

# Reiki Reduces Burnout Among Community Mental Health Clinicians

Renee M. Rosada, PsyD,<sup>1</sup> Beverly Rubik, PhD,<sup>1</sup> Barbara Mainguy, MA,<sup>2,\*</sup>  
Julie Plummer, BSN, RN,<sup>3</sup> and Lewis Mehl-Madrona, MD, PhD<sup>1-4,\*</sup>

## Abstract

**Background:** Clinicians working in community mental health clinics are at high risk for burnout. Burnout is a problem involving emotional exhaustion, depersonalization, and reduced personal accomplishment. Reiki is a holistic biofield energy therapy beneficial for reducing stress. The purpose of this study was to determine if 30 minutes of healing touch could reduce burnout in community mental health clinicians.

**Methods:** We utilized a crossover design to explore the efficacy of Reiki versus sham Reiki, a pseudo treatment designed to mimic true Reiki, as a means to reduce symptoms of burnout. Subjects were randomized to whether they started with Reiki or sham. The Maslach Burnout Inventory–Human Services Survey (MBI-HSS) and the Measure Your Medical Outcome Profile Version 2 (MYMOP-2) were used as outcome measures. Multilevel modeling was used to represent the relations among variables.

**Results:** Reiki was statistically significantly better than sham Reiki in reducing burnout among community mental health clinicians ( $p=0.011$ ). Reiki was significant in reducing depersonalization ( $p<0.001$ ), but only among single people. Reiki reduced the primary symptom on the MYMOP also only among single people ( $p=0.03$ ).

**Conclusions:** The effects of Reiki were differentiated from sham Reiki. Reiki could be helpful in community mental health settings for the mental health of the practitioners.

## Introduction

**B**URNOUT AMONG HUMAN SERVICE professions is a problem that has not yet adequately been addressed.<sup>1–5</sup> The risk of clinician burnout is particularly high for newer clinicians and for those practicing in community mental health.<sup>2,6–9</sup> Clinicians employed in community mental health settings typically work with clients who struggle with the effects of trauma, chronic mental health problems, and poverty.<sup>4,5,10</sup> This vulnerable population exposes the clinician to seemingly insurmountable issues on a daily basis.<sup>9,11</sup> Most often there are limited resources and training in ways to manage the stress of chronic exposure to these challenges.<sup>12,13</sup> Publicly funded, community-based providers deliver over 70% of psychological care nationwide.<sup>14</sup> Therefore, this population needs researchers further exploring factors influencing the manifestation of burnout and identifying ways of ameliorating this silent threat to mental health providers.

Reiki is a type of holistic energy work, or biofield therapy, that promotes energetic balance.<sup>15</sup> As a holistic practice, Reiki treats the entire person incorporating the totality of one's physical, mental, emotional, and spiritual dimensions. Reiki practitioners act as conduits for Reiki energy, or *universal life-force energy*, to flow through them in order to balance and heal the recipient's energy. As a holistic practice, "it may be that healing needs to happen first at the emotional level, with the releasing of anger, guilt or hatred, or it may be required first at the mental level, releasing negative thoughts, concepts or attitudes, before the physical symptoms can be addressed."<sup>16</sup> The Reiki practitioner does not direct the flow of energy, but rather allows the body's innate intelligence to guide the energy to where it can do the most good.

Research demonstrates stress-reducing benefits and healing properties of Reiki.<sup>17–23</sup> It is noteworthy that there have been mixed results in the literature about the benefits of Reiki; the majority of concern stemming from a lack of

<sup>1</sup>Union Institute & University, Psychology Program, Brattleboro, VT.

<sup>2</sup>Coyote Institute, Augusta and Bangor, ME.

<sup>3</sup>Eastern Maine Medical Center and Acadia Hospital, Bangor, ME.

<sup>4</sup>University of New England College of Osteopathic Medicine, Biddeford, ME.

\*Present affiliation: Coyote Institute, Orono, ME.

randomized controlled trials.<sup>24,25</sup> However, both reviews cited here found promising results from various types of complementary interventions including Reiki and other hands-on approaches.

