

Original Research

Assessing the Ability of Reiki Practitioners to Detect Human Energy FieldsGabriel Moss¹, Gi-Ming Wang¹, Bethanny Bristol¹, Hasina Momotaz¹, Ming Li¹, Richard T. Lee^{1, 2, 3, *}

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Received: May 05, 2022**Accepted:** July 28, 2022**Published:** August 04, 2022**Abstract**

Reiki is a form of energy healing that has gained popularity in the United States, but there remains skepticism about its scientific validity. This study examines the ability of Reiki practitioners (RP) to detect human energy fields (HEF). Volunteer RP were asked to identify the location of a human hand under blinded conditions for a total of 20 trials. Four potential options existed for subjects (right, left, both, or neither); thus, random chance would predict a success rate of 25%. A success rate of >40% was considered significant, and these individuals would be asked to conduct another 40 trials. A control group of non-energy trained volunteers were also asked to complete the same task. A total of 67, mainly female (91%), RP participated in this study. The majority were Reiki Masters (90%) and practiced Reiki an average of 11.4 years (± 6.2 , 1.5-24). They had a mean success rate of detecting HEF of 25.4%, (median 5 ± 1.8 , 1-10), while the control group ($n = 25$) had an average success rate of 24.2% (median 5 ± 1.6 , 2-8). One subject met criteria for repeat testing for a final 42% accuracy rate. Level of training (masters versus level II), years of experience (>10), age (>60), female sex, handedness, or time



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to detect HEF (average >20 sec) did not correlate to an increase in accuracy for RP. RPs' ability to HEF was equivalent to chance and similar to the control group of non-energy trained volunteers. The mechanism by which reiki provides benefits to patients is still unknown, and while this study indicates that it may not be through the manipulation of energy fields, alternate explanations include physical touch and healing touch, both of which should be explored in future research.

Keywords

Complementary and alternative medicine; reiki; energy healing

1. Introduction

According to the National Institutes of Health National Center for Complementary and Integrative Health (NCCIH), Reiki is considered a complementary medicine and is a type of energy healing therapy [1]. It dates back thousands of years, when it was developed as a secret method for shamans to heal, provide spiritual guidance, and foster interactions with nature. Reiki, for centuries, had been passed through generations without being revealed to the public, until 1922 when it was formalized and publicized by Dr. Mikao Usui. He discovered Reiki while fasting atop Mt. Kumara and decided that its power must be shared with the world, which led him to open a school in Tokyo. It was one of his patients, Hawayo Takata, who first brought Reiki to the United States in 1938, and it was her disciples that made Reiki a global phenomenon [2].

Reiki derives its name from the Japanese words "rei," meaning universal and "ki," meaning energy; thus, reiki is the universal energy. It is believed that the universal energy connects the Great Universe (Mother Nature) to its individual organisms and is everything from the ability to heal, to the power to live with vigor. This "life energy," such as the energy humans emit, is known by other names such as aura, vitality, and life magnetism. The technique of Reiki allows the practitioner to heal by providing a channel for the universal energy to flow through. According to Hiroshi Doi, the modern day leader of Reiki, no training is necessary once the pathway of reiki is opened by attunement [3]. Additionally, the ability is never lost, the power increases with practice, no concentration is necessary (the process is automatic), no bad energy is carried, and it is effective regardless of the individuals' beliefs. The practice itself involves a practitioner either holding their hands above or gently placing them on the patient so that the energy may travel into them. Reiki theory states that the flow of energy within the body can be disrupted and cause blockages, which can produce energetic imbalances that are the cause of physical ailments and illnesses. Reiki treatment opens these blocked passageways that carry energy, called chakras, and allows healing to occur. A common component of Reiki practice deals with detecting the "life energy," or human energy fields (HEF) through byosen scanning in order to detect energy imbalances so that the Reiki therapy may be directed to these areas [4]. Thus, RP are often trained to feel a person's energy and disruptions in them, so that they can direct the energy towards these blockages. While this is the most common practice, not all RP are trained the same, and therefore may not practice under this philosophy.

