experiences from a novel regimen using intravenous S-ketamine as add-on therapy in treatment-resistant depression. *J Neural Transm (Vienna), 123*(5), 549-552. doi:10.1007/s00702-015-1500-7

Kryak, E., & Vitale, A. (2011). Reiki and its journey into a hospital setting. *Holistic Nursing Practice, 25*(5), 238-245. doi:10.1097/HNP.0b013e31822a02ad

LaTorre, M. A. (2005). Integrative perspectives. *Perspectives in Psychiatric Care, 41*(4), 184-187.

Lee, M. S., Pittler, M. H., & Ernst, E. (2008). Effects of Reiki in clinical practice: A systematic review of randomised clinical trials. *International Journal of Clinical Practice, 62*(6), 947-954. doi:10.1111/j.1742-1241.2008.01729.x

Rand, W. L. (2015). *An evidence based history of Reiki*: Southfield, MI: International Center for Reiki Training.

Malhi, G. S., Hitching, R., Berk, M., Boyce, P., Porter, R., & Fritz, K. (2013). Pharmacological management of unipolar depression. *Acta Psychiatrica Scandinavica. Supplementum* (443), 6-23. doi:10.1111/acps.12122

Mansour, A., Beuche, M., Laing, G., & Leis, A. (1999). A study to test the effectiveness of placebo Reiki standardization procedures developed for a planned Reiki efficacy study. *The Journal of Alternative and Complementary Medicine, 5*(2), 153-164.

Miles, P., & True, G. (2003). Reiki- Review of a biofield therapy history, theory, practice, and research. *Alternative Therapies, 9*(2), 62-72.

Miyata, S., Hattori, T., Shimizu, S., Ito, A., & Tohyama, M. (2015). Disturbance of oligodendrocyte function plays a key role in the pathogenesis of schizophrenia and major depressive disorder. *Biomed Research International, 2015*, 492367. doi:10.1155/2015/492367

Nield-Anderson, L., & Ameling, A. (2001). Reiki: A complementary therapy for nursing practice. *Journal of Psychosocial Nursing and Mental Health Services, 39*(4), 42-49.

Popa-Velea, O., Gheorghe, I. R., Trutescu, C. I., & Purcarea, V. L. (2015). Current challegnes and pitfalls in the pharmacological treatment of depression. *Journal of Medicine and Life, 2*(2), 181-186.

Richeson, N. E., Spross, J. A., Lutz, K., & Peng, C. (2010). Effects of Reiki on anxiety, depression, pain and physiological factors in community-dwelling older adults. *Research in Gerontological Nursing, 3*(3), 187-198.

Rizvi, S., Grima, E., Tan, M., Rotzinger, S., Lin, P., McIntyre, R., & Kennedy, S. H. (2014). Treatment-resistant depression in primary care across Canada. *Canadian Journal of Psychiatry, 59*(7), 349-357.

Ruhe, H. G., Mason, N. S., & Schene, A. H. (2007). Mood is indirectly related to serotonin, norepinephrine and dopamine levels in humans: A meta-analysis of monoamine depletion studies. *Molecular Psychiatry, 12*(4), 331-359. doi:10.1038/sj.mp.4001949

Smith, D. (2004). *A history and understanding of Reiki*. Indianapolis, IN: Intuition Bridge Publishing.

Uher, R., & Pavlova, B. (2016). Long-term effects of depression treatment. *Lancet Psychiatry, 3*(2), 95-96. doi:10.1016/S2215-0366(15)00578-7.

van Schaik, D. J., Klijn, A. F., van Hout, H. P., van Marwijk, H. W., Beekman, A. T., de Haan, M., & van Dyck, R. (2004). Patients' preferences in the treatment of depressive disorder in primary care. *General Hospital Psychiatry, 26*(3), 184-189. doi:10.1016/j.genhosppsych.2003.12.001

Vandergrift, A. (2013). Use of complementary therapies in hospice and palliative care. *Omega, 67*(1-2), 227-232. doi:10.2190/OM.67.1-2.z2

vanderVaart, S., Gijsen, V. M., de Wildt, S. N., & Koren, G. (2009). A systematic review of the therapeutic effects of Reiki. *Journal of Alternative and Complementary Medicine, 15*(11), 1157-1169. doi:10.1089/acm.2009.0036

Vitale, A. (2014). Initiating a Reiki or CAM program in a healthcare organization--Developing a business plan. *Holistic Nursing Practice, 28*(6), 376-380. doi:10.1097/HNP.0000000000000052

Zimmerman, M., McGlinchey, J. B., Chelminski, I., & Young, D. (2006). Diagnosing major depressive disorder V: Applying the DSM-IV exclusion criteria in clinical practice. *Journal of Nervous and Mental Disease, 194*(7), 530-533. doi:10.1097/01.nmd.0000224882.67660.3d

Abstract

Objective: To determine if the utilization of Reiki in the current treatment of depression as a viable option for patient care. **Methods:** The following topics as they relate to Reiki in the treatment of depression are covered: the history of Reiki, what Reiki is, what depression is, current treatments for depression, explanations of non-compliance with current depression treatment, why people seek integrative medicine, whether Reiki provides a significant treatment effect and the utilization of Reiki in the treatment of depression. **Inclusion criteria:** Articles less than 40 years old, Reiki in the effects of depression, Depression. **Exclusion criteria:** Articles not in English. **Conclusion:** Reiki is a viable option as an addition to current treatment of depression but cannot be used as an independent treatment. The integration of Reiki treatment to the healthcare setting will prove difficult in finding a budget plan that could include Reiki masters or integration of Reiki into current nursing programs.

Consent Form for the Digital Publishing of Senior and Graduate Projects on The University of Toledo Digital Repository

I, (print) Tilia Gonzalez, a student of the Physician Assistant program at the University of Toledo, give my permission for my project to be published on The University of Toledo Digital Repository (utdr.utoledo.edu) by the University or a third party it designates. I understand that while the World Wide Web provides public access to this information, I hold the copyright to my project with a default Creative Commons License (Attribution-NonCommercial-NoDerivatives 4.0 International: CC BY-NC-ND 4.0) associated with this file in the digital repository. I also understand that digital publishing constitutes publishing, and some publishers may decline a subsequent publication of this work. Once deposited, a work will not be withdrawn; however, under some circumstances (such as plagiarism, factual inaccuracy, and potential copyright infringement) it may be removed from view.

Name: Tilia Gonzalez

Signature: Tilia Gonzalez

Department: Physician Assistant Studies College: Medicine and Life Sciences

Project Type (Circle one): **Doctoral Project** **Masters Project** **Senior Project**

Complete Title: Reiki in the treatment of depression.

Date Completed: 12/14/16 Date Approved: 12/2016

Date Signed: 12/16/2016