Hyland<sup>26</sup> suggests that the element of healing in both psychotherapy as well as complementary and alternative medicine is human interaction and the direct effect of the practitioner rather than the treatment, a concept also supported by Catlin and Taylor-Ford.<sup>27</sup> Research demonstrates the benefits of Reiki and other complementary healing practices for reducing stress in nurses.<sup>18,19,21,22,28</sup> One must wonder: Can Reiki reduce stress for community mental health clinicians working in human services, ultimately reducing burnout?

## Materials and Methods

We utilized a repeated-measures, crossover design to determine the effect of Reiki on clinician burnout.<sup>29</sup> Participants were blind to the order of the interventions they received, while the crossover design allowed for all participants to receive both Reiki and placebo interventions during the course of the study (see Table 1).

### Participants

Participants were recruited from community mental health agencies in New England. Eligible participants were at least master's level clinicians who worked a minimum of 30 hours per week with at least 50% of that time in direct service with clients. Individual participants were recruited by convenience sampling based on participation from clinicians employed by the involved organizations. We attended staff meetings at the agencies and presented the study requesting that interested clinicians volunteer. All participants and practitioners gave Informed Consent Form. We recruited 45 participants. Participants were randomly assigned to either group 1 or group 2.

TABLE 1. DEMOGRAPHICS

	Subjects	Mean	SE of mean	Median	SD
Total ( <i>n</i> )	45				
Location					
1	6				
2	5				
3	11				
4	23				
Gender					
Female	33				
Male	12				
Ethnicity					
White	30				
Nonwhite	15				
Yrs clinical experience		15.18	2.10	1	11.56
Yrs in CMH		11.82	1.68	9	9.62
Hrs direct services/wk		25.55	1.76	29	10.09
Total hrs worked/wk		46.82	2.31	45	13.22

CMH, Community Mental Health; SD, standard deviation; SE, standard error.

### Assessment instruments

Maslach Burnout Inventory–Human Services Survey. Newell and MacNeil<sup>5</sup> have suggested that the Maslach Burnout Inventory (MBI) be used in human service agencies to assess for burnout and other trauma-related conditions in their health service providers. In this well-validated 22-item survey,<sup>30–32</sup> respondents rate their frequency of experience in response to each statement on a 7-point Likert scale from “never” to “every day.” The MBI measures three components of burnout, identified as emotional exhaustion (EE), depersonalization (DP), and reduced sense of personal accomplishment (PA). The Maslach Burnout Inventory–Human Services Survey (MBI-HSS) produces three scores and the breakdown of questions per score is as follows: emotional exhaustion (nine items reflecting fatigue or stress), depersonalization (five items referring to feelings of callousness or indifference in regard to recipients or students), and personal accomplishment (eight items about feelings of enthusiasm and effectiveness in working with the people). The administration of this instrument requires no training, can be completed in a group, and takes approximately 10 minutes for participants to complete.

Measure Your Medical Outcome Profile Version 2. The Health Services Research Collaboration of the United Kingdom's Medical Research Council has put together an individualized self-report measure called the Measure Your Medical Outcome Profile (MYMOP).<sup>33</sup> This well-validated patient-centered outcome asks the patient to select two symptoms to monitor—things that matter to him/her.<sup>33</sup> They also monitor two other things: an activity, and general sense of well-being. Medications are monitored as well. The Measure Your Medical Outcome Profile Version 2 (MYMOP-2) was found to be effective as a measure for the benefits of complementary and alternative medicine treatments.<sup>34</sup>

Procedure. Data were collected from participants at baseline, after their first treatment, before their second treatment, and after their second treatment. In addition, each participant completed a background questionnaire to capture basic demographic information. Participating clinicians were volunteers solicited from community mental health agencies in southern Vermont and western Massachusetts.

During the course of the study, we worked with a total of 16 different Reiki practitioners; all were at least level 2, and 6 were Reiki masters. All practitioners were known by us to be ethical and effective in their community. The minimum years of practice were 5 and the range was 5–21 years of practice. The average was 10 years, with a standard deviation of 6.6 years. The practitioners were our colleagues and friends and were asked to participate on that basis.