Energy healing therapies are a controversial part of complementary medicine, despite their increasing popularity in clinical settings. A survey in 2004 by the American Hospital Association reported that 25% of responding hospitals provided therapeutic touch inpatient services and 30% provided outpatient services [5]. Even though healing touch and energy healing therapies are found throughout U.S. hospitals, there is a lack of scientific data showing their efficacy. The NCCIH website states that “Reiki hasn’t been clearly shown to be useful for any health-related purpose” in large part due to the lack of high-quality clinical studies. One often cited study published in 1997 questioned the validity of therapeutic touch, another type of energy healing. Rosa et al. found that practitioners of therapeutic touch were not able to detect HEF using a simple study design [6]. Conversely, a literature review looking at clinical studies involving reiki found support for Reiki having benefits beyond placebo [7]. Additional literature reviews found evidence that reiki and other energy healing techniques can reduce pain [8, 9]. We sought to investigate a specific component of the theory of Reiki by determining if Reiki practitioners are able to detect the HEF of a human hand via a similar research design to that of Rosa et al.’s paper on therapeutic touch.

2. Methods

The study design was based on the study of therapeutic touch practitioners by Rosa et al [6]. Before finalizing our experimental design, we discussed with six Reiki masters about our study design - one of whom is considered to be one of the most senior practitioners in Northeast Ohio and another is considered a national leader in Reiki. They all felt that the study design was appropriate for the scientific question, and one master RP stated that a RP should be able to detect the difference between “a rock and a human hand”. To be eligible for the study, practitioners had to be at least 18 years old, fluent in English, provide an informed consent, have completed level two or master level training, provide documentation of their training completion, had to be practicing for at least one year, performed Reiki on at least 100 people, and must have practiced Reiki within the last thirty days. The protocol was approved by the Case Western Reserve University IRB.

Practitioners were recruited from June through August of 2017 through flyers and emails sent to local Reiki centers and local practitioners registered to the International Association of Reiki Practitioners. They were then screened for eligibility. A control group consisting of 25 non-Reiki practitioners were recruited through a local institution. Upon arrival, practitioners received a pre-study questionnaire, which covered date of birth, ethnicity, gender, dominant hand, when Reiki training commenced, organization that completed the training, date of most recent training completion, level of Reiki achievement, approximate date when the practitioner began providing Reiki treatments, whether they are a current member of a Reiki organization, and if so which and for how long, how long they have been practicing, how many people they treat with Reiki monthly, price per session, duration of an average session, and their ability to detect HEF compared to other practitioners. The non-Reiki practitioner control group received pre-and post-study questionnaires similar to those of the Reiki practitioners. These questionnaires were developed for this study (Supplemental File 1).

Following the session, practitioners completed a post-study questionnaire, which asked difficulty in detecting HEF, comfort during the study procedures, their accuracy, the speed of the trials, overall experience, opinion of the study design, and recommendations for changes. Following the survey, the practitioners received \$100 and non-practitioners received \$25 for their time.

The apparatus design was based on that of Rosa et al. and was custom built for this study. We used a 36.0 in. × 36.0 in. plywood barrier in addition to two 36.0 in. × 24.0 in. plywood flaps to shield the practitioner from seeing the researcher (Figure 1). Within the plywood barrier, we utilized two circular, felt-lined holes, each 5.9 inches in diameter. Black linen cloth hung from the top of the circular holes to prevent the practitioner from seeing to the other side. We placed a wooden box measuring 36 in. × 18 in. on the other side of the barrier, which we designed to simulate a Reiki session. The box had a top that was 0.2 in. thick and had two large 9.4 in. × 9.4 in. rectangular cut outs. A piece of wood separated the left and right side so participants' hands could not touch during the session. The cut outs were covered with 2 layers of black cotton cloth so that the Reiki practitioner would not be able to feel the hand below the cloth. The cotton cloth simulated clothing, as most practitioners perform Reiki on clothed patients.



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Figure 1 Illustration of the testing apparatus.

Participants completed the study in a quiet, secure room. Participants were encouraged to take time to prepare as if they were performing a normal Reiki session. Once they were ready, participants placed their arms through the circular cut outs in the barrier and either rested or hovered their hands, palms down, above the black cloth covering the rectangular cutouts on the box. Once the practitioner confirmed that they were ready, the trials began. Twenty timed trials took place. A random number generator determined which hand (real or prosthetic), would be under which of the practitioner's hands (right or left). The practitioner was informed of the four possible options: 1) right hand, 2) left hand, 3) both hands, or 4) neither hand. The researcher asked the participant to identify the location of the human energy field(s) coming from the human hand(s). If no human hand was placed under the RP's hand(s), then a prosthetic hand was placed instead. The researchers warmed the prosthetic hands using heating pads to simulate a human hand so that the participant would not be able to detect changes in temperature when attempting to determine

where the human energy field was located. If the practitioner correctly identified the location of the human hand >8 out of 20 trials, this was considered statistically significant, and they were invited back to repeat the process for an additional 40 trials.