The researcher recruited both Reiki practitioners and individuals untrained in Reiki to act as sham Reiki practitioners for this project. Sham Reiki providers had no prior training in Reiki practices. All practitioners were instructed by the researchers in performing identical hand positions for a relaxing 30-minute hands-on chair session. The practitioners lightly placed the open palms of their hands on the participants at specific locations correlating with energy centers of the body according to the Usui Reiki tradition.<sup>15</sup> The Reiki and sham Reiki practitioners performed identical

hand positions so as to blind the participants to the intervention they received.

Those participants randomly assigned to group 1 received weekly 30-minute hands-on Reiki treatments over a 6-week period. The group 2 participants received weekly 30-minute hands-on sham Reiki treatments mimicking group 1. The sham Reiki providers were pretending to perform Reiki and maintained mental arithmetic throughout the sessions to assuage positive and/or healing intentions toward the participant. For all sessions, participants were seated in a chair during the Reiki/sham Reiki interventions that occurred onsite at their workplace.

A washout period occurred between treatments in which no interaction occurred between practitioners and participants for at least 6 weeks. Then, participants received 6 weeks of the opposite treatment (crossover); that is, group 1 received sham Reiki sessions and group 2 received Reiki treatments.

**Analysis.** Multilevel modeling<sup>35</sup> was used as implemented in the Mixed Procedure of SPSS, version 22. Linear modeling was used since exploratory data analysis did not uncover any nonlinear relationships. A two-level model was used in which individuals were the level 1 unit. Nested within individuals were repeated outcome measures from four specific time points, treatment order, and demographic information.<sup>35,36</sup> Sidak corrections were made for the level at which to declare statistical significance due to the number of permutations of models that were explored. Random errors were modeled on both levels. The researcher aimed to find the lowest level of the  $-2$  restricted log likelihood while maintaining good theoretical sense. This meant that we were looking to maximize explanation of variability while maintaining intelligibility of the results. The repeated covariance type was AR(1). Type III sum of squares was used for fixed effects. An unstructured covariance matrix was used for random effects. No difference was found between facilities, and so nesting individuals within facilities was not necessary. Interactions among variables were also tested. Multilevel modeling allowed for statistical control of a number of potentially confounding factors, such as people's expectations for which treatment they were receiving, the level of their prior experience with Reiki, their belief about which treatment they had actually received after the treatment was completed, their years working in mental health, their marital status, the number of hours they worked each week, and the like.

In summary, we sought to determine if Reiki had an effect, controlling for order of presentation of sham or actual Reiki, controlling for demographic variables, beliefs about treatment, work-related variables, and random error inherent in the measurements.

## Results

### Participant demographics

The demographics table outlines the composition of the participants in the study (see Table 1). The total participants ( $n=45$ ; 33 females, 12 males) for the study came from 4 participating agencies.

The dependent variable (burnout) was represented by the emotional exhaustion (MBI\_EE), depersonalization (MBI\_DP), and personal accomplishment (MBI\_PA) scores measured using the MBI-HSS.

TABLE 2. MASLACH BURNOUT INVENTORY\_EMOTIONAL EXHAUSTION

	<i>Beta estimate</i>	<i>SE</i>	<i>p</i>	<i>95% CI</i>
Time	-1.64	0.30	<0.001	-2.54, -1.03
Age	1.12	0.10	<0.001	0.91, 1.32
Reiki	-2.03	0.79	0.011	-3.58, -0.47
Order effect	-25.04	10.23	0.016	-45.92, -4.88
Yrs MH experience	-1.67	0.43	<0.001	-2.54, -0.81
Hrs/wk worked	0.96	0.30	0.002	0.36, 1.57

CI, confidence interval; MH, mental health.

### Maslach Burnout Inventory

On MBI\_EE (see Table 2), the intercept was significant, meaning that people started at very different levels of MBI\_EE, an average of  $-39.69$ , when all other variables were held to zero. People significantly improved during the time they were in the study ( $\beta = -1.64$ ,  $SE = 0.30$ ,  $p < 0.001$ ,  $95\% CI = -2.24$  to  $-1.03$ ). Older age was associated with lower rates of improvement ( $\beta = 1.12$ ,  $SE = 0.10$ ,  $p < 0.001$ ,  $95\% CI = 0.91$  to  $1.32$ ), meaning that younger participants improved faster than older participants. Reiki was more effective than sham Reiki ( $\beta = -2.03$ ,  $SE = 0.79$ ,  $p = 0.011$ ,  $95\% CI = -3.58$  to  $-0.47$ ). An order effect was found. Reiki worked better when it was received second after sham Reiki ( $\beta = -25.04$ ,  $SE = 10.23$ ,  $p = 0.016$ ,  $95\% CI = -45.92$  to  $-4.88$ ). People with the most years of experience in mental health had higher rates of improvement during the study ( $\beta = -1.67$ ,  $SE = 0.43$ ,  $p < 0.001$ ,  $95\% CI = -2.54$  to  $-0.81$ ). Working higher numbers of hours per week lowered the rate of improvement ( $\beta = 0.96$ ,  $SE = 0.30$ ,  $p = 0.002$ ,  $95\% CI = 0.36$  to  $1.57$ ).

For MBI\_DP (see Table 3), the intercept was not statistically significant, meaning that there was no difference in where people began on this scale. A statistically significant change occurred in MBI\_DP over the time during which

TABLE 3. MASLACH BURNOUT INVENTORY\_DEPERSONALIZATION

	<i>Beta estimate</i>	<i>SE</i>	<i>p</i>	<i>95% CI</i>
Time	-1.50	0.41	<0.001	-2.31, -0.60
Ethnicity	55.12	4.93	<0.001	45.35, 84.89
Reiki <sup>a</sup>	-63.55	5.16	<0.001	-73.77, -53.34
Order effect	-5.57	0.23	<0.001	-9.23, -1.90
Sham Reiki	-50.27	4.38	<0.001	-58.95, -41.60
No prior experience	-45.52	4.38	<0.001	-49.87, -35.17
Some prior experience	-31.55	3.20	<0.001	-37.88, -25.22
Expecting sham Reiki	31.75	2.36	<0.001	27.08, 36.44
Yrs work experience	-2.61	0.23	<0.001	-3.06, -2.16
Hrs/wk worked	1.90	0.17	<0.001	1.57, 2.24
Yrs MH experience	2.85	0.23	<0.001	2.40, 3.31

<sup>a</sup>Only in single people.

people were in the study (estimate = -1.50, SE = 0.41,  $p < 0.001$ , 95% CI = -2.31 to -0.69). For this variable, a significant interaction with marital status existed. Reiki decreased the MBI\_DP score only for single people (estimate = -63.55, SE = 5.16,  $p < 0.001$ , 95% CI = -73.77 to -53.34). Sham Reiki also had a statistically significant effect on reducing the depersonalization score (estimate = -50.27, SE = 4.38,  $p < 0.001$ , 95% CI = -58.95 to -41.60) but to a lesser extent than actual Reiki. Sham Reiki showed a significant interaction with treatment order, having a greater impact when it occurred first (estimate = -5.57, SE = 0.23,  $p < 0.001$ , 95% CI = -9.23 to -1.90). White ethnicity was associated with a higher MBI\_DP score (estimate = 55.12, SE = 4.93,  $p < 0.001$ , 95% CI = 45.35 to 84.89). Lesser degrees of past experience with Reiki were associated with lower MBI\_DP scores (score 0 had an estimate of -42.52, SE = 4.38,  $p < 0.001$ , 95% CI = -49.87 to -35.17; score 1 had an estimate of -31.55, SE = 3.20,  $p < 0.001$ , 95% CI = -37.88 to -25.22). Expecting that one was receiving sham Reiki was associated with lower rates of improvement on the MBI\_DP score (estimate = 31.76, SE = 2.36,  $p < 0.001$ , 95% CI = 27.08 to 36.44). Greater years of experience was associated with greater rates of reduction in the MBI\_DP score (estimate = -2.61, SE = 0.23,  $p < 0.001$ , 95% CI = -3.06 to -2.16). Greater hours of work per week was associated with higher MBI\_DP scores (estimate = 1.90, SE = 0.17,  $p < 0.001$ , 95% CI = 1.57 to 2.24). The greater the years in community mental health, the higher the MBI\_DP score (estimate = 2.85, SE = 0.23,  $p < 0.001$ , 95% CI = 2.40 to 3.31).