3. Statistical Analysis

Descriptive statistics were used to summarize the characteristics and HEF successful rates of participants by group (e.g. RP and Control). ANOVA was used to test for differences in age, and Chi-square test was used for differences in sex and handedness, with $p < 0.05$ as a significance threshold. The comparison of successful rates of detecting HEF between RP group and Control group for overall, right-handedness, and left-handedness, as well as that between RP levels (2 and 3) and between RP's handedness (right-handedness and left-handedness) were performed using Chi-square test. The comparison of detecting HEF correctly (>25%) between Reiki Masters and non-Reiki Masters was also performed using Fisher's test. All analyses of this study were performed using R (v3.6.2) and its libraries.

4. Results

A total of 82 individuals contacted our center to participate in the study. Fifteen individuals were ineligible for the following reasons: limited experience as a RP (8), less than 1 year as a certified RP (3), unable to provide Reiki certifications (2), already discussed the study design with the RP (1) and did not agree with the study (1). Eventually, 67 RP participated in and completed the study. The RP had a mean age of 60.3 (± 11.9 , range 30-79) and most were female (91%). The majority were Reiki Masters (90%) and had practiced Reiki an average of 11.4 years (± 6.2 , 1.5-24) (Table 1). RP were actively treating patients with an average of 19.2 (± 23.4 , range 1-100) patients the previous month. Approximately 28.8% self-reported having above average ability to detect HEF while 59.6% reported having an average ability.

Table 1 Demographics.

	Reiki Practitioners (n = 67)	Control (n = 25)	p-value
Age	60.3 \pm 11.9 (range 30-79)	37.5 \pm 11.2 (range 25-62)	<0.001
Female	61 (91%)	19 (76%)	0.12
Right-handed	59 (88%)	23 (92%)	0.87
Years of Reiki Practice	11.4 (± 6.2)		
Reiki Training			
II	7 (10%)		
III	60 (90%)		
Number of patients treated last month	19.2 (± 23.4 , range 1-100)		

All RP were able to complete 20 trials for a total of 1,340 individual trials with each taking an average of 18.7 seconds (± 20.1 , 3-190). RP had a mean success rate of detecting HEF at 25.4%,

(median 5 ± 1.8, 1-10). The control group of 25 non-energy trained volunteers had an average success rate of 24.2% (median 5 ± 1.6, 2-8), which was not statistically different (p = 0.65). One subject correctly detected the HEF in 50% of the trials and met criteria for repeat testing for a total accuracy rate of 25/60 or 41.7%. No significant difference in success rate was found between level II and III (master) RP, 20.0% vs. 26.0% (p = 0.15) (Table 2). Reiki Masters were more likely to detect HEF correctly (>25%) than non-Reiki Masters (41.7% vs. 0%, p = 0.03). Age (>60), handedness, years of experience (>10), average time to complete the task (>20 seconds), self-reported ability, how easy they felt it was to detect HEF, and how frequently they believed they detected HEF had no correlation to having >5 correct responses. In regard to handedness, practitioners' accuracy rate for the left and right hands were 49.0% vs. 49.6%, p = 0.76.

Table 2 Human Energy Fields Detection Results.

Category	Reiki Practitioners (n = 67)	Control (n = 25)	p-value
Overall	25.4%	24.2%	0.65
Right Hand	49.0%	52.6%	0.18
Left Hand	49.6%	49.6%	>0.99
Reiki Practitioners:			0.15
Level II	20.0%		
Level III	26.0%		

Over half of participants (58%) reported feeling very comfortable or comfortable during the test and 19% reported feeling uncomfortable. Nearly a quarter of RP (23%) felt they could very easily or easily detect the HEF during the test while 42% reported feeling neutral about their ability. When asked how frequently they were able to detect the researcher's hand(s), 29% reported all the time or most of the time, while about half (53%) reported some of the time. Only 6 RP felt they needed more time to detect the HEF. RPs' self-report ability to detect HEF did not correlate with an increased ability to detect HEF.