MBI\_PA (see Table 4) improved over the time the person spent in the study (estimate = 0.72, SE = 0.19,  $p < 0.001$ , 95% CI = 0.34 to 1.10). An interaction effect occurred between Reiki versus sham Reiki and treatment order. Reiki was statistically significantly different from sham Reiki only when it was received first (estimate = 25.62, SE = 6.51,  $p < 0.001$ , 95% CI = 12.57 to 28.67). Being older was associated with higher MBI\_PA scores (estimate = 0.33, SE = 0.06,  $p < 0.001$ , 95% CI = 0.20 to 0.46). Being white was associated with a higher MBI\_PA score (estimate = 23.06, SE = 6.78,  $p < 0.001$ , 95% CI = 9.46 to 36.66). Being partnered was associated with a higher MBI\_PA score (estimate = 37.34, SE = 7.86,  $p < 0.001$ , 95% CI = 21.57 to 53.11). Having no past experience with Reiki was associated with a lower rate of change in the MBI\_PA score (estimate = -16.42, SE = 4.76,  $p < 0.001$ , 95% CI = -25.97 to -21.57). Total hours worked per week was associated

TABLE 4. MASLACH BURNOUT INVENTORY\_PERSONAL ACCOMPLISHMENT

	Beta estimate	SE	p	95% CI
Time	0.72	0.19	<0.001	0.34, 1.10
Order effect	25.62	6.51	<0.001	12.57, 28.67
Age	0.33	0.06	<0.001	0.20, 0.46
Ethnicity	23.06	6.78	<0.001	9.46, 36.66
Partner status	37.34	7.86	<0.001	21.57, 53.11
No prior experience	-16.42	4.76	0.001	-25.97, -53.11
Hrs/wk worked	-0.40	0.19	0.042	-0.78, -0.02

TABLE 5. MEASURE YOUR MEDICAL OUTCOME PROFILE VERSION 1

	Beta estimate	SE	p	95% CI
Time	-0.26	0.07	<0.001	-0.40, -0.13
Reiki <sup>a</sup>	-0.89	0.38	<0.001	-1.64, -0.14
Some prior experience	0.77	0.35	0.030	0.07, 1.46
Hrs/wk worked	-0.06	0.07	<0.001	-0.09, -0.03
Ethnicity	-2.54	0.35	<0.001	-3.23, -1.86

<sup>a</sup>Only in single people.

with lower rates of change in the PA Scores (estimate = -0.40, SE = 0.19,  $p = 0.042$ , 95% CI = -0.78 to -0.02).

#### MYMOP-2

For the MYMOP-2 variables, the structure of the data was better modeled by a scaled identity matrix for both fixed and random effects.

MYMOP1. For the rating of the most bothersome symptom (see Table 5), change did occur over time (estimate = -0.26, SE = 0.07,  $p < 0.001$ , 95% CI = -0.40 to -0.13). Reiki was associated with a statistically significant improvement only for single people (estimate = -0.89, SE = 0.38,  $p < 0.001$ , 95% CI = -1.64 to -0.14). Past experience with Reiki (score 1) was associated with a higher symptom rating (estimate = 0.77, SE = 0.35,  $p = 0.03$ , 95% CI = 0.07 to 1.46). Total hours worked was associated with lower ratings of symptom severity (estimate = -0.06, SE = 0.07,  $p < 0.001$ , 95% CI = -0.09 to -0.03). Nonwhites had lower symptom scores than whites (estimate = -2.54, SE = 0.35,  $p < 0.001$ , 95% CI = -3.23 to -1.86).

MYMOP2. The MYMOP2 score that consisted of ratings for the second most bothersome symptom (see Table 6) also improved over time (estimate = -0.52, SE = 0.10,  $p < 0.001$ , 95% CI = -0.72 to -0.32). Reiki had a statistically significant effect only for people who had no previous experience with Reiki (estimate = -1.18, SE = 0.47,  $p = 0.013$ , 95% CI = -2.11 to -0.26). Believing that one had not received Reiki was associated with improvement (estimate = -1.57, SE = 0.34,  $p < 0.001$ , 95% CI = -2.23 to -0.90). Total years of experience in counseling was associated with lower MYMOP2 scores (estimate = -0.05, SE = 0.02,

TABLE 6. MEASURE YOUR MEDICAL OUTCOME PROFILE VERSION 2

	Beta estimate	SE	p	95% CI
Time	-0.52	0.10	<0.001	-0.72, -0.32
No prior experience	-1.18	0.47	0.013	-2.11, -0.26
Expecting sham Reiki	-1.57	0.34	<0.001	-2.23, -0.90
Yrs work experience	-0.05	0.02	0.013	-0.09, -0.01
Hrs/wk worked	0.04	-0.02	0.027	0.01, 0.08

TABLE 7. MEASURE YOUR MEDICAL OUTCOME PROFILE VERSION 3

	Beta estimate	SE	p	95% CI
Yrs work experience	-0.46	0.26	0.005	-1.09, -0.16
Hrs/wk worked	0.07	0.01	0.002	0.03, 0.10
Sham Reiki <sup>a</sup>	2.48	0.74	0.002	0.98, 3.98
Reiki <sup>a</sup>	0.98	0.37	0.014	0.22, 1.75
Partnered	-2.87	0.70	<0.001	-4.28, -1.45
No prior experience	-1.83	0.36	0.005	-2.79, -0.87
Some prior experience	-2.04	0.42	0.023	-3.48, -0.59

<sup>a</sup>Only in single people.

$p=0.013$ , 95% CI = -0.09 to -0.01). Total hours worked per week was associated with higher symptom ratings (estimate = 0.04, SE = 0.02,  $p=0.027$ , 95% CI = 0.005 to 0.08).

**MYMOP3.** The MYMOP3 measured improvement in activities that were being restricted or curtailed by the symptoms (see Table 7). This did not change statistically significantly over time. Overall, having more years of experience was associated with less restriction (estimate = -0.46, SE = 0.26,  $p=0.005$ , 95% CI = -1.09 to 0.16). Working more hours per week was associated with more restrictions (estimate = 0.07, SE = 0.01,  $p=0.002$ , 95% CI = 0.034 to 0.101). However, both sham Reiki and Reiki were associated with higher restrictions for single people (sham: estimate = 2.48, SE = 0.74,  $p=0.002$ , 95% CI = 0.98 to 3.98; Reiki: estimate = 0.98, SE = 0.37,  $p=0.014$ , 95% CI = 0.22 to 1.75). Reiki was associated with improvement for partnered people (code 2) (estimate = -2.87, SE = 0.70,  $p<0.001$ , 95% CI = -4.28 to -1.45). People with no past experience with Reiki receiving sham Reiki tended to improve (estimate = -1.83, SE = 0.36,  $p=0.005$ , 95% CI = -2.79 to -0.87) as did people who had previously received Reiki (estimate = -2.04, SE = 0.42,  $p=0.023$ , 95% CI = -3.48 to -0.59). People attuned in Reiki did not improve with sham Reiki.

**MYMOP4.** The MYMOP4 is a measure of quality of life (see Table 8). This improved over time (estimate = -0.25, SE = 0.09,  $p=0.005$ , 95% CI = -0.42 to -0.08). Total hours worked was associated with a lower quality of life (estimate = 0.03, SE = 0.01,  $p<0.001$ , 95% CI = 0.01 to 0.04). Sham Reiki among people with no experience with Reiki

TABLE 8. MEASURE YOUR MEDICAL OUTCOME PROFILE VERSION 4

	Beta estimate	SE	p	95% CI
Time	-0.25	0.09	0.005	-0.42, -0.08
Hrs/wk worked	0.03	0.01	<0.001	0.01, 0.04
No prior experience	1.47	0.33	<0.001	0.82, 2.18
Some prior experience	1.36	0.30	<0.001	0.76, 1.96

was associated with worsening of quality of life (estimate = 1.47, SE = 0.33,  $p<0.001$ , 95% CI = 0.82 to 2.18). Similarly, people who had previously received some Reiki were also associated with a worsening quality of life when receiving sham Reiki (estimate = 1.36, SE = 0.30,  $p<0.001$ , 95% CI = 0.76 to 1.96).