5. Discussion

Reiki practitioners were able to detect where the HEF was located at a rate of 25.2%, which is in the range of random chance. One person was able to detect the location of the HEF at a higher rate than pure chance, and therefore may have some ability to detect HEF. This ability never exceeded 50% and thus remained limited at best. The ability to detect HEF does not necessarily correlate to the ability to channel energy because these are independent skills, though having one skill theoretically should affect the other. For example, if an interventional cardiologist was not able to use fluoroscopy during percutaneous transluminal coronary angioplasty (PTCA), the physician would not be able to identify which coronary artery was narrowed and thus may not provide the procedure to the proper artery. Not being able to use the fluoroscopy does not mean the cardiologist is not able to perform angioplasty, but it would make one question whether he is able to provide the PTCA in an effective manner. Similarly, a Reiki practitioner that is unable to detect HEF may still be able to channel energy, but this may not be done in as an effective of a manner, because they would not know where to channel the energy. While knowing where to channel energy is not essential to Reiki,

those practitioners who can, are theoretically more effective at treating patients because they are then able to target the blocked chakras. Thus, while the Reiki practitioners included in this study may still be able to channel energy and perform Reiki, their inability to detect the HEF suggests that they are unable to determine where the blocked areas are located, and therefore may have more of a challenge focusing the energy into the affected locations. This does not directly indicate if Reiki is ineffective, but rather is an indication that Reiki practitioners are unable to detect HEF. The aim of this study was to assess practitioners' ability to detect HEF, not their ability to channel energy, which we are unable to test at this present time.

This study found that Reiki practitioners are not able to detect HEF, but Reiki may still be beneficial due to the positive effects of human touch. This study focused on whether Reiki practitioners can detect human energy fields and did not test its benefits to patients. Previous studies have found a correlation between human touch and pain relief. For example, researchers have found that gentle touch has a positive effect on reducing pain in premature newborns [10]. This is in concurrence with a study which found that empathy between individuals could explain the effects of social touch on pain alleviation [11]. Grewen et al., found that contact with a partner increases the concentration of plasma oxytocin, a hormone that increases empathy and generosity [12]. Thus, while the theory of Reiki and energy healing is unclear, the presence of another human being and the effects of their touch may explain why Reiki patients may report benefit from treatment. Studies have found potential positive benefits, such as a study conducted with cancer patients found that Reiki can reduce stress, anxiety, and pain, while increasing overall quality of life to an even greater extent than yoga and massage [13]. Thus, while the mechanism of Reiki remains unclear, it may have benefits for patients.

Of note, most studies for Reiki have compared this therapy to a control group or another therapy rather than a placebo (sham), thus high quality clinical trials are limited. A meta-analysis by Dogan et al., focusing on placebo controlled randomized controlled trials was associated with improved pain management [8]. The study by McManus identified 13 randomized controlled trials with a placebo arm, but only 11 of these studies were conducted in humans. He found that six human randomized control trials of Reiki therapy showed positive results and the other five with negative findings [14-23]. We were able to identify an additional 4 placebo controlled randomized controlled trials of Reiki, and two found statistically significant beneficial findings while the other two found no difference between Reiki and placebo Reiki [24-27]. Thus, the results of placebo controlled randomized controlled trials remains mixed. A systematic review of randomized controlled trials of Reiki is beyond the scope of this study, but should be considered in the future.

While our study was an improvement on previous studies, it still had some limitations. We had a relatively small sample size and all participants came from Northeast Ohio, and therefore do not necessarily represent the national or global population. Additionally, the room and environment did not perfectly recreate a true Reiki session but given the purpose of the study this would have been difficult to accomplish without revealing a real person and a mannequin.

6. Conclusions

In summary, this study indicates RP are not able to reliably detect HEF, and thus the potential benefits of Reiki may come from other mechanisms such as the benefits of physical touch or practitioner-patient interactions.

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Author Contributions

Gabriel Moss: conceptualization, formal analysis, investigation, methodology, writing - original draft, and writing - review and editing; Gi-Ming Wang: formal analysis, methodology, writing - review and editing; Bethanny Bristol: investigation, writing - review and editing; Hasina Momotaz: formal analysis, methodology, writing - review and editing; Ming Li: formal analysis, methodology, writing - review and editing, Richard T. Lee: conceptualization, formal analysis, funding acquisition, investigation, methodology, project administration, resources, supervision, writing - original draft, and writing - review and editing.

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Competing Interests

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Additional Materials

The following additional material are uploaded at the page of this paper.

1. Supplemental File 1

References

1. Reiki [Internet]. Bethesda: National Center for Complementary and Integrative Health; 2018. Available from: <https://nccih.nih.gov/health/reiki-info>.
2. Usui M. The original reiki-handbook of Dr. Mikao Usui. Twin Lakes: Lotus Press; 1999.
3. Doi H. A modern reiki method for healing. Southfield: Vision Publications; 2014.
4. Petter FA. Understanding Byosen Scanning, Part II [Internet]. Available from: <https://www.reiki.org/articles/understanding-byosen-scanning-part-ii>.
5. Horrigan B. Growing number of hospitals offer complementary and alternative medicine. *Explore*. 2006; 2: 482-485.
6. Rosa L, Rosa E, Sarner L, Barrett S. A close look at therapeutic touch. *JAMA*. 1998; 279: 1005-1010.
7. McManus DE. Reiki is better than placebo and has broad potential as a complementary health therapy. *J Evid Based Complement Altern Med*. 2017; 22: 1051-1057.