## Discussion

The primary hypothesis that Reiki will reduce a clinician's experience of burnout symptoms was confirmed. This was shown by reductions in areas of emotional exhaustion and depersonalization symptoms for burnout and in improvements in personal accomplishment as measured by the MBI. Several secondary hypotheses were also supported. For example, the more hours a clinician works each week correlates to higher levels of reported burnout symptoms. Younger participants improved more overall than older participants. Single people benefited from participating in the study more than did partnered people. In keeping with current research, clinicians with more experience endorse higher levels of personal accomplishment,<sup>3,4</sup> which is a protective factor against burnout symptoms. This study also found that white participants reported higher experiences of personal accomplishment than nonwhite participants.

Overall, the results of this study support the primary hypothesis: 30 minutes of weekly healing touch for 6 weeks reduces burnout symptoms in community mental health clinicians. Furthermore, Reiki performed better than sham Reiki in reducing symptoms of burnout.

## Limitations

A crossover design runs the risk of a carryover effect, meaning that the effect of phase 1 may "carry over" into the phase 2 treatment condition. One way to ameliorate this carryover effect was to imbed a washout period between phases. The washout period appears to have been effective in preventing a carryover effect since the first treatment was more effective overall than the second treatment, regardless of the intervention. Rather than a carryover effect, this may indicate a novelty effect. The first intervention, whether it was real Reiki or sham Reiki, resulted in decreased reports of burnout.

Another important limitation of this study to consider is the potential for the Hawthorne effect. Participants may report an improvement in symptoms of burnout as a result of choosing to participate in a study targeting relaxation with a goal of reducing burnout. This may have influenced their perceived benefit or inflated their experience of the interventions.

Additionally, due to the length of the study and the commitment required from the participants working in a high-stress environment, it was likely that there would be a high dropout rate, thereby limiting the implementation of the crossover design. Two participants dropped out of the study before completion. One left the study after participating in only the first session (Reiki). She decided that she could not commit her time (30 minutes a week) for this project due to her busy caseload. The other participant left the study after completing phase 1. She was unable to continue participating in phase 2 after the washout period due to difficulties in her personal life. Their data were not included in the analysis.

### Future research

The crossover design provided each participant with both interventions (Reiki and sham Reiki), which increased the power, showing an effect among a small sample. Repeating the study with a larger sample could elicit more information about the benefits of hands-on stress-reducing interventions in the workplace.

The findings show that the initial phase of the intervention, regardless of whether it was Reiki or sham Reiki, had the greatest effect. A future study design with three randomly assigned groups (group 1: Reiki; group 2: sham Reiki; group 3 control–wait list) might produce evidence for the importance of community mental health agencies bringing hands-on stress-reducing interventions into the workplace. Perhaps a study with a focus on understanding employee productivity, as it correlates with reducing symptoms of burnout, would entice employers into developing programs to provide stress-reducing interventions for their employees. Considering the high operational costs associated with training new employees, it would be interesting for researchers to track possible changes in agency morale or potential improvements in employee retention rates when agencies incorporate stress-reducing interventions for their employees.

The results of this study show that Reiki has an effect on reducing stress, particularly for unpartnered clinicians. One might speculate that partnered people receive positive, gentle touch in their intimate relationships and therefore the measurable benefits of hands-on healing are less dramatic. Future research could focus more specifically on the differences between single and partnered people who are employed in stressful careers, gathering more information about their experience and/or frequency of touch in their lives. This could lead to a deeper understanding of how important a role touch plays in reducing stress.

The specific benefits of Reiki are difficult to pinpoint when there are so many factors mediating a person's experience. More randomized controlled trials designed to understand how Reiki reduces stress could provide evidence for implementing Reiki and other stress-reducing practices for employees working in community mental health clinics. However, it is exciting to report that the primary hypothesis of this proposed research was supported: Reiki had a positive effect on reducing burnout in community mental health clinicians.

### Author Disclosure Statement

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Address correspondence to:  
*Lewis Mehl-Madrona, MD, PhD*  
*Coyote Institute*  
*P.O. Box 39*  
*Orono, ME 04473*  
 E-mail: mehlmadrona@gmail.com