8. Demir Doğan M. The effect of reiki on pain: A meta-analysis. *Complement Ther Clin Pract.* 2018; 31: 384-387.
9. Bao Y, Kong X, Yang L, Liu R, Shi Z, Li W, et al. Complementary and alternative medicine for cancer pain: An overview of systematic reviews. *Evid Based Complement Alternat Med.* 2014; 2014: 170396.
10. Herrington CJ, Chiodo LM. Human touch effectively and safely reduces pain in the newborn intensive care unit. *Pain Manag Nurs.* 2014; 15: 107-115.
11. Goldstein P, Shamay-Tsoory SG, Yellinek S, Weissman-Fogel I. Empathy predicts an experimental pain reduction during touch. *J Pain.* 2016; 17: 1049-1057.
12. Grewen KM, Girdler SS, Amico J, Light KC. Effects of partner support on resting oxytocin, cortisol, norepinephrine, and blood pressure before and after warm partner contact. *Psychosom Med.* 2005; 67: 531-538.
13. Rosenbaum MS, Velde J. The effects of yoga, massage, and reiki on patient well-being at a cancer resource center. *Clin J Oncol Nurs.* 2016; 20: E77-81.
14. Alarcão Z, Fonseca JRS. The effect of reiki therapy on quality of life of patients with blood cancer: Results from a randomized controlled trial. *Eur J Integr Med.* 2016; 8: 239-249.
15. Dressen LJ, Singg S. Effects of reiki on pain and selected affective and personality variables of chronically ill patients. *Subtle Energ Energy Med.* 1998; 9: 51-82.
16. Salles LF, Vannucci L, Salles A, da Silva MJP. The effect of reiki on blood hypertension. *Acta Paulista de Enfermagem.* 2014; 27: 479-484.
17. Erdogan Z, Cinar S. The effect of reiki on depression in elderly people living in nursing home. *Indian J Tradit Know.* 2016; 15: 35-40.
18. Witte D, Dundes L. Harnessing life energy or wishful thinking? Reiki, placebo reiki, meditation, and music. *Altern Complement Ther.* 2001; 7: 304-309.
19. Bourque AL, Sullivan ME, Winter MR. Reiki as a pain management adjunct in screening colonoscopy. *Gastroenterol Nurs.* 2012; 35: 308-312.
20. Gillespie EA, Gillespie BW, Stevens MJ. Painful diabetic neuropathy: Impact of an alternative approach. *Diabetes Care.* 2007; 30: 999-1001.
21. Kundu A, Lin Y, Oron AP, Doorenbos AZ. Reiki therapy for postoperative oral pain in pediatric patients: Pilot data from a double-blind, randomized clinical trial. *Complement Ther Clin Pract.* 2014; 20: 21-25.
22. Catlin A, Taylor-Ford RL. Investigation of standard care versus sham reiki placebo versus actual reiki therapy to enhance comfort and well-being in a chemotherapy infusion center. *Oncol Nurs Forum.* 2011; 38: E212-E220.
23. Assefi N, Bogart A, Goldberg J, Buchwald D. Reiki for the treatment of fibromyalgia: A randomized controlled trial. *J Altern Complement Med.* 2008; 14: 1115-1122.
24. Shiflett SC, Nayak S, Bid C, Miles P, Agostinelli S. Effect of reiki treatments on functional recovery in patients in poststroke rehabilitation: A pilot study. *J Altern Complement Med.* 2002; 8: 755-763.
25. Bat N. The effects of reiki on heart rate, blood pressure, body temperature, and stress levels: A pilot randomized, double-blinded, and placebo-controlled study. *Complement Ther Clin Pract.* 2021; 43: 101328.
26. Mackay N, Hansen S, McFarlane O. Autonomic nervous system changes during reiki treatment: A preliminary study. *J Altern Complement Med.* 2004; 10: 1077-1081.

27. Shore ALG. Long-term effects of energetic healing on symptoms of psychological depression and self-perceived stress. *Altern Ther Health Med*. 2004; 10: 42-48.